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Best Practices in Schizophrenia Treatment (BeST) Center

Ohio Coordinating Center for Integrating Care

Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio

- Models of Integrated Care
- Hands-on Tools
- Lessons Learned

Produced by the Best Practices in Schizophrenia Treatment (BeST) Center, Department of Psychiatry, Northeastern Ohio Universities Colleges of Medicine and Pharmacy and the Ohio Coordinating Center for Integrated Care

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BeST Center
Best Practices in Schizophrenia Treatment (BeST) Center

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Ohio Coordinating Center for Integrating Care

Tips for Using the *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio*

The *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio* is designed to assist community leaders and behavioral health and primary care service providers in developing and implementing action plans to improve health outcomes, efficiency and access to care. The implementation guide is not a comprehensive "how to" manual, rather, it is a living document. It is intended to be used in conjunction with integrated care consultants, resources, legal counsel and billing/financial experts who can advise organizational leaders about how to best address the unique needs of the individuals and communities they serve.

The implementation guide includes an overview of integrated care, tools, examples and lessons learned. Users of this guide are encouraged to pick and choose the resources and tools that they feel will be most beneficial for the particular needs of their organizations and the populations they serve. The guide has been designed to allow users to navigate between modules and tools easily. By placing the cursor over underlined text and simultaneously pressing the Control (Ctrl) key and clicking the mouse, users can be taken directly to the module, tool or resource they wish to review.

Module One, Implementation Guide Overview, summarizes the key points within each module, and we suggest reviewing this module as a good starting place for exploring integrated care program development. In addition, users will find a list of tools within each module in the Table of Contents. Furthermore, the guide is provided in both PDF and Microsoft Word 2007 formats, so that users have the original tools available to use with planning team members.

About the Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio

The *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio* is published by the Best Practices in Schizophrenia Treatment (BeST) Center in the Department of Psychiatry at the Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM) and the Ohio Coordinating Center for Integrating Care in July 2010.

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Executive Summary

The *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio* includes an overview of integrated care, tools, examples and lessons learned. It focuses on adults who receive services from the public behavioral health system and is a living document. It is not intended to be a comprehensive "how to" manual that provides all the answers to an organization's questions about integrating care. It is an organizational framework for program development that is intended to be used in conjunction with integrated care consultants, resources, legal counsel and billing / financial experts.

The premature death rate of individuals with severe mental illness is significantly higher than the mortality rates for members of the general population. Sadly, many individuals with severe mental illness die from preventable illnesses and conditions – conditions that might have been treatable if these individuals had received primary care services. The current U.S. health care system and its associated funding mechanisms often inadvertently discourage integrated behavioral health and primary care. Individuals affected by mental illness, policy makers, advocates, service providers and funders need to work together to realign the U.S. health care system to address system barriers that impede integrating care among providers. However, in the meantime, many leaders are finding ways to improve health outcomes for individuals affected by mental illness, despite system barriers.

The integration of behavioral health and primary care has significant implications for every aspect of providers' organizations and clinical practices – and the implications for organizational change when integrating care are always underestimated. Successful implementation of integrated care requires nothing less than a fundamental shift in the behavioral health provider's core identity and how the provider interacts with the rest of the health care system. The *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio* includes organizational change tools to aid leaders in intentionally realigning their organizations to foster and support integrated care.

Traditionally, behavioral health providers have not focused on two initiatives that are central to primary care: chronic disease management and the development of person-centered health care homes. Insurance reform is challenging traditional thinking. Behavioral health and primary care providers need to reexamine their roles in improving overall health outcomes for individuals with mental illness. The recovery concepts from behavioral health need to be integrated into the medical model of disease management and the concept of health care homes. It is important to build a collaborative infrastructure and to collect the appropriate data to understand needs and to make the case that integrated care improves health outcomes.

Mental health consumer movements across America are increasingly focused on educating their peers about wellness, actively pursuing health and wellness and advocating for better health care as part of the recovery movement. Consumers are also becoming more active in delivering mental health and primary care, promoting and engaging their peers to engage in wellness services and fostering better coordination of care and collaboration among providers.

Research about effective integrated care for individuals affected by mental illness is still emerging; however, many organizations seeking to integrate care are facing similar challenges. Openly sharing learning about integrated care is an important way to improve health outcomes and eliminate morbidity and avoidable deaths. This guide includes a discussion of common barriers to integrating care and suggestions for overcoming these barriers. Organizational leaders can use effective change management techniques to bring about changes in the organization’s core identity, realign services, leadership practices, operations and financial systems to support integrated care.

This guide provides an overview of the key aspects of the integrated care program development as they pertain to three points along the health care home continuum: 1) Coordination, Referral and Consultation, 2) Partnered-Care and 3) Single-Provider Care. It is important that an organization achieve Coordination, Referral and Consultation before moving to other points on the continuum. This guide addresses the service, leadership, operations and finance components that apply to each point on the continuum, and includes Integrated Care Program Development Tools for each point. Direct clinical, collaborative and prevention and

wellness services should be available to consumers regardless of the integrated care model used.

This implementation guide focuses primarily on delivering primary care in behavioral health settings. However, delivering behavioral health care in primary care settings is also important, and a brief overview of this approach is included. The importance of strong behavioral health and primary care partnerships is also emphasized. The Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) is discussed as an example of effective behavioral health care delivery in a primary care setting.

Creating a fiscally viable approach to integrated care is often a challenge. This guide includes information and resources on payers and reimbursement, including Ohio Medicaid, Medicaid-Managed Care, reimbursement, coding, documentation, Medicare and financial planning. It is vital that leaders working to integrate behavioral health and primary care understand the payers, reimbursement system and documentation/compliance system. Reimbursement for some key services—such as collaboration—is a challenge. Financial planning is very important when implementing integrated care. Leaders and clinicians also need to have a solid understanding of the requirements and expectations for clinical quality and productivity.

This guide includes tools for evaluating and developing a business case to help leaders evaluate integrated care programs and to articulate the value of integrated care. Information about need, process measures, fiscal impact and consumer outcomes is imperative for improving quality, increasing efficiency, leading change and influencing policy changes. At first, less is more. We suggest that organizations begin by collecting a small number of outcome and fiscal measures and expanding the number of metrics as needed.

This implementation guide concludes with appendices and references to help increase the impact and effective implementation of integrated care when used in conjunction with integrated care consultants, legal counsel and billing/financial experts.

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- The Best Practices in Schizophrenia Treatment (BeST) Center in the Department of Psychiatry at the Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM)
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- The Ohio Coordinating Center for Integrating Care
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About the Partners

The **Best Practices in Schizophrenia Treatment (BeST) Center's** mission is to promote recovery and improve the lives of as many people with schizophrenia as possible by accelerating the adoption of evidence-based and promising practices. To achieve its mission, the BeST Center works with mental health consumers, family members, expert consultants, policy makers and mental health partners. The BeST Center is in the Department of Psychiatry at the Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM). The BeST Center does not provide direct services; rather, it offers training, consultation, evaluation, education and outreach activities to build the capacity of local systems to provide state-of-the-art care. To learn more about the BeST Center and the latest news related to schizophrenia, please visit http://www.neoucom.edu/bestcenter/.

The **Ohio Coordinating Center for Integrating Care (OCCIC)** was created by the Ohio Department of Mental Health to share information and resources about integrating and coordinating physical and mental health care in Ohio. OCCIC helps providers, consumers and communities identify needs, plan and implement integrated care solutions, evaluate need and efficacy and share successes and obstacles. The Health Foundation of Greater Cincinnati hosts the OCCIC. To learn more about the OCCIC, please visit http://www.occic.org/.

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Disclaimer

The *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio* is a resource produced by the Best Practices in Schizophrenia Treatment (BeST) Center in the Department of Psychiatry and the Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM) and Ohio Coordinating Center for Integrating Care (OCCIC). It is a program development guide to assist community and organizational leaders to develop customized action plans that meet the specific needs of their communities. The implementation guide does not provide the definitive answers to the complex questions of integrated care; it is intended to be used in conjunction with integrated care consultants, legal counsel, billing/financial experts and other professionals.

MODULE 1

Implementation Guide Overview

Key Points

The key points in this module include:

- The *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio* is not a "how to" manual or a recipe book. It is a program development guide intended to be used in conjunction with other integrated care experts and resources to plan or improve programs.
- This module includes information about the purpose of the guide, key terminology and summaries of the key points for each module.

Purposes of the Implementation Guide

The purposes of this implementation guide are to:

- Provide information and resources to help communities improve health outcomes.
- Increase the understanding of the integrated care philosophy to improve the implementation of the person-centered health care approach.
- Assist behavioral health providers to implement effective integrated care and adapt to a changing health care system.
- Improve access to behavioral health and primary care.

This implementation guide is intended to assist communities that identify access to integrated behavioral health and primary care as a need and to help treatment providers work together to integrate care in order to improve outcomes, efficiency and access. It has been developed for several different audiences and needs, including:

- **Community leaders** (direct service providers of behavioral health and primary care, hospital administrators, consumers, families, experts, funders and regulators) can use this implementation guide, along with other technical assistance resources, to create a community leadership group to assess the needs and develop an action plan to improve health outcomes for individuals with severe mental illness.
- **Direct behavioral health and primary care service providers** can use this implementation guide, along with other technical assistance resources, to assess their organizations, engage their staffs and create and implement plans to improve health outcomes.

Terminology

The following terms are used throughout the implementation guide:

- ***Consumers:*** People affected by mental illness
- ***Behavioral health:*** Mental health and addiction treatment
- ***Integrated care:*** Close collaboration of health care services such as primary care, behavioral health, pharmacy, lab work, specialty care and dental services
- ***Health care:*** Primary care, behavioral health, pharmacy, specialty care and dental services
- ***Organization:*** The organization where primary care, behavioral health services and potentially other services are co-located or provided as a single-provider organization
- ***Provider*:** The clinician or organization delivering health care
- ***Point along the health care home continuum:*** The role of a behavioral health provider in providing integrated care. Providers may have different roles when serving different populations. There are many possibilities, but three points along the health care home continuum which are addressed in detail in this guide are: 1) Coordination, Referral and Consultation, 2) Partnered-Care and 3) Single-Provider Care.
- ***Services*:** Refers to three types of services: Direct Clinical Services, Services offered in Collaboration with other health care providers, and Prevention and Wellness Services

Contents of Implementation Guide Modules

This implementation guide includes an overview of integrated care, tools, examples and lessons learned. It focuses on adults who receive services from the behavioral health system and is intended to be a living document and not intended to be comprehensive. It is recommended that this implementation guide be used in conjunction with other resources and

experts in integrated care planning, legal, billing/finance, clinical and operations. Users of this guide may pick and choose the resources and tools from this collection that they feel service their organizations best.

- **Module 1: Implementation Guide Overview**
    - The *Implementation Guide for Integrating Behavioral Health and Primary Care in Ohio* is not a "how to" manual or a recipe book. It is a program development guide intended to be used in conjunction with other integrated care experts and resources to plan or improve programs.
    - This module includes information about the purpose of the guide, key terminology and summaries of the key points for each module.
- **Module 2: The Need for Integrated Care**
    - The current health outcomes of people served by the public mental health system are unacceptable.
    - Behavioral health care providers who are already engaging individuals with mental illness need to determine how they can help reduce the morbidity and mortality of the individuals whom they serve.
- **Module 3: Organizational Change Tools that Increase Implementation Effectiveness**
    - The organizational change implications for integrated care projects are *always* underestimated.
    - The integration of behavioral health and primary care has extensive implications for every aspect of the behavioral health provider's organization and clinical practices. It requires a shift in the behavioral health provider's core identity, as well as a change in how the provider interacts with other entities in the health care system.

- This module contains organizational change tools that improve implementation effectiveness and help leaders intentionally realign their organizations.

- **Module 4: Overview of Frameworks that Drive Integrated Behavioral Health and Primary Care**
  - Traditionally, behavioral health has not focused on key health care concepts employed by others in the health care system, such as chronic disease management and person-centered health care homes, but that needs to change.
  - Insurance reform is challenging traditional thinking.
  - Integrated care teams need to begin to merge recovery and medical models in order to achieve better results.
  - Integrated care requires a robust reexamination of the behavioral health providers' roles in improving the overall health outcomes for the consumers they serve.

- **Module 5: Common Lessons Learned**
  - Integrated care represents a major philosophical shift for many behavioral health providers.
  - Large systemic issues need to be addressed in order to improve the overall health of people served by the public mental health system.
  - Successfully integrating behavioral health and primary care requires providers to address the tensions inherent between the recovery and traditional medical models.
  - Integrated care requires behavioral health providers to reassess their role in primary care and how they fit within their local health care systems.

- Common lessons learned related to the following are provided in this module:
  - Philosophical shifts and identity changes
  - Services
  - Leadership
  - Operations
  - Finance

- **Module 6: Integrated Care Program Development**
  - Behavioral health providers need to determine their role related to integrated care and health care homes. Three points along the health care home continuum include:
    - Coordination, Referral and Consultation
    - Partnered-Care
    - Single-Provider Care
  - Services, leadership, operations and finance need to be addressed at each point on the health care home continuum.
  - Direct Clinical Services, Collaboration Services and Prevention and Wellness Services should be provided at each point on the continuum.

- **Module 7: Coordination, Referral and Consultation Between Behavioral Health and Primary Care**
  - Coordination, Referral and Consultation must be achieved before moving to one of the other points on the health care home continuum.

    - The Integrated Care Program Development Tools contained in this module will help improve Coordination, Referral and Consultation.

- **Module 8: Partnering with a Specific Primary Care Resource**
    - This module highlights Integrated Care Program Development tools and information about partnering with a specific primary care resource within a behavioral health provider organization.

- **Module 9: Single Provider Organization for Behavioral Health and Primary Care**
    - The Integrated Care Program Development Tools in this module will help leaders implement and improve fully integrated health care homes within a Single Provider.

- **Module 10: Case Study: Community Support Services, Akron, Ohio**
    - It is important for providers to share what they have learned about integrated care openly in order to improve health outcomes and eliminate avoidable deaths.
    - The team in Akron, Ohio, identified numerous learning points that are applicable to many other integrated care approaches. The top lessons the team learned are discussed in this module.

- **Module 11: Delivering Behavioral Health Care in Primary Care**
    - It is important to meet people where they are and create bi-directional service delivery between behavioral health and primary care.
    - This implementation guide focuses mostly on the delivery of primary care in behavioral health settings, but the delivery of behavioral health in primary care is also important.

- The Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) model is an example of an effective way to deliver behavioral health within a primary care setting.

- **Module 12: Payers, Reimbursement and Fiscal Planning**
  - It is critical that leaders working to improve the integration of behavioral health and primary care understand the payers (Behavioral Health (Community) Medicaid, other forms of Medicaid, Medicare, private insurance and other sources of funding), reimbursement system and documentation/compliance system.
  - Reimbursement for some key services, such as collaboration, is a challenge.
- **Module 13: Evaluation and Business Case Development**
  - Information about the need, process measures, fiscal impact and consumer outcomes is imperative for improving quality, increasing efficiency, leading change and influencing policy changes and articulating the value of integrated care projects.
  - At first, less is more. Start collecting a small number of outcome and fiscal measures and expand the number of metrics as needed.
- **Appendix**
  - This section of the implementation guide concludes with numerous appendices and references that will increase impact and effective implementation.

MODULE 2

The Need for Integrated Care

Key Points

The key points in this module include:

- The current health outcomes of people served by the public mental health system are unacceptable.
- Behavioral health care providers who are already engaging individuals with mental illness need to determine how they can help reduce the morbidity and mortality of the individuals whom they serve.

Reduced Quality of Life and Premature Death

Individuals with severe mental illness have a premature death rate that is much higher than individuals in the general population. A study by the National Association of State Mental Health Program Directors (NASMHPD) found that people who are served by the U.S. public mental health system die decades earlier than members of the general population. While suicide and injury account for about 30-40% of the excessive mortality, the majority of causes of early death are preventable medical conditions associated with modifiable risk factors such as obesity, substance abuse and poor access to primary care services. For example, 60% of the premature deaths in people with schizophrenia are due to cardiovascular, pulmonary, infectious and other preventable diseases (NASMHPD, 2006).

Proactive communities are examining the quality of life and the premature death rate of individuals with mental illness and determining what can be done to address these problems. Poverty, disempowerment, stigma, symptoms of mental illness, side effects of treatments and poor access to integrated behavioral health and primary care are some of the factors that may contribute to morbidity and mortality. More research is needed to understand how to reduce morbidity and mortality in individuals with severe mental illness and to evaluate the effectiveness of different approaches. All health care is local; therefore, it is very important to use a systems approach to access the needs of individual communities.

As organizations and communities develop plans to improve the integration of care, promoting a recovery-oriented framework that fosters self-care, self- determination and personal empowerment is important and will help shift the focus of behavioral health care from episodic care to recovery.

MODULE 3

Organizational Change Tools that Increase Implementation Effectiveness

Key Points

The key points in this module include:

- The organizational change implications for integrated care projects are *always* underestimated.
- The integration of behavioral health and primary care has extensive implications for every aspect of the behavioral health provider's organization and clinical practices. It requires a shift in the behavioral health provider's core identity, as well as a change in how the provider interacts with other entities in the health care system.
- This module contains organizational change tools that improve implementation effectiveness and help leaders intentionally realign their organizations.

Tools in this Module

- The Five Critical Steps of Integrating Care Implementation
- The Stages of Change Self-Assessment
- Integrated Care Root-Cause Analysis Tool
- Community Leadership Forum Tools
- Internal Leadership Forum Tools
- Behavioral Health and Primary Care Integration Action Planning Tool

Advice from People Implementing Integrated Care

Some advice from people who are successfully integrating health care:

- *"Implementing an integrated care program requires many more organizational changes than implementing clinical, evidence-based practices."*
- *"It's a process that takes several years to go through."*
- "*At first you look at it through the eyes of a behavioral health provider, but you do not know all that you need to do until you are able to look at it through the eyes of a primary care provider.*"
- "*You think that you have done enough change management, but until you actually do it, you don't know all that you need to do. If you do not use the change management tools when you initiate the project, use the tools when issues are encountered."*
- *"Ask each person to describe what integration looks like to them and then compare and discuss the differences."*
- *"Building infrastructure is a constant process."*
- "*Seek input from consultants who and organizations that have done this before!"*

The Five Critical Steps of Integrated Care Implementation

This tool was created by Suzanne Clifford and Jonas Thom with portions adapted from Robert E. Drake, Kim T. Mueser, William C. Torrey, Alexander L. Miller, Anthony F. Lehman, Gary R. Bond, Howard H. Goldman and H.Steven Leff. *Evidence-Based Treatment of Schizophrenia. Current Psychiatry Reports,* Volume 2 (5), Sept. 2000, 393-397, and personal communication with Michelle P. Salvers.

As individuals, organizations and communities move from contemplating to preparing for integrated care, action plans should be developed to address five critical steps. More detail about these steps is included in the other modules of this implementation guide.

Step one: Build a strong, diverse coalition that articulates:

- Clear reasons why better integration is needed
- Goals for integration (including process and result measures)
- Principles
- Guidelines
- Specific expectations of the key individuals who are accountable for implementing integrated care

Step two: Identify the root causes of why integrated care is not occurring and realign the organization and system to support and drive change.

Step three: Provide leadership, clinical oversight, operational implementation plans, fiscal resources, training, networking and support.

Step four: Offer ongoing problem-solving support, training, coaching and technical assistance.

Step five: Collect, communicate and celebrate quantifiable information about the processes and the results.

The Stages of Change Self-Assessment

According to the Institute of Medicine report, *Crossing the Quality Chasm: a New Health System for the 21st Century*, the gap between identifying effective treatment approaches in research settings and implementing these approaches at the provider level is often 15-20 years. Given that effective approaches for integrating care are still being explored, techniques

for streamlining the time from research to practice are important. The National Implementation Research Network has identified excellent implementation technology resources that can help to close the science-to-service gap. While many principles and tools that improve implementation and promote effective change may appear to be common sense, unfortunately, these principles and tools are underused or sometimes not used at all.

The Stages of Change model is a useful way to articulate an individual's readiness to change specific behaviors, but it is also a useful tool to assess the readiness of leaders and organizations to change. The Stages of Change Self-Assessment Tool describes the six stages of change.

Stages of Change Self-Assessment Tool

(Clifford and Thom, 2010)

The following tool was adapted from the Stages of Change model described in Prochaska, J.O., DiClemente, C.C. & Norcross, J. (1992) "In search of how people change: Applications to addictive behaviors." *American Psychologist*, 47:1102-1114. Please ask individuals to check the box that best describes their readiness for integrated care and then discuss the responses.

Pre-contemplation – Is the person or organization aware of the need to improve the integration of health care? *If the answer is no, the person or organization is in pre-contemplation phase.*

Contemplation – Is the person or organization aware of the need to improve the integration of health care, and do they intend to take action within the next six months? *If the answer is yes for the previous question and no for this question, then the person or organization is in the contemplation phase.*

Preparation – Is the person or organization developing a plan to improve the integration of health care? *If the answer is yes for the previous question and no for this question, then the person or organization is in the preparation phase.*

Action – Is the person or organization implementing the plan to improve the integration of health care? *If the answer is yes for the previous question and no for this question, then the person or organization is in the action phase.*

Maintenance – Is the person or organization measuring outcomes associated with the integration of health care and ensuring that those outcomes continue to improve? *If the answer is yes for the previous question and no for this question, then the person or organization is in the maintenance phase.*

Termination – Are the improvements associated with the integration of health care embedded in the culture and part of the way that the organization operates? *If the answer is yes for the previous question and no for this question, then the person or organization is in the termination phase.*

Root-Cause Analysis

It is important to identify the root causes that make it difficult to integrate behavioral health and primary care. The Integrated Care Root-Cause Analysis Tool can help an organization identify the root causes of poor integration so they can be addressed and not impede implementation. Common root causes for a lack of integration between behavioral health and primary care include:

- Fragmented funding streams and organizations that often unintentionally discourage integrated care
- Lack of a shared mindset about the importance of treating the whole person and helping each individual live a healthier, more fulfilling life
- Lack of leadership reinforcing the goal of improving overall behavioral health and primary care outcomes
- Misalignment of the community and organization

To promote integrated care and to bring about better health outcomes for individuals affected by mental illness, many federal and state policy issues need to be addressed. However, some communities are not waiting for transformation at the federal and state levels; they are taking matters into their own hands and working to transform local systems of care. Successful integrated care initiatives tend to share the following characteristics:

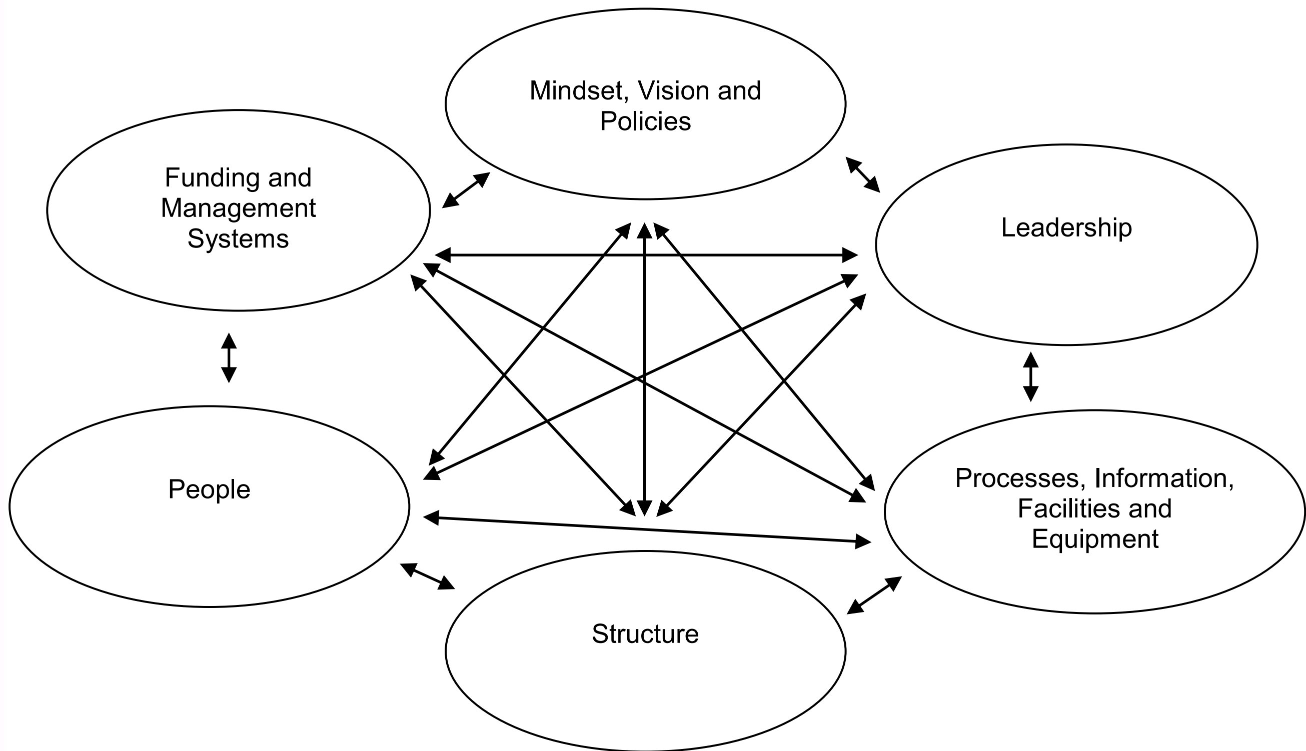
- The collaborators challenge current assumptions and develop a shared mindset that focuses on the health and social service outcomes of the whole person.
- The collaborators leverage funds from government, foundations or other sources to cover construction, equipment, program administration and other start-up costs.
- Executive, operational and clinical leaders make wellness a priority, identify out-dated assumptions, promote new thinking and behaviors and align their organizations to promote integrated care and wellness.

Addressing the root causes and realigning the system essential for improving consumer health outcomes. *Please see Appendix B for an example of a detailed root-cause analysis.*

Integrated Care Root-Cause Analysis Tool

(Clifford, 2001)

The Integrated Care Root-Cause Analysis Tool is a powerful instrument that is used by quality programs to help understand the key reasons for suboptimal performance. Following the identification of root causes for a lack of integrated care, planning teams can develop specific action plans. Initially, this framework may seem complicated. However, when organizations step back and understand how their systems and subsystems are misaligned, numerous opportunities for improvement emerge.



Integrated Care Root-Cause Analysis Tool

(Clifford, 2001)

Design Element	Root Causes of Barriers to Integration	Plan to Address the Barriers
Mindset, vision and policies: The ways that key stakeholders view the world and the system; transformation cannot occur without challenging at least one assumption and shifting mindsets; the direction and priorities of the system		
Leadership: Individuals who are able to challenge inaccurate assumptions, shift mindsets, set direction and lead change		

Design Element	Root Causes of Barriers to Integration	Plan to Address the Barriers
Processes, information systems, facilities and equipment: The flow of work, people, products and information; the facilities and equipment needed to achieve the work		
Structure**:** The way the system is organized, including authority, responsibilities and roles; it is important to recognize that formal and informal structures have an impact a system		
People**:** The key stakeholders within the system, including individuals served by the system, working in the system, influencing the system and affected by the system; the interests, skills and knowledge of the people should be considered during system design/redesign		
Funding and management systems**:** The fiscal and non-fiscal incentives, recognition, performance feedback and monitoring systems		

Building the Collaborative Leadership Infrastructure

Ensuring that key external and internal leaders are engaged integrated care is vital to successful implementation. The following information and tools will help mobilize key stakeholders.

Involved community leaders and experts will help drive change and remove barriers. We recommend creating a Community Leadership Forum to achieve the following goals:

- ***Forum:*** Create a public forum for collaboration and problem-solving as the community implements integrated care.

- ***Information:*** Identify and monitor objective data and criteria that define need, service capacity and outcomes improvement.

- ***Alignment:*** Clarify roles, address boundary issues and develop a plan to realign the system in order create a continuum of care.

The Community Forum Stakeholder Identification and Community Forum Leadership Planning tools can be used to ensure that there is at least one representative from each stakeholder group included in the forum. It is important to balance involving key individuals and keeping the group at manageable size.

Community Leadership Forum Stakeholder Identification Tool

(Clifford and Thom, 2009)

Critical Groups for the Community Leadership Forum	Individual(s) who should be included	Who will invite individual(s) to get involved?	Due date for inviting the individual(s)
Direct services (Behavioral Health and Primary Care)			
Hospitals			
Consumers and families (peer support, receiving services, advocacy groups, etc.)			
Experts (Academics, workforce development, technical assistance, legal, etc.)			
Funders/regulators (government, foundations, boards, managed care, etc.)			

Community Leadership Forum Planning Tool

(Clifford and Thom, 2009)

Goals	Summary of Achievements
Forum: Create a public forum for collaboration and problem-solving as the community implements integrated care. Develop strong partnerships and integrated care projects.	
Information: Identify and monitor objective data and criteria that define the need, service capacity and outcomes improvement.	
Alignment: Clarify roles, address boundary issues and develop a plan to realign the system in order create a continuum of care.	

Internal Leadership Forum Tools

In order to promote effective implementation of an integrated care program, an Internal Leadership Forum needs to be created in addition to the Community Leadership Forum. The commitment of the leadership within an organization is critical to the successful implementation of integrated care. Leaders within the organization need to work together to set direction, realign the organization to support critical changes, engage staff and remove barriers. The organization's CEO provides leadership for the Internal Leadership Forum, and an integrated care consultant is often involved in the planning and early implementation processes.

The Internal Leadership Forum should address the following goals:

- ***Forum:*** Create a forum for collaboration and problem-solving as the organization implements integrated care.
- ***Information:*** Identify and monitor objective data and criteria that define the need, service capacity and outcomes improvement.

- ***Alignment:*** Develop a plan for organizational improvement and program development. Clarify roles, address boundary issues and develop a plan to realign the organization to improve integration and outcomes.

During the first year of the project, Internal Leadership Forums usually meet weekly. During the second year and beyond, it usually meet monthly. There is a need for initial and continuous oversight of the collaboration by high-level staff from both organizations, such as:

- CEO to CEO
- CMO to Vice President for Medical Affairs
- COO to Senior. Vice President
- Director to Director
- Manager to Manager
- Clinician to Clinician

Leaders need to promote, support and advocate for integrated care. They set the overall vision for the program and communicate this vision to key individuals involved in implementing and sustaining the change. Leaders also need to identify a champion who is dedicated to the success of the project, who is authorized to move change forward within both organizations and who will closely monitor a system that will be tempted to regress back to the old system.

The Internal Leadership Forum Identification and Internal Leadership Forum Planning tools can be used to ensure that each key constituency is represented in the planning and implementation of integrated care. It is important to balance involving critical partners (who could either promote or impede integrated care) and keeping the group a manageable size.

Internal Leadership Forum Stakeholder Identification Tool

(Clifford and Thom, 2009)

Critical Groups for the Internal Leadership Forum	Individual(s) who should be included	Who will ask the individual(s) to be involved?	Due date for inviting the individual(s)
Project Manager with clear accountability and strong influence in the organization			
Chief Executive Officer			
Chief Operations Officer			
Chief Financial Officer			
Consumers and families (peer support, receiving services and advocacy groups)			
Clinical Leadership (leader[s] for psychiatric care, primary care, pharmacy, laboratory service , case managers, therapists and nurses)			

Internal Leadership Forum Planning Tool

(Clifford and Thom, 2009)

Goals	Summary of Achievements
Forum: Create a forum for collaboration and problem-solving as the organization implements integrated care.	
Information: Identify and monitor objective data and criteria that define the need, service capacity and outcomes improvement.	
Alignment: Develop a plan for organizational improvement and program development. Clarify roles, address boundary issues and develop a plan to realign the organization to improve integration and outcomes.	

Behavioral Health and Primary Care Integration Action Planning Tool *(Clifford and Thom, 2009)*

Integrating behavioral health and primary care can be very complicated. The Behavioral Health and Primary Care Integration Action Planning Tool is an easy way to track the work, accountability and due dates. This tool is intended to be used by an integrated care consultant who is facilitating planning sessions with community and internal leadership forums. Leaders can also use it to keep a running list of action items as they review the implementation guide and discuss lessons learned with experts. The tool is especially useful for holding individuals accountable for critical action items. Color-coding the action items by owners reinforces accountability and makes it easier for everyone involved to understand his/her role. The tool contains the following categories to help organize the action plans into manageable sections: philosophical shifts, organization's core identity, change management, services, leadership, operations and finance. Modules 4 and 5 provide more details and examples.

In addition to consulting this implementation guide, please consult integrated care, reimbursement, clinical and legal experts for additional potential issues and lessons learned.

Philosophical Shifts

Action	Point Person	Others Involved	Due Date	Lessons Learned

Changes in an Organization's Identity

Action	Point Person	Others Involved	Due Date	Lessons Learned

Change Management

Action	Point Person	Others Involved	Due Date	Lessons Learned

Services

Action	Point Person	Others Involved	Due Date	Lessons Learned

Leadership

Action	Point Person	Others Involved	Due Date	Lessons Learned

Operations

Action	Point Person	Others Involved	Due Date	Lessons Learned

Finance

Action	Point Person	Others Involved	Due Date	Lessons Learned

MODULE 4

Overview of Frameworks that Drive Integrated Behavioral Health and Primary Care

Key Points

The key points in this module include:

- Traditionally, behavioral health has not focused on key health care concepts employed by others in the health care system, such as chronic disease management and person-centered health care homes, but that needs to change.
- Insurance reform is challenging traditional thinking.
- Integrated care teams need to begin to merge recovery and medical models in order to achieve better results.
- Integrated care requires a robust reexamination of the behavioral health providers' roles in improving the overall health outcomes for the consumers they serve.

Engagement and Recovery

Individuals who are receiving behavioral health care are often not receiving primary care services. Behavioral health providers are skilled at engaging consumers in treatment, and their engaging skills can be applied to helping consumers seek primary care. The behavioral health system needs to continue to transform into a recovery-oriented system that promotes consumer hope and empowerment. Traditionally, behavioral health has not focused on key health care concepts such as chronic disease management and person-centered health care homes, but that needs to change. Behavioral health providers also need to incorporate recovery into the medical models of disease management and health care homes.

Wellness is a key part of recovery. Consumer movements around the country are increasingly focusing on peer wellness education and promotion. Consumers are becoming more active in the delivery of mental health and primary care clinical services, coordination of care, prevention and wellness services and other activities that engage consumers in improving their own health and well-being. Research has shown that culturally competent, recovery-oriented services that include the principles of trauma-informed care are the most effective treatment interventions.

It is important to address other barriers, such as poverty, unemployment, lack of transportation, inadequate housing and stigma, which adversely affect recovery and wellness. It is difficult to improve wellness when a consumer does not have access to transportation to health care providers or only has access to high simple carbohydrate foods at a homeless shelter.

Chronic Disease Management

In 1998, Wagner introduced the chronic disease management model to improve care for chronic illnesses. Please see Wagner, E.H., Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998:1 (1):2-4 for more details. The model explains how communities and health systems can work together to produce informed, engaged consumers and prepared, proactive practice teams that result in improved outcomes for individuals with chronic illnesses. For more information about the chronic care

model, please go to
http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Modelands=2.

Medical Homes

The chronic disease management model led to the development of the concept of a medical home. The concept of medical homes was incorporated into the recently passed insurance reform. Medical homes are a mechanism for coordinating health care in order to:

- Improve recovery and health
- Increase patient satisfaction and engagement
- Enhance access and integration
- Ensure the delivery of efficient and effective health care that leads to improved outcomes

In March 2007, the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians and American Osteopathic Association released the following Joint Principles of the Person-Centered Medical Home. (For more information, please go to http://www.ncqa.org/tabid/631/Default.aspx):

- Each consumer has an ongoing relationship with a personal clinician.
- The personal clinician collaborates with a team of clinicians who collectively take responsibility for the ongoing care of consumers and the improvement of health outcomes.
- The personal clinician is responsible for providing for all of the consumer's health care needs or ensuring that other qualified professionals provide the care in order to improve health outcomes.

- “Whole person” health care is coordinated and integrated across all elements of the health care system.
- Quality and safety are critical characteristics of the health care system.
- Improved access to behavioral health, primary care, specialty care, labs, pharmacy, dental care and other key elements of effective health care are available.
- Payment and other incentives appropriately recognize the added value and improved outcomes associate with a Person-Centered Medical Home.

The medical home for an individual will vary based on his or her needs and the resources available in their communities. Often, an individual will find that his or her primary care provider is the most appropriate place for his or her medical home. However, a person with one or more chronic illnesses may find that a specialty care provider is the appropriate medical home. People with severe and persistent mental illness often find that a behavioral health provider is most appropriate medical home. For additional information on medical homes go to:

- Fact Sheets, Joint Principles and Other Information on Person-Centered Medical Homes: http://www.ncqa.org/tabid/631/Default.aspx
- Ten Steps to Person-Centered Medical Homes: http://www.aafp.org/online/en/home/publications/journals/fpm/preprint/kuzel.html
- Person-Centered Medical Home Checklist: http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/checklist.Par.0001.File.tmp/PCMHChecklist.pdf

Person-Centered Health Care Homes

The National Council for Community Behavioral Health proposes the creation of person-centered health care homes. The person-centered health care home is similar to the medical home concept, but it focuses on individuals with severe mental illness. The National Council's full recommendations are included in a report, *Behavioral Health/Primary Care Integration and the Person-Centered Health Care Home,* http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Health care%20Home.pdf.

A Person-Centered Health Care Home for persons with severe mental illness can be achieved by adding services within a behavioral health provider organization or by building strong partnerships among behavioral and primary care providers. The report suggests the following components be included in a person-centered health care home:

- Regular screening and registry tracking/outcome measurement at behavioral health appointments
- Primary care nurse practitioners/physicians located in behavioral health settings
- A supervising primary care physician who works closely with behavioral health clinicians
- An embedded care manager
- Evidence-based practices to improve the recovery and health of people with serious mental illnesses
- Prevention and wellness programs

Barriers to integrated care, such as financing, policy and regulation, workforce, information sharing and the need for greater research relating to the costs, cost offsets and health outcomes of person-centered health care homes are discussed in the report.

Person-Centered Health Care Home Evaluation Tool

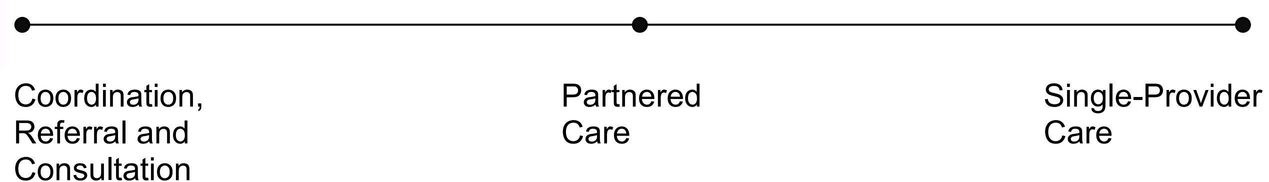
(Adapted from the AAP, AAFP, ACP and AOA Joint Principles of the Patient-Centered Medical Home, March 2007: http://www.ncqa.org/tabid/631/Default.aspx). This tool can be used to guide discussion about core elements of a Person-Centered Health Care Home.

Person-Centered Health Care Home Service Element	Evaluation of the Organization's Current Delivery of the Service Element	Organization's Desired Improvements for Each Person-Centered Health Care Home Service Element
Consumers have access to the primary care, behavioral health care, specialty care, labs, pharmacy services, dental care and other care that they need. If any of these services are not available within the health care home, the health care home ensures that consumers receive these services from a qualified provider.		
Consumers have access to "whole-person", integrated health care. Primary care, behavioral health care, specialty care, pharmacy services, dental care and other health services are integrated, which result in better outcomes, fewer errors and effective use of health care resources. Payments and other incentives for health care services should promote integration and improved outcomes.		
Consumers receive care management services to ensure effective integration of care. Care managers work with clinicians in a variety of settings such as primary care, behavioral health care, specialists, pharmacies, labs, residential facilities, hospitals, nursing homes and home health organizations. Care management services are critical when a consumer has multiple serious health conditions or when the consumer is not able to coordinate care on his or her own. Appropriate payment for care management services is available.		
All consumers have access to prevention and wellness services. Person-centered health car homes should focus on recovery and proactive, and not just reactive, health care. Payments for prevention and wellness services should be available for clinicians who and organizations that focus on recovery and keeping consumers healthy and productive. Outcomes rather than activities should be rewarded.		

Behavioral Health Provider’s Role in Health Care Homes

Behavioral health providers must examine their role in improving the overall health outcomes for the individuals they serve and identify the person-centered health care homes model they wish to use. Various models of person-centered health care fall on a continuum that is dynamic and multifaceted. Three points along the health home continuum are: Coordination, Referral and Consultation, Partnered-Care and Single- Provider Care.

Behavioral Health Provider’s Health Care Home Role in Integrated Care



Additional Helpful Resources

- Research about the possibilities for improved health outcomes for persons with serious mental illness through integrated care is ongoing. Organizations are celebrating individual success stories, but evidence-based practices with proven results that can be replicated for integrating care are still emerging. In addition, because communities often have different consumer needs, health care systems, payers and resources, we recommend taking a customized approach that is informed by lessons learned, expert technical assistance and a review of the available literature. Appendix Integrated Care Annotated Bibliography and Appendix D include a Webography on Behavior Health and Primary Care Integration.
- The National Association of State Mental Health Program Directors’ (NASMHPD) report, *Morbidity and Mortality in People with Serious Mental Illness,* can be found at http://www.nasmhpd.org/publicationsmeddir.cfm. This report states that

“people with serious mental illness (SMI) die, on average, 25 years earlier that the general population.” It describes the problem, identifies preventable causes and provides recommendations at the federal, state, provider organization/clinician and person served/family/community levels.

- The Agency for Health Care Research and Quality’s (AHRQ) report, *Integration of Mental Health/Substance and Primary Care*, is located at http://www.ahrq.gov/clinic/tp/mhsapctp.htm. The report describes different models for behavioral health care delivery in primary care settings and primary care delivery in behavioral health settings that are being implemented in the U.S. It assesses the effectiveness of each model. The report also highlights challenges related to initiating and sustaining programs, health information technology and payment/reimbursement. The report concludes that, “in general, integrated care achieved positive outcomes” and “efforts to implement integrated care will have to address financial barriers.”
- The NCQA developed standards for the Physician Practice Connections® - Patient-Centered Medical Home™ that can be found at http://www.ncqa.org/tabid/1034/Default.aspx.

Please see the Appendix for additional integrated care publications, references, Web sites and other resources.

MODULE 5

Common Lessons Learned

Key Points

The key points in this module include:

- Integrated care represents a major philosophical shift for many behavioral health providers.
- Large systemic issues need to be addressed in order to improve the overall health of people served by the public mental health system.
- Successfully integrating behavioral health and primary care requires providers to address the tensions inherent between the recovery and traditional medical models of care.
- Integrated care requires behavioral health providers to reassess their role in primary care and how they fit within their local health care systems.
- Common lessons learned related to the following are provided in this module:
  - Philosophical shifts and identity changes
  - Services
  - Leadership
  - Operations
  - Finance

Lessons Learned

This module discusses lessons learned from leaders who are integrating behavioral health and primary care. Traditionally, behavioral health providers intentionally created systems that were separate from other parts of the health care system. As behavioral health leaders begin to transform their systems to include integrated behavioral health and primary care, they will face major systemic issues. Changes of this magnitude often move more slowly than desired, so it is important to manage change proactively. We recommend using an organization-wide change management process and setting reasonable timelines for implementing systemic improvements. As with most transformational change, integrating care and creating person-centered health care homes inevitably takes longer than anticipated.

The current health care system and funding mechanisms often inadvertently discourage integrated behavioral health and primary care. Consumers, policy makers, advocates, service providers and funders need to realign systems to promote collaboration and overall wellness. Many leaders are finding immediate, incremental ways to improve health outcomes, while still advocating for long-term policy improvements.

While seeking improved wellness and health care for persons with serious mental illness, it is also important to remove other barriers to recovery and wellness that keep people stuck in poverty. These barriers include unemployment, lack of access to transportation, inadequate housing and stigma.

Stigma adversely impacts treatment outcomes. Some primary care providers may be hesitant to work with people with severe mental illness; this may be due to fear, negative past experiences or insufficient training. Other factors, such as the complexity of the consumers' medical needs or their resistance to primary care, lack of insurance, legal issues and the need for extended social services, such as housing, can also be issues for primary care providers. Many primary care providers are frustrated with the behavioral health system because it is often difficult to refer individuals for behavioral health treatment due to by tight eligibility

guidelines, lack of adequate insurance coverage, workforce shortages and/or long waiting lists for services.

It is strongly recommended that organizations that are billing for new services work with a very strong billing expert and have a certified coder who conducts regular audits. Billing staff should attend training at least annually to learn about the American Medical Association's Current Procedural Technology(CPT) codes. Several behavioral health providers who recently started billing for primary care services delivered at their sites recommend the Ohio State Medical Association's coding training program.

Philosophical and Identity Challenges

Integrating care and establishing health care homes involve changing organizational vision, mission and values and how an organization fits within the health care system.

Providers must address two fundamental challenges as they initiate integrated care. First, they need is to identify the desired philosophical shifts (what they want the outcome to be) and to determine how to facilitate the desired outcomes. Leaders also need to address the tensions between recovery-oriented and medical models of care. Second, they need to redefine the organization's core identity in the context of the local health care system and clearly define the population(s) they plan to serve and the services they plan to provide.

Organizational cultures and clinical practices within behavioral health and primary care organizations are quite different. For example, primary care providers tend to be brief and concise in their interactions, while behavioral health providers are often process-oriented and provide longer explanations. Primary care appointments are typically much shorter than behavioral health appointments. Traditional behavioral health processes may need to be modified to meet productivity expectations. Understanding the differences between and aligning the two systems is to successful integration of care.

Health care homes need to be designed to promote people taking responsibility for their own health and health care. They also need to balance long-term health versus short-term disease mitigation.

Integrated care also has implications for universities and other organizations that train health care professionals. Today's health professions students need to understand how to integrate care and to work as leaders and members of health care teams.

After a clear change management plan has been developed to address changes in organizational philosophy and identity, four program areas need to be addressed: services, leadership, operations and finance.

Services

To provide optimal integrated care, providers will need to modify existing services and add new ones. When determining the appropriate mix of services, providers should ensure access to or provision of the three broad types of culturally component, recovery-oriented services: comprehensive direct clinical services, clinical coordination services and prevention and wellness services.

Comprehensive Direct Clinical Services:

  - Behavioral health
  - Primary care
  - Specialty care
  - Pharmacy
  - Dental care
- Clinical collaboration
- Prevention and wellness education and activation services

Leadership

Effective leadership, governance and accountability significantly improve the effectiveness of integrated care implementation. Developing strong community and internal organizational leadership infrastructures facilitates the implementation of health care homes that promote integration and overall wellness. Module 3 contains tools for implementing Community and Internal Leadership forum. Strong partnerships that engage executive, clinical, operational and consumer leadership promote trust, productive relationships, communication and change management.

The leadership group needs to develop clear, consumer-driven goals, plans and metrics. They also need to resolve cultural differences related to the different systems, workforce, clinical practices and the roles of providers. Leaders also need to identify and resolve regulatory, finance, quality improvement and compliance differences.

Communication and keeping everyone involved informed about what is planned and what is occurring is crucial. Holding regular meetings to discuss what is and what is not working is also very valuable.

Operations

Implementing integrated care affects every aspect of an organization's operations. Leaders need to realign their system intentionally to achieve improved results. The Root-Cause Analysis Tool in Module 3 can help leaders identify barriers to integration and then redesign the system so that the resources and operational processes ensure access and quality care.

An organization's ability to promote efficiency and effectiveness of their clinicians is a critical success factor for integrated care. This requires:

- Efficient and effective clinicians
- An effective scheduling system and a very well organized person who schedules back-to-back primary care and mental health appointments whenever possible and appropriate
- A productive layout of the facility
- The ability to prepare multiple consumers in different exam rooms so that clinicians can move swiftly from room to room
- The ability to reduce the number of appointment no-shows
- The ability to recruit consumers from the lobby and other clinicians when there are openings in the schedule
- The ability to communicate and promote services to increase the number of consumers participating in integrated care

Finance

Leaders must develop an infrastructure to support informed financial decisions and manage risk. Common financial challenges related integrated care include:

- Confusion about Behavioral Health (Community) Medicaid, especially what is billable and what is not
- Implementation of Clinic Medicaid:
    - Obtaining the proper types of Medicaid numbers
    - Getting credentialed on managed-care panels

- Identifying which services to bill and which codes to use
- Ensuring proper documentation

- Funding collaboration
- Information sharing and incompatible health care systems
- Partnering with managed care:
    - Finding an advocate within a managed care organization is invaluable. The advocate can communicate the vision to his/her organization and ensure that proper processes and procedures are followed in a timely manner.
    - Different managed care companies may pay different amounts for the same billing codes, so it is important to understand the rates for each organization.
    - Creating an effective process to obtain prior authorizations is crucial.

Some common financial issues and suggestions for integrating care are listed below:

- **New services, which are not paid for, are needed for integrated care.**
    - ***Problem:*** Behavioral health providers are working to become better specialty care providers (consulting and collaborating with primary care) and fully integrated providers (e.g. offering both primary and behavioral health care within a health care home model). In both instances, there are three broad categories of services that make up integrated care. Only one of these types is currently paid for.
    - ***Clinical Services***: Services—primary care, psychiatry, counseling, etc.—are currently paid for, but rates are low, and start-up costs are high.
    - ***Collaboration Services***: These services are at the heart of health care homes, including single-provider homes, those coordinating care for consumers who

receive services across disciplines within a single organization (e.g. psychiatry/ primary care) and between health care homes and outside specialty care providers (e.g. between primary care and psychiatry). These services are not paid for, which inhibits quality care and access.

- ***Prevention and Wellness Services***: Services to educate consumers about prevention and wellness and to empower them to play an active role in their health care are vital parts of a health care home. However, viable funding is often not available for these services. Reimbursement is needed for programs and services that have demonstrated effective outcomes with high need/high cost persons, especially those services developed for persons with mental illnesses.

- ***Suggestions:*** Payers should consider including behavioral health providers as both health care homes and specialty care providers and pay for all three types of services, both within a single health care home and between medical homes and specialty care providers for vulnerable/high-risk populations with chronic health conditions.

- **Medical interventions are not paid for at sufficient rates for people with complex medical and engagement needs.**

  - ***Problem:*** People with mental illness who also have chronic health conditions are frequently medically complex and difficult to engage and treat within standard appointment/encounter times. This problem is exacerbated when a provider's entire consumer population has these needs. Primary care providers, who typically see 4-8 people an hour, often only see an average of 1 or 2 people with severe mental illness in integrated care clinic settings.

  - ***Suggestions****:* Federally Qualified Health Centers (FQHC) waivers and other designations provide cost-based payment for risk-adjusted populations. Developing mechanisms and opportunities for enhanced (fair) payments for people with complex

needs through pilot programs or other mechanisms is possible. It is important to pay providers for the actual costs of service delivery for persons with chronic mental illness, or these individuals will continue not receive primary care services.

- **There are separate Medicaid and related systems**.
  - ***Problem:*** Separate Medicaid and related systems currently require separate regulation, oversight and infrastructure. As providers seek to develop integrated care services, they report increased administrative burden, the need to learn an entirely new oversight and billing system and the need for resources to develop new infrastructure such as billing, compliance and accreditation.
  - ***Suggestions:*** Develop technical assistance and cross-system regulatory and billing information for providers. Seek to align regulatory policy where possible.
- **Implementation and start-up costs are high, and initially, revenue is low.**
  - ***Problem:*** As providers develop new services, related infrastructure and clinical competencies, they incur high costs and generate low revenue. At a time when behavioral health providers and consumers have seen tremendous cuts to funding, many programs have been discontinued, and many basic behavioral health services are threatened. Providers know that new ventures that are not clearly sustainable are risky. However, behavioral health providers are stepping up to develop integrated care services. It is essential that they be included in opportunities for start-up or pilot funding.
  - ***Suggestions:*** Behavioral health providers are developing integrated care services. It is essential that they be included in any opportunity for start-up or pilot funding for health care related services such as electronic health records and health care home pilot programs.

- **For the uninsured, eligibility is only part of the problem.**
  - ***Problem:*** Adults with severe and persistent mental illness are often difficult to engage in health care, and they may have cognitive impairments or poor memories related to their medical histories. Even when individuals are entitled to Medicaid, it is often difficult and time-consuming to obtain and to keep receiving benefits. The application and redetermination process is laborious, and people who are entitled to Medicaid frequently do not receive it. Additionally, frequent institutional involvement—such as being in prison, jail, nursing homes and hospitals—often leads to long periods without Medicaid coverage after discharge.
  - ***Suggestions:*** Some of this issue will be addressed through the increased eligibility criteria for Medicaid that is part of insurance reform. However, suspending and not terminating Medicaid entitlements for institutional placement and simplifying the Medicaid application/redetermination process will also lead to more stability among the insured population with severe mental illness.

MODULE 6

Integrated Care Program Development

Key Points

The key points in this module include:

- Behavioral health providers need to determine their role related to integrated care and health care homes. Three points along the health care home continuum include:
  - Coordination, Referral and Consultation
  - Partnered-Care
  - Single-Provider Care
- Services, leadership, operations and finance need to be addressed at each point on the continuum.
- Direct Clinical Services, Collaboration Services and Prevention and Wellness Services should be provided at each point on the continuum.

Tools

- Integrated Care Program Development Framework
- Integrated Care Program Development Tool

The Continuum of the Health Care Home

The continuum of the health care home is dynamic and multifaceted. There are an infinite number of points along this continuum because there are many approaches to integrated care that a behavioral health provider might choose.

The three points along the health care home continuum addressed in detail in this guide are: 1) Coordination, Referral and Consultation, 2) Partnered-Care and 3) Single-Provider Care. This module addresses Coordination, Referral and Consultation.

Behavioral Health Provider's Health Care Home Role in Integrated Care

Although each point on this continuum represents a different type of integrated care, the points are not completely independent from one another. As a behavioral health organization decides which type of integrated care it desires to provide, the organization should be aware that Coordination, Referral and Consultation must be achieved before moving to another point on the continuum.

By engaging in an organizational process to review a Coordination, Referral and Consultation program, an organization will be better informed about whether it should consider Partnered-Care or Single-Provider Care—or whether to just advocate more strongly for access and referral to existing services.

As a behavioral health organization considers its role within the health care home continuum, it is important that it assess the local system and infrastructure. The implementation plan for any of the three points along the continuum will be individualized based on potential partners, current system resources and the population to be served. Regardless of which point on the

continuum providers wish to achieve, they will need to consider four areas of program development: services, leadership, operations and finances. The table below depicts the areas to be addressed for each point along the health care home continuum.

Integrated Care Program Development Framework

(Clifford and Thom, 2009)

	Coordination, Referral and Consultation	Partnered-Care	Single-Provider Care
Services			
Leadership			
Operations			
Finance			

Providers will need to assess the following:

1. Services
    - Direct clinical services
    - Collaboration
    - Prevention and wellness
2. Leadership
    - Charter
    - Community affiliation: partnerships
3. Operations
    - Processes
    - Human resources

- Data
- Resources
- Oversight

4. Finance
    - Existing services / payers
    - New services / payers
    - Compliance

Organizations in any stage of integrated care development (contemplation, early action, action, etc.) may benefit from using a clear, consistent program development tool to assist with implementation. The Integrated Care Program Development Tool compiles many of the major considerations and areas for action into a single document. Most importantly, this tool can be used to create a program development plan to guide an organization as it develops integrated care.

The Integrated Care Program Development Tool is not meant to be an exhaustive checklist of things to accomplish before taking another step toward integrated care. The tool is meant to serve as a framework and guide the process of implementing integrated care. Most organizations will want to use this tool with an integrated care consultant who is trained in using this framework.

The program development tool is not a fidelity tool, such as the tools used for implementation of evidence-based practices. However, this tool may be used in a similar fashion to conduct baseline assessments and review progress regularly.

Integrated Care Program Development Tool

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source		Action Plan
Services	*Content Focus:* Direct Clinical Services					
	DCS1	*Direct Clinical Service 1:* primary care, psychiatry, and needed specialty care		Provider / partners provide	% of consumers receiving these services	
	DCS2	*Direct Clinical Service 2:* disease and risk identification		Provider / partners provide	% of consumers receiving these services	
	DCS3	*Direct Clinical Service 3:* monitoring health conditions		Provider / partners provide	% of consumers receiving these services	
	Content Focus: Collaboration					
	CC1	*Collaboration Services 1:* provider identification, utilization monitoring and referral		Provider / partners provide	% of consumers receiving	
	CC2	*Collaboration Services 2:* collaboration		Provider / partners provide	% of consumers receiving	
	CC3	*Collaboration Services 3:* consultation		Provider / partners provide	% of consumers receiving	
	Content Focus: Prevention and Wellness Services					
	PW1	*Prevention and Wellness Services 1:* education		Provider / partners provide	% of consumers receiving	
	PW2	*Prevention and Wellness Services 2:* empowerment / activation		Provider / partners provide	% of consumers receiving	

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source	Action Plan	Focus Area	Item Number
Leadership	L1	*Leadership Task 1:* develop a vision that includes collaboration, fit and wellness		Vision	Mission	Policies	
	L2	*Leadership Task 2:* Find and maintain partner resources for consumers' access to health care		Vision	Mission	Policies	
Operations	O1	*Operations Task 1:* problem identification		Processes	Human resources	Oversight	Available Data
	O2	*Operations Task 2:* problem monitoring		Processes	Human resources	Oversight	Available Data
	O3	*Operations Task 3:* access		Processes	Human resources	Oversight	Available Data
	O4	*Operations Task 4:* referral		Processes	Human resources	Oversight	Available Data
	O5	*Operations Task 5:* utilization		Processes	Human resources	Oversight	Available Data
	O6	*Operations Task 6:* collaboration and consultation protocols		Processes	Human resources	Oversight	Available Data
	O7	*Operations Task 7:* develop physical plant resources and infrastructure		Processes	Human resources	Oversight	Available Data
Finance	F1	*Finance Task 1:* current funding		Services with payers	Services without payers	Certification / accreditation	
	F2	*Finance Task 2:* potential funding		Services with payers	Services without payers	Certification / accreditation	
	F3	*Finance Task 3:* compliance		Services with payers	Services without payers	Certification / accreditation	

Cultural Differences

Identifying and planning to address the cultural differences between behavioral health organizations and primary care providers has been identified as an important consideration for program development. Since systems, staff and offices develop separately, differences in organizations, environments and clinicians need to be taken into account.

A list of potential differences to consider follows. Please keep in mind it is important to understand the unique cultures of specific providers, and generalizations do not always apply.

Organizational Differences (System-Level)

- Reimbursement methodology leading to different practices
    - Fee for service vs. encounter-based
- Documentation requirements
    - Short form / checklist vs. long form / narrative
- Small number of codes vs. large (and changing)
    - Six Medicaid services (10+ years of stability) vs. thousands of CPT codes (yearly changes)

Environmental Differences (Physical Plant)

- Disease self-monitoring tools
  - Blood pressure cuffs, scales and glucose monitoring systems available in some primary care waiting rooms (empowering consumers to take control of their own health)
- Waiting room
  - Short waiting room stay in primary care vs. congregational milieu (in some behavioral health providers)

Clinician Differences (Training and Work Flow)

- Outcomes monitoring
  - Lab values vs. self-report
- Workflow of physician
  - Frequent / expected interruptions vs. scheduled 15-30 minute times with no interruptions
- Appointment length
  - Physician: short for primary care vs. 15-30 min. for psychiatry
  - Advanced practice nurses (APN) and registered nurses (RN): long APN appointment vs. short RN / APN checks in psychiatry
- Medication checks / monitoring
  - Medical assistant in primary care vs. nurse in behavioral care

MODULE 7

Coordination, Referral and Consultation between Behavioral Health and Primary Care

Key Points

The key points in this module include:

- Coordination, Referral and Consultation must be achieved before moving to one of the other points on the health care home continuum.
- The Integrated Care Program Development Tools contained in this chapter will help improve Coordination, Referral and Consultation.

Tools in this Module

- Integrated Care Program Development Framework
- Direct Clinical Service 1: Primary Care, Psychiatry and Needed Specialty Care Checklist
- Problem Identification Checklist
- Monitoring Primary Care Conditions Checklist
- Checklist for Provider Identification and Utilization
- Referral Elements Checklist
- Collaboration Protocols
- Consult Protocol Checklist
- Prevention and Wellness Access
- Collaboration Services Checklist
- Mission Vision Process Checklist
- Local Capacity Checklist
- Leadership Checklist

- Operations Task 1: Problem Identification and Monitoring Checklist
- Operations Task 2: Access / Referral and Utilization Checklist
- Collaboration and Consultation Checklist
- Physical Plant / Resources Checklist
- Tool: Management Oversight Checklist
- Operations: Collaboration and Consultation Checklist for Readiness Assessment
- Collaboration Fiscal Checklist
- Collaboration and Consultation Finance Checklist for Readiness Assessment

Integrated Care Program Development Framework

(Clifford and Thom, 2009)

This module focuses on the areas of integrated care development shaded below:

	Coordination, Referral and Consultation	Partnered- Care with a Specific Resource	Single-Provider Care
Services			
Leadership			
Operations			
Finance			

All behavioral health providers should consider developing specific practices to improve their work with primary and other health care resources in their community. Improving health and functioning is central to the mission of all health care organizations, yet many consumers affected by mental illness either do not use or do not have access to primary care. Also, many behavioral health providers do not have the primary care information to improve outcomes.

Effective Coordination, Referral and Consultation requires the development and maintenance of community relationships, a clear identity as a specialty care provider and organization-wide practices that ensure behavioral health and primary care information is shared.

The Core Activities of Coordination, Referral and Consultation between Behavioral Health and Primary Care

The following activities describe an organization's role in ensuring access to services:

- ***Services:*** Ensure access to behavioral health and primary care services; engage in disease identification and monitoring; and develop protocols for consistent collaboration and prevention and wellness services.

- ***Leadership:*** Develop community resources to ensure access to all three types of integrated care services and clarify the organization's mission to articulate the fit within the local health care system.
- ***Operations:*** Implement routine data collection, appropriate information sharing and monitoring of health conditions and service utilization.
- ***Finance:*** Review use of Behavioral Health (Community) Medicaid and inclusion of collaboration in indirect service costs.

Use of the Tools in this Module

This module contains tools that will improve the integration of health care. The tools contain a lot of information. Most groups will save considerable time and will gain more value from using these tools with the help of an integrated care consultant who is trained to facilitate teams.

Possible New Resources Needed

- Amended job descriptions
- Updated policies and forms
    - Continuity of care (Release of Information / Consent for Treatment / HIPPA Policy)
    - Communication Protocols
- Staff performance indicators and staff evaluation processes
- Relationships to enhance consumer behavioral health and primary care access in the community
- Amended mission and vision for the behavioral health organization's fit and responsibilities within the health care system
- Community Leadership and Internal Leadership Forums

- Updated measurement tools
  - Health status
  - Health care utilization
- Consumer-level data: Chronic health conditions and outside service utilization

Services

This section provides detailed information about Service Coordination, Referral and Consultation between the behavioral health and outside primary care providers. Three types of services provided are:

- Direct Clinical Services
- Collaboration Services between health care professionals
- Prevention and Wellness Services

Direct Clinical Services

Direct Clinical Services involve existing staff members providing treatment that falls within their scope of practice and licensure to consumers. Three Direct Clinical Services should be considered: 1) Primary care, behavioral health and required specialty care, 2) disease and risk identification and 3) monitoring identified health conditions.

Direct Clinical Service 1: Primary Care, Behavioral Health and Required Specialty Care

All individuals should have access to psychiatry, primary care and specialty care (within both behavioral health and primary care). These services are at the core of a health care home. Providing or ensuring access to these services is required at this point along the continuum.

Primary Care, Behavioral Health and Required Specialty Care Checklist

(Clifford and Thom, 2009)

Services	Provider	Population	Location
Behavioral health			
○ Psychiatry			
○ Specialty Behavioral Health Care (case managers, psychiatric nurses, therapists, etc.)			
○ Labs			
○ Other			
Physical Health Conditions (beside behavioral health)			
○ Primary Care			
○ Specialty Care (cardiologists, endocrinologists, etc.)			
○ Labs			
○ Other			
Pharmacy			
Dental			
Other			

Direct Clinical Service 2: Disease and Risk Identification

Identifying health status and chronic conditions is critical to behavioral health work. A number of reports and resources address identifying primary care problems in behavioral health settings. Organizations should identify the primary care conditions that they will routinely screen for and address. As screening and data collection processes are established, consider selecting data that can be used in both behavioral health and primary care settings when possible. The consistency of data collection will facilitate continuity of care and improve

communication among providers. At a minimum, consider screening or collecting information on the health conditions / indicators listed in the Problem Identification Checklist. (Adapted from NASMHPD Medical Directors Council Technical Report – Measurement of Health Status for People with Serious Mental Illnesses. Editors: Joe Parks, Dale Svendsen, Patricia Singer, Mary Ellen Foti, Technical writer: Barbara Mauer, 2006).

Problem Identification Checklist

(*Clifford and Thom, 2009*)

Area/Data Element	Data Source	Collection Point and Frequency	How the Data is Used	Frequency of Data Use
Risk Factors				
Family/personal history of diabetes, hypertension, and/or cardiovascular disease				
History of substance abuse and/or tobacco use				
Antipsychotic, cardiovascular, obesity and diabetes monitoring*				
Other:				
Clinical Values				
Glucose/HbA1C				
Blood pressure				
Waist circumference				
BMI (weight/height)				
Lipid profile				
Other:				
Identified Chronic Health Conditions				
Diabetes				
Cardiovascular illnesses				
Obesity				
Dyslipidemia				
Asthma				
Other:				

** See the American Psychiatric Association Guidelines for screening consumers who are prescribed antipsychotic medications*

Direct Clinical Service 3: Monitoring Identified Health Conditions

Chronic primary care conditions need to be monitored. It is beneficial to train staff to educate and assist consumers in advocating for effective follow-up care. Staff members and consumers should be educated about standard medical management protocols so they can advocate for and routine checks chronic primary care conditions each time they see a health care provider.

The Monitoring Chronic Primary Care Condition Checklist will help organizations evaluate how effectively they monitor chronic conditions.

Monitoring Primary Care Conditions Checklist

(Clifford and Thom, 2009)

Identified chronic condition	**Information for staff and consumers about medical management**	**Specific clinical value monitoring: data and frequency**
Diabetes		
Obesity/waist circumference		
Hypertension		
Heart Disease		
Other:		

Resources:

- The Ohio Coordinating Center for Integrating Care (OCCIC) Disease Monitoring Protocols
- See the Operations section of this module

Collaboration Services

The activities and services listed below are central for specialty-care providers in the health care home framework.

Collaboration Services 1: Provider Identification, Utilization Monitoring and Referral

Ensuring access to the range of outside primary care professionals is a service unto itself. Developing relationships with other organizations to ensure access and utilization of services is essential. Many providers make up the current service array for behavioral health consumers. As the health care system moves to a health care home model, the health care home will take on these responsibilities. In the meantime, it is critical to establish access to health care. Behavioral health providers are encouraged to have ongoing relationships with the primary care and specialty providers that the consumers who they serve use.

Checklist for Provider Identification and Utilization *(Clifford and Thom, 2009)*

This information should be identified for each consumer and then compiled into a list of options for consumers needing a provider.

Provider type(s)	**Provider name and contact information**	**Source of the utilization data***
Health care home		
Primary care		
Hospital (inpatient)		
Emergency room		
Pharmacy		
Dental		
Prevention and wellness services		

**Report from a provider, managed care utilization data, consumer self-report, etc.*

Referral Elements Checklist

	On referral form?	Data Source (where was this information found?)
Demographic Information		
Diagnosis		
Referral Purpose		
Medications		
Insurance/Payer		
Provider Collected Clinical Data		
Requested Clinical Data		
Brief History		
Contact information		

Collaboration Services 2: Collaboration Protocols

All organizations have policies and protocols for sharing health information. As organizations develop clear expectations about identifying clinical problems and ensuring access to health care, developing policies to address collaboration and communication will improve management oversight and (see Operations section) consumer health outcomes.

Collaboration Protocols

(Clifford and Thom, 2009)

Does the organization have the following policies/protocols?

Does the organization have policies about…	Who collaborates?	What information?	How information is shared (means)	How often (frequency)
…internal collaboration?	Across departments			
	Within medical			
…external collaboration?	Medical home			
	Primary care			
	Specialty care			
	Emergency dept.			
	Hospital (inpt.)			
	Other:			

Resources:

- OCCIC Confidentiality/Release of Information paper
- Ohio Association of Community Health Centers

Considerations:

- Consider the electronic health record and other health information technology (HIT) systems.

Collaboration Services 3: Consultation

Many organizations have informal relationships between internal and external providers. For treating individuals with particularly complex medical conditions, developing consultation resources and protocols may enhance response to psychiatric treatment and improve overall health. The following checklist is meant to provide guidance as agencies develop policy / protocols for consultation.

Consult Protocol Checklist
(*Clifford and Thom, 2009*)

Does the organization have policies / practices in place for its health care providers that pertain to:

When (circumstance) providers seek consultation?

With whom? (internal/external, person, practice, discipline)

How providers access consulting physicians?

What information providers share/seek?

Resources:

- OCCIC Continuity of Care: Confidentiality/Release of Information paper.
- Consider bi-directional consultation as a means to garner outside consulting services.

Prevention and Wellness Services

Prevention and wellness (PW) services are critical to managing chronic conditions and speak directly to the goal of all provider organizations: wellness. In the context of Coordination, Referral and Consultation, PW services are delivered outside of the behavioral health organization. Therefore, behavioral health staff members promote access to PW services by identifying and referring consumers to wellness education and empowerment / activation activities.

Prevention and Wellness Services 1: Education

- General wellness information
- Disease-specific information for frequently noted chronic health conditions
    - Symptoms / course / cause
    - Treatment options / prognosis
- Advanced Directive information for medical and psychiatric services

Prevention and Wellness Services 2: Empowerment / Activation

- Communication skills
- Assertiveness (communicating with HCPs / ADs)
- Support / universality / social
- Self-management

Prevention and Wellness Access

(Clifford and Thom, 2009)

	Name and contact information (outside of provider)	**Specific services provided**
Education		
General wellness		
Disease information: symptoms, course, cause		
Disease information: treatment options, prognosis		
Advance directive information / assistance		
Self management		
Empowerment/activation		
Communication skills (see *Education*)		
Assertiveness (communicating with HCPs/ADs)		
Support, universality, social		
Self management*		

*Teach self management of medical illness skills, such as how to take one's own blood pressure

Resources:

- OCCIC Prevention and Wellness Paper
- Prevention and Wellness Bibliography
- National Council of State Mental Health Program Directors (NASMHPD) Morbidity and Mortality report

Collaboration Services Checklist

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source		Action Plan
Services	*Content Focus:* Direct Clinical Services					
	DCS1	*Direct Clinical Service 1:* primary care, psychiatry, and needed specialty care		Provider / partners provide	% of consumers receiving these services	
	DCS2	*Direct Clinical Service 2:* disease and risk identification		Provider / partners provide	% of consumers receiving these services	
	DCS3	*Direct Clinical Service 3:* monitoring health conditions		Provider / partners provide	% of consumers receiving these services	
	Content Focus: Collaboration					
	CC1	*Collaboration Services 1:* provider identification, utilization monitoring and referral		Provider / partners provide	% of consumers receiving	
	CC2	*Collaboration Services 2:* collaboration		Provider / partners provide	% of consumers receiving	
	CC3	*Collaboration Services 3:* consultation		Provider / partners provide	% of consumers receiving	
	Content Focus: Prevention and Wellness Services					
	PW1	*Prevention and Wellness Services 1:* education		Provider / partners provide	% of consumers receiving	
	PW2	*Prevention and Wellness Services 2:* empowerment / activation		Provider / partners provide	% of consumers receiving	

Leadership

In order to ensure that consumers receive the Coordination, Referral and Consultation services they need, behavioral health leaders will need to identify health care resources and to create a vision for how their organizations will fit within a health care home and the local health care community.

Leadership Task 1: Develop a Vision that Includes Wellness, Collaboration and Fit

The leadership of an organization may consider amending its core vision, mission and policies to reflect attention to wellness by ensuring access to and collaboration with local health care resources. The Mission Vision Process Checklist suggests some areas for specific focus.

As organizations articulate their roles within the health care home and create access to health care services, reviewing the organization's charter may be in order. Thoughtfully reflecting on mission and vision may suggest changes to policies and practices that promote wellness.

Mission Vision Process Checklist

(Clifford and Thom, 2009)

	Question	Vision/Mission
Wellness	How does access to and collaboration with existing health care assist the organization's vision for consumer wellness?	
Organization as a Specialty Care Provider within a Medical Home	Is the organization seen as a specialty care provider by primary care providers?	
	How does the organization see itself in relation to other local health services?	
Services	What services does the provider deliver to coordinate care with local health care resources?	
Ensuring Access	How does the provider ensure access to needed health care services?	
Population	If the organization has a primary care clinic (or partners to provide primary care), which consumers go to the clinic, and which ones use other local resources?	

Leadership Task 2: Find and Maintain Partner Resources for Consumers' Access to Health Care

Many adults served by behavioral health providers need to find and develop relationships with health care providers. As an organization seeks to develop collaboration services, leaders can play critical roles in identifying resources and connecting consumers with the most appropriate resources. As an organization develops consistent protocols for collaboration, other health

care providers may be more receptive to taking referrals. Finding and developing primary and other health care referral sources is critical for any behavioral health organization seeking to develop integrated care. The Local Capacity Checklist suggests some key action steps.

Local Capacity Checklist

(Clifford and Thom, 2009)

Service	Provider Name/Contact	Accepting Referrals?	Provider Organization Contact
Primary care			
Primary care (health care home)			
Specialty care			
Hospital (inpatient)			
Pharmacy			
Prevention and wellness services			
Emergency department			
Dental care			

Resources:

- National Council's Person-Centered Health Care Home paper
- National Council's Four Quadrant model
- Community Leadership Forum Section of this implementation guide

Possible resources for identifying capacity:

- Resources serving existing consumers
- Community Leadership Forums
- Insurers (including Managed Care)
- Hospitals

Leadership Checklist

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source			Action Plan
Leadership	L1	*Leadership Task 1:* develop a vision that includes collaboration, fit and wellness		Vision	Mission	Policies	
	L2	*Leadership Task 2:* Find and maintain partner resources for consumers' access to health care		Vision	Mission	Policies	

Operations

As a behavioral health organization prepares to implement any integrated care service, there are five operational and administrative areas to be addressed: 1) processes, 2) human resources, 3) data, 4) resources and 5) oversight.

Operations Task 1: Problem Identification and Monitoring

Identification and monitoring of a consumer's health status and conditions are suggested services for all behavioral health organizations. If an organization is not providing primary care

on site (either by direct staffing or through a partnership), it stills need to clarify the mechanism by which it will monitor health status and conditions.

Operations Task 1: Problem Identification and Monitoring Checklist *(Clifford and Thom, 2009)*

	Problem Identification			**Ongoing Monitoring (when health condition identified)**		
	Current	Goal	Needs	Current	Goal	Needs
Processes						
Human Resources						
Data						
Resources						
Oversight						

Operations Task 2: Access / Referral and Utilization

Access/Referral and Utilization is similar to Problem Identification and Monitoring; all organizations need to implement a monitoring process and collect monitoring data. An organization can proactively develop relationships and services that will facilitate greater access to a full range of health care services. Health care providers do want collaborative relationships with other providers, especially when consistent collaboration and communication mechanisms are clear. Developing these relationships is largely the work of respective organizational leaders. However, implementing referral, monitoring utilization and informing staff of the availability of the collaborative services are the responsibilities of the organization. The following checklist is meant to aid in the organizational development of the access and referral processes and monitoring utilization.

Operations Task 2: Access / Referral and Utilization Checklist

(Clifford and Thom, 2009)

	Access			**Referral**			**Utilization Monitoring**		
	Current	Goal	Needs	Current	Goal	Needs	Current	Goal	Needs
Processes									
Human Resources									
Data									
Resources									
Oversight									

Resources:

- Community Leadership Forum and other leadership groups
- Current Leadership Integrated Care Plan
- Current Operations Integrated Care Plan Consumer

Operations Task 3: Collaboration and Consultation

Collaboration and consultation with outside health providers requires new staff activities and considerations. The Collaboration and Consultation Checklist can help an organization in identifying new resource requirements and necessary organizational changes.

Collaboration and Consultation Checklist

(*Clifford and Thom, 2009)*

	Collaboration			**Consultation**		
	Current Status	Goal (Preferred Status)	Needs to Fill the Gap	Current Status	Goal (Preferred Status)	Needs to Fill the Gap
Processes						
Human Resources						
Data						
Resources						
Oversight						

Operations Task 4: Develop the Physical Plant infrastructure and resources

The physical plant and supplies also need to be accessed. Depending on the type of services the organization plans to provide, it should consider the following:

Physical Plant / Resources Checklist

(*Clifford and Thom, 2009)*

	Needs	Resources	Timeframe	Maintenance
Space				
Build out				
Office				
Exam				
Records: EMR is essential. Determine which EMR is used at various levels of care.				
Other				
Patient flow				
Front window				
Sick/Well Space				
Waiting room				
Other				
Staff Flow				
Charting				
Congregate area				
Other				
Tools				
Supplies				
Equipment				
Other				

Implementation of any integrated care service should build on current resources and practices. Start with reviewing current practice and identify gaps. Decide on the administrative structure, processes, goals and resources needed. Create and execute the implementation plan.

Tool: Management Oversight Checklist

(Clifford and Thom, 2009)

The Management Oversight Checklist assists in the management and oversight of collaboration. If an organization has the data necessary to implement this tool, the organization has a pathway to implement the administrative processes for Coordination, Referral and Consultation.

	Service Provider	Number of Consumers in Provider	Number of Consumers who Need Primary Care	Provider Organization Staff Lead	Provider Organization Goal	Action Steps
Problem Identification						
% Screened Annually						
Monitoring						
% Monitored (of ID Conditions)						
Access						
ID Primary Care						
Specialty Access						
ID Consultation Sources						
ID # of Hospital / ED (if used)						
# of PW services						
Utilization						
Primary Care						
Monthly-annual contacts						
Collaboration						
# ISPS collaboration goals						

Operations: Collaboration and Consultation Checklist for Readiness Assessment

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source			Action Plan
Operations	O1	*Operations Task 1:* problem identification		Processes	Human resources	Oversight	Available Data
	O2	*Operations Task 2:* problem monitoring		Processes	Human resources	Oversight	Available Data
	O3	*Operations Task 3:* access		Processes	Human resources	Oversight	Available Data
	O4	*Operations Task 4:* referral		Processes	Human resources	Oversight	Available Data
	O5	*Operations Task 5:* utilization		Processes	Human resources	Oversight	Available Data
	O6	*Operations Task 6:* collaboration and consultation protocols		Processes	Human resources	Oversight	Available Data
	O7	*Operations Task 7:* develop physical plant resources and infrastructure		Processes	Human resources	Oversight	Available Data

Finance

There are very few current payers for Coordination, Referral and Consultation services or for behavioral health providers. Behavioral Health (Community) Medicaid is meant for the exclusive benefit of the consumer and does not pay for collaboration or consultation services. Furthermore, the services must be for the behavioral health needs of the consumers served.

As public and private payers begin to develop payment mechanisms for health care homes, collaboration services are increasingly being considered as activities for reimbursement. In the meantime, we recommend reviewing current activities, calculating costs (direct vs. indirect) and consulting with fiscal experts.

Behavioral Health (Community) Medicaid Rehabilitative in nature:

- Medically necessary
- For the exclusive benefit of Medicaid beneficiary
- Addresses psychiatric need Medicaid:
- Must address needs identified in the assessment treatment plan

Indirect Costs:

- Review current indirect cost formulas to ensure they capture these services as appropriate.

Collaboration Fiscal Checklist

(*Clifford and Thom, 2009)*

	Current			**Potential**			**Compliance**		
Service	Discrete Services	Cost	Current Payer	Current Rate	Potential Payer	Fiscal Need	Billing Infra-structure	Provider organization Certification /Accreditation	Individual Provider Certification / Accreditation Provider Organization
Clinical Direct									
Collaboration									
Prevention and Wellness									

Collaboration and Consultation Finance Checklist for Readiness Assessment

(Clifford and Thom, 2009)

Focus Area	**Item Number**	**Content Focus**	**Description of Current Practice**	Services with payers	Services without payers	Certification / accreditation	**Action Plan**
Finance	F1	*Finance Task 1:* current funding					
	F2	*Finance Task 2:* potential funding					
	F3	*Finance Task 3:* compliance					

MODULE 8

Partnering with a Specific Primary Care Resource

Key Points

The key points in this module include:

- This module highlights Integrated Care Program Development tools and information about partnering with a specific primary care resource within a behavioral health provider.

Tools

- Integrated Care Program Development Framework
- Primary Care, Behavioral Health and Needed Specialty Care Checklist
- Disease and Risk Identification Checklist
- Monitoring Identified Health Conditions Checklist
- Provider Identification, Utilization Monitoring and Referral Checklist
- Collaboration Protocols
- Partnership Consult Protocol Checklist
- Partnership Prevention and Wellness Services Checklist
- Partnership Services Checklist
- Partnership Mission and Vision Process Checklist
- Agreement Checklist
- Data Elements for Partnering Checklist
- Potential Partner Resources Checklist
- Leadership Checklist
- Problem Identification and Monitoring Checklist
- Access / Referral and Utilization Checklist

- Operations Task 3: Collaboration and Consultation Checklist
- Physical Plant / Resources Checklist
- Management Oversight Checklist
- Operations: Partnership Checklist
- Partnership Fiscal Checklist
- Finance Checklist

Integrated Care Program Development Framework

(Clifford and Thom, 2009)

This module focuses on integrated care program development for the shaded areas below.

	Coordination, Referral and Consultation	Partnered-Care with a Specific Resource	Single-Provider Care
Services			
Leadership			
Operations			
Finance			

Use of the Tools in this Module

This module contains tools that will guide organizations as they seek to improve integrated behavioral health and primary care. The tools contain a considerable amount of information. Most groups will save a significant amount of time and will increase the value they gain from using the tools if they pair them with the assistance of an integrated care consultant trained to facilitate teams.

Many of the program development activities for developing Partnered-Care with a Specific Resource are the same as the activities for developing Coordination, Referral and Consultation care. With an identified partner, several additional considerations define the relationship and scope of the partnership. The arrangement must also take business and legal relationships, oversight mechanisms, target populations and financial considerations into account.

This module is organized like the other modules, but further detail is provided for specific areas that are determined by whether the partner is co-located (a primary care clinic that is part of the grounds of a behavioral health organization) or partnered (located on a separate site).

The Core Activities of Partnering

- *Services:* These include specific referral opportunities for specialty care.
- *Leadership:* Finding and developing partnerships is difficult and requires ongoing learning. A plan and agreement that are clear about scope and responsibilities are required.
- *Operations:* Depending upon the specific arrangement, co-located clinics may require new operational processes and infrastructure, including changes to the physical plant. Data sharing and oversight mechanisms need to be created, and patient flow needs to be addressed.
- *Finance:* This involves developing an understanding and ability to assist both organizations with payment, insurance and compliance.

Possible New Resources

Some possible new resources may include:

- Memorandum of Understanding / Business Agreement
- Consumer group assignment mechanism
- Collaboration infrastructure
- Data for oversight
- Insurance status
- Utilization Monitoring
- Data sharing
- Community Leadership Forum expansion for finding partners

- Physical plant changes
- Customer flow
- Marketing

Direct Clinical Service 1*:* Primary Care, Behavioral Health and Needed Specialty Care Checklist

(*Clifford and Thom, 2009)*

For organizations using a Partnered-Care framework, each partner should identify which services they are providing and for which populations they are providing these services.

Services	Provider	Population	Location
Behavioral health			
Psychiatry			
Specialty Behavioral Health Care			
Labs			
Other			
Primary Care			
Specialty Care			
Labs			
Other			
Pharmacy			
Dental			
Other			

Direct Clinical Service 2: Disease and Risk Identification

Identifying specific health conditions is central to all health care practice. Each organization has processes that and staff who assess need. This focus area aims to articulate the means and responsibilities for problem identification in a partnership.

Disease and Risk Identification Checklist

(*Clifford and Thom, 2009)*

	Population	Provider	Frequency	Charting
Assessment Point				
Information collected				

Resources:

- Module 5
- National Council of State Mental Health Program Directors (NASMHPD) Morbidity and Mortality report
- ADA/APA / AACE / NAASO Monitoring Protocol: Consensus on Antipsychotic Drugs and Obesity and Diabetes

Direct Clinical Service 3: Monitoring Identified Health Conditions

Monitoring chronic health conditions and treatment is critical to ensuring quality care. As both organizations will be seeing the same consumers, establishing an understanding of monitoring responsibilities and data is very helpful.

Monitoring Identified Health Conditions Checklist

(*Clifford and Thom, 2009)*

Chronic Illness	Tool/Value	Provider	Frequency	Charting
• **Behavioral Health**				
○ Psychotic Disorders				
○ Mood Disorders				
○ Anxiety Disorders				
○ Personality Disorders				
○ Substance Use Disorders				
○ Other:				
• **Primary care**				
○ Diabetes				
○ Cardiovascular				
○ Obesity				
○ Other:				

Resources:

- Module 5
- National Council Of State Mental Health program Directors (NASMHPD) Morbidity and Mortality report
- See OCCIC Disease Monitoring Protocols
- See Operations section of this module

Collaboration Services 1: Provider Identification, Utilization Monitoring and Referral

Although covered in the Operations and Leadership sections of this module, both partnered organizations must undertake clinical services and processes to identify consumer needs and fit. This may be a straightforward area of program development, as both organizations are attending to consumer need and current service connection. Specifically articulating the clinical intervention and the process of identifying the population for the partnered clinical providers is an important action step in collaborative practice building.

As an example, several partnered efforts in Ohio are focusing on diabetes management, while other partners are addressing depression and primary care. The project may be targeting those with low utilization of health care from outside providers. If so, identifying where the people who are using outside providers are getting treatment is critical. Identifying a population and means-utilization tracking are essential parts of clinical assessment and referral when two organizations are working together to serve the same consumers.

Provider Identification, Utilization Monitoring and Referral Checklist (*Clifford and Thom, 2009*)

	Target Population	Assessment Info	Referral Process	Utilization Monitoring
Primary Health Clinic				
Outside Primary Care				

Collaboration Services 2: Collaboration Protocols

All organizations have policies and protocols for sharing health-related information. As partnered organizations develop clear expectations about clinical problem identification and health care access, developing policies to address collaboration and communication expectations specifically will improve the provider organization's oversight (see Operations section) and consumer health outcomes.

Collaboration Protocols

(*Clifford and Thom, 2009*)

Does the provider organization have the following policies/protocols?

	Who (staff) collaborates?	What information?	How information is shared (means)	How Often (frequency)
• **Internal - Behavioral Health**				
○ Across Departments				
○ Within Medical				
• **Partner:**				
○ Primary Care				
• **Outside:**				
○ Pharmacy				
○ Specialty Care				
○ Emergency Department				
○ Hospital (Inpatient)				
○ Other:				

Collaboration Services 3: Consultation

Many organizations have informal relationships between internal and external health service providers. Consultation resources are one of the indirect benefits that come from a partnership. For particularly complex medical conditions, development of a specific consultation resource and protocol between the partnered organizations may serve to enhance consumers' response to psychiatric treatment and improve overall health. The Partnership Consult Protocol Checklist provides guidance as agencies develop policy and protocols for consultation services.

Partnership Consult Protocol Checklist

(*Clifford and Thom, 2009)*

Does the organization have policies and practices in place for its health care providers?

	Primary Care	**Psychiatry/ Behavioral Health**
When (circumstance) do the organization's providers seek consultation?		
With whom?		
How does the organization access consulting providers?		
What information is needed / shared with other providers?		
How do providers chart?		
Do providers have a routine/standing consultation group?		

Prevention and Wellness Services

Prevention and wellness services are critical to managing chronic conditions and speak directly to the goal of all health care organizations: wellness. Because this module addresses partnered arrangements with primary care resources, the program development activities are the same as those in Module 5. However, with additional primary care resources and expertise, there are several areas for program development consideration: cross-training and cross-availability of services by both organizations.

Prevention and Wellness Services 1: Education

- General wellness information
- Disease-specific information for frequently noted chronic health conditions
  - Symptoms / course / cause
  - Treatment options / prognosis

- Advanced directive information for both medical and psychiatric services
- Consideration of training behavioral health staff on all of the above

Prevention and Wellness Services 2: Empowerment / Activation

- Communication skills
- Assertiveness (communicating with HCPs / ADs)
- Support / universality / social
- Self-management
- Consideration of training primary care staff on recovery

Partnership Prevention and Wellness Services Checklist

(Clifford and Thom, 2009)

Service	Primary Care Provider	Behavioral Health Provider	Partnership	Outside Provider
Education				
General wellness				
Disease information: Symptoms / course / cause				
Disease Information: treatment options / prognosis				
Advance Directive Information/Assistance				
Self -Management				
Empowerment Activation				
Communication Skills (see Education)				
Assertiveness (communicating with HCPs / Ads)				
Support / Universality / Social				

Resources:

- Patient Charts
- Electronic Management System
- Shared staff (e.g. CPST workers, nurses, etc.)
- OCCIC Confidentiality / release of Information paper
- Module 5
- OCCIC Continuity of Care: Confidentiality/Release of Information paper
- Also, consider bi-directional consultation to gain technical assistance

Partnership Services Checklist

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source		Action Plan
Services	*Content Focus:* Direct Clinical Services					
	DCS1	*Direct Clinical Service 1:* primary care, psychiatry, and needed specialty care		Provider / partners provide	% of consumers receiving these services	
	DCS2	*Direct Clinical Service 2:* disease and risk identification		Provider / partners provide	% of consumers receiving these services	
	DCS3	*Direct Clinical Service 3:* monitoring health conditions		Provider / partners provide	% of consumers receiving these services	
	Content Focus: Collaboration					
	CC1	*Collaboration Services 1:* provider identification, utilization monitoring and referral		Provider / partners provide	% of consumers receiving	
	CC2	*Collaboration Services 2:* collaboration		Provider / partners provide	% of consumers receiving	
	CC3	*Collaboration Services 3:* consultation		Provider / partners provide	% of consumers receiving	
	Content Focus: Prevention and Wellness Services					
	PW1	*Prevention and Wellness Services 1:* education		Provider / partners provide	% of consumers receiving	
	PW2	*Prevention and Wellness Services 2:* empowerment / activation		Provider / partners provide	% of consumers receiving	

Leadership

Since this point along the health care home continuum involves partnering, leadership for program development is very important. Leaders should strive to establish and articulate a structured, clear relationship that reflects the mission and vision of both organizations.

Leadership Task 1: Develop a Vision that Includes Collaboration and Fit

Ensuring a vision and mission that are aligned with the local health care system requires consistent commitment from both parties. In addition to aligning missions, the leadership goal is to articulate the shared vision and to produce two specific agreements: a legal partnership agreement and an agreed-upon data set for monitoring project goals.

As organizations move to articulate their role in the health care home and ensure access to health care services, reviewing the organization's charter may be in order. Reflectively reviewing policies and practices may reveal action steps that will promote an overarching approach to wellness.

See task 1 for both organizations: mission / vision / population / fit.

The following process tool can be used to facilitate a partnership mission / vision discussion (adapted from previous module).

Partnership Mission and Vision Process Checklist

(Clifford and Thom, 2009)

		Behavioral Health	Primary Care	Common
Wellness	How do both organizations define and approach their role in assisting people in achieving wellness?			
Role as a Provider within a Community	How does the organization see itself within the local health care continuum?			
	How does the organization see itself in relation to other local health services?			
Services	What services does the provider organization deliver to attend to wellness?			
Ensuring Access	How does the provider organization ensure access to needed health care services?			
Population	How does the organization decide who it serves and who is served outside of the organization?			

Defining the relationship between the two organizations requires common understanding and shared expectations. We suggest developing a Memorandum of Understanding, a Business Agreement or an Affiliation Agreement. The type of agreement will depend on each organization's needs and the scope of the project. There are many resources and sample agreements available from multiple sources. Rather than prescribing a specific type of

agreement, we suggest that all parties consider the following elements when preparing agreements:

Agreement Checklist

(Clifford and Thom, 2009)

	Included in the Agreement?
Project goals	
Individual and joint responsibilities	
Individual and joint resources	
Governing / collaborative structure	
Term	
Finance	
HIPAA / confidentiality	
Performance indicators	
Staff hiring and addressing performance issues	
Mechanism for amending	
Dispute resolution	
Other	

Data collection, reporting and monitoring can be challenging. It is important to identify the types of data that the partnership will use to assess efficacy, viability and achievement of its shared vision and goals.

Data Elements for Partnering Checklist

(Clifford and Thom, 2009)

• **Clinical**	
o Services Provision	
o Staff Utilization	
o Consumer Utilization	
• **Organizational**	
o Physical Plant	
o Chart/Records	
o Patient Flow	
• **Fiscal**	
o Start-up	
o Primary Care	
o Behavioral Health	
o Insurance Status	

Leadership Task 2: Find and Maintain Partner Resources for Consumers' Access to Health Care

Many adults served by behavioral health providers need to find and develop relationships with primary care providers. As an organization seeks to develop partnered resources, finding a partner is one of the main tasks. As a behavioral health provider develops better collaboration with other health care providers, identifies consumer needs and shares its vision and role in the local health care continuum, partners will be easier to find. The Community Leadership Forum can serve as a means for identifying potential partners.

Data about current health care utilization by consumers, local safety net resources, payers and local access initiatives are all resources for finding and building partnerships.

Potential Partner Resources Checklist

(Clifford and Thom, 2009)

	Partner Type	Consumer Utilization	Contact	In Community Leadership Forum?
Health Care	Primary care connection			
	Medical home connection			
	Inpt. hospital (primary care)			
	Inpt. hospital (psychiatric / crisis)			
Community Safety Net Resources	Free clinics			
	Federally-qualified health centers (FQHCs)			
	School-based health centers			
	City / county health departments			
	Other			
Payer	Mental health board			
	Managed Care			
	Insurers			
Local Access Initiatives	*Community-specific*			

Possible Resources for identifying capacity:

- Resources serving existing consumers
- Community Leadership Forums
- Insurers (including Managed Care)
- Hospitals

Leadership Checklist

(*Clifford and Thom, 2009*)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source			Action Plan
Leadership	L1	*Leadership Task 1:* develop a vision that includes collaboration, fit and wellness		Vision	Mission	Policies	
	L2	*Leadership Task 2:* Find and maintain partner resources for consumers' access to health care		Vision	Mission	Policies	

Operations

At any point along the health care home continuum, integrated care requires staff and resources throughout an organization. As a behavioral health organization prepares to implement any integrated care service, there are five operational and administrative areas that should be addressed: processes, human resources, data, resources and oversight.

Operations Task 1: Problem Identification and Monitoring

Identification and monitoring of each consumer's health status and conditions are suggested services for all behavioral health providers. Because this is a partnered arrangement, it is important to clarify the responsibilities of each partner as mechanisms for problem identification and monitoring are developed. The following is a checklist for the key operational areas. This includes clarification of each organization's responsibilities for policy and practice regarding the following:

What are the data, processes, resources, staff and oversight for health status problem identification and monitoring?

Problem Identification and Monitoring Checklist

(Clifford and Thom, 2009)

		Problem Identification				**Ongoing Monitoring (when health condition identified)**		
	Current: Behavioral Health	Current Primary Care	Goal	Needs	Current: Behavioral Health	Current Primary Care	Goal	Needs
Processes								
Staff								
Data								
Resources								
Oversight								

Implementation of any new integrated care service should build upon current resources and practices. It is recommended that an organization begin by reviewing current practices; decide on the organizational, administrative and process goals and the resources needed; and use them to implement the process of problem Identification and monitoring of health status.

Areas for consideration include:

- Processes: Intake and medical appointment processes and information from Progress Notes
- Human Resources: Responsibilities and monitoring expectations of current job descriptions and staff responsibilities, including intake, medical and clinical staff
- Data: Existing EMR and management data
- Resources: Health Assessment, diagnostic assessment and management reports
- Oversight: Current management oversight process at staff, program and leadership levels

Operations Task 2: Access / Referral and Utilization

It is essential that partnered-care collaborations meet both partner and consumer needs. Utilization of services is a key indicator of organizational and consumer satisfaction with the program. In order to ensure that utilization expectations are clear, developing operational processes with clear targets and referral criteria is essential.

Access / Referral and Utilization Checklist

(Clifford and Thom, 2009)

	Access			**Referral**			**Utilization Monitoring**		
	Current	Goal	Needs	Current	Goal	Needs	Current	Goal	Needs
Processes									
Staffing									
Data / Targets									
Resources									
Oversight									

Operations Task 3: Collaboration and Consultation

Operational collaboration and consultation processes involve multiple staff members from throughout the organization. In a partnership arrangement, there are more resources for collaboration available. Current processes, data and electronic health records are potential resources for facilitating ongoing clinical collaboration and consultation between the organizations.

Operations Task 3: Collaboration and Consultation Checklist

(Clifford and Thom, 2009)

	Collaboration				Consultation			
	Current Behavioral Health	Current Primary Care	Goal	Needs	Current Behavioral Health	Current Primary Care	Goal	Needs
Processes								
Human Resources								
Data								
Resources								
Oversight								

Operations Task 4: Develop the Physical Plant Infrastructure and Resources

Depending on the type of services that will be delivered, an organization should consider the changes in Physical Plant / Resources Checklist as part of its integrated care planning.

Physical Plant / Resources Checklist

(Clifford and Thom, 2009)

		Needs	Resources	Timeframe	Maintenance
Space	Construction and refurbishing				
	Office				
	Exam				
	Records				
	Other				
	Front window				
Consumer flow	Sick and well space				
	Waiting room				
	Other				
	Charting and paperwork				
Staff Flow	Congregating area				
	Other				
	Supplies				
Tools	Equipment				
	Other				

Clarify the needed operational infrastructure and designated responsibilities for ensuring access / referral / utilization for each organization:

- Process
    - Do the processes and workflows for each organization align?
    - How does referral work?
- Human Resources
    - Which staff members are critical to involve in planning?
    - Which staff members are responsible for ensuring access / referral and utilization?
    - Does the organization need to consider amending job descriptions of medical and records staffs to include collaboration responsibilities?
- Data
    - What data sources are to be used in oversight and QI and how frequently?
    - Who collects and compiles the data?
- Resources
    - What additional resources are needed to ensure utilization and access?
- Oversight
    - What oversight process will be used to review processes and persons responsible for ensuring access and utilization?
    - Does the organization need to consider amending chart review process?

Management Oversight Checklist

(Clifford and Thom, 2009)

The following tool is meant to assist in defining operational processes and data management used for management oversight. If an organization has the data necessary to implement this tool, the organization has a pathway to implement the administrative processes for this point along the health care home continuum.

		Service Provider	Number of consumers in provider organization	Number of consumers that need the service to the left	Provider organization Staff Lead	Provider organization Goal	Action Steps
Problem Identification	% Screened (annually)						
Monitoring	% Monitored (of ID Conditions)						
Access	ID Primary Care						
Specialty Access	ID Consultation Sources						
	ID # of Hospital / ED (if used)						
	# of PW services						
Utilization	Primary Care						
	Monthly-annual contacts						
Collaboration	# of ISPS with collaboration?						

Operations: Partnership Checklist

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source			Action Plan
Operations	O1	*Operations Task 1:* problem identification		Processes	Human resources	Oversight	Available Data
	O2	*Operations Task 2:* problem monitoring		Processes	Human resources	Oversight	Available Data
	O3	*Operations Task 3:* access		Processes	Human resources	Oversight	Available Data
	O4	*Operations Task 4:* referral		Processes	Human resources	Oversight	Available Data
	O5	*Operations Task 5:* utilization		Processes	Human resources	Oversight	Available Data
	O6	*Operations Task 6:* collaboration and consultation protocols		Processes	Human resources	Oversight	Available Data
	O7	*Operations Task 7:* develop physical plant resources and infrastructure		Processes	Human resources	Oversight	Available Data

Finance

There are very few current payers for partnering with a specific primary care partner for services or for behavioral health providers. Behavioral Health (Community) Medicaid is meant for the exclusive benefit of the consumer and does not pay for collaboration or consultation services. Furthermore, the services must be for the behavioral health needs of the consumers served. As public and private payers begin to develop payment mechanisms for health care homes, they are increasing considering collaboration services as reimbursable activities. For now, however, it is suggested that organizations review current activities, calculate direct and indirect costs and consult with fiscal experts.

Behavioral Health (Community) Medicaid:

- Rehabilitative in nature

- Medically necessary
- For the exclusive benefit of the Medicaid beneficiary
- Addresses psychiatric need
- Must address needs identified in the assessment and treatment plan

Indirect Costs:

- Review the organization's current indirect cost formulas to ensure they capture the inclusion of these services as appropriate.
- Behavioral Health (Community) Medicaid's limits / coverage
- Other funding: Limits / coverage
- Compliance: Documentation / charting and prerequisites

Partnership Fiscal Checklist

(Clifford and Thom, 2009)

	Current			Potential			Compliance		
Service	Discrete Services	Cost	Current Payer	Current Rate	Potential Payer	Fiscal Need	Billing Infrastructure	Provider organization Certification / Accreditation	Individual Provider Certification / Accreditation Provider organization
Clinical Direct									
Collaboration									
Prevention and Wellness									

Finance Checklist

Focus Area	Item #	Content Focus	Description of Current Practice	Services with payers	Services without payers	Certification/ Accreditation	Action Plan
Finance	F1	*Finance Task 1:* current funding					
	F2	*Finance Task 2:* potential funding					
	F3	*Finance Task 3:* compliance					

Profiles

Interviews with Executives: Two examples of behavioral health organizations that are in the process of implementing integrated care by partnering with specific providers follow.

Greater Cincinnati Behavioral Health Services (GCB) and the Health Care Connection (THCC)

Greater Cincinnati Behavioral Health Services (GCB) is the most comprehensive behavioral health provider organization in Hamilton County, Ohio, serving more than 4,000 adults with severe mental illness annually. The Health Care Connection (THCC) is a Federally-Qualified Health Center (FQHC) and a leader in providing primary care to low-income, underinsured and uninsured people in northern Hamilton County. These two organizations engaged in a pioneering effort to collaborate to provide behavioral health and primary care to people affected by severe mental illness.

We interviewed Jeff O'Neil, Community Support Services Director at GCB, who pointed out that, on average, people affected by severe mental illness die much earlier than members of the general population. The disparities and barriers that contribute to this problem are well-recognized and include poverty, substance abuse, stigma and inadequate access to both behavioral health and primary care. The GCB-THCC partnership aims to provide greater access to health care and improved outcomes for the individuals served.

Several years ago, GCB began providing limited primary care to its consumers through a small pilot program that included the services of one part-time nurse practitioner. The Health Foundation of Greater Cincinnati provided the majority of the funding for the pilot project. A merger between two behavioral health agencies (which resulted in what is now GCB) and a stronger focus on integrating behavioral health and primary care lead to increased referrals to the primary care clinic.

As the pilot program came to a close, GCB and The Health Foundation searched for a new primary care partner who was willing to sustain the services and meet increased needs. In 2007, THCC co-located a primary health care clinic at GCB's new location at 1501 Madison Road. This allowed for an increase in service capacity and the ability to serve more than 500 consumers at the clinic. An additional grant from The Health Foundation provided the funding necessary to support expanded services.

At present, a THCC primary care physician and other clinical staff provide primary care to nearly 900 GCB consumers in the same location where they receive their behavioral health care each year.

O'Neil told us that the need for and the concept of integrated care have received increasingly wide support from state and national behavioral health organizations, including the Ohio Department of Mental Health (ODMH), the National Council For Community Behavioral Health care and the Substance Abuse and Mental Health Services Administration (SAMHSA). However, significant barriers to integrated care remain.

Currently, as O'Neil pointed out, the care provided by GCB and THCC is done by the two separate organizations with separate funding sources; the partners have agreed to co-locate so they can improve access to care. Except for short-term grants intended to help jump-start the efforts and fund demonstration projects, there is currently a lack of funding in Ohio to support many of the activities involved in these efforts. Additional funding is needed to achieve greater integration, including increased sharing of important consumer health data, greater

collaboration between medical and psychiatric staff members, tracking of longitudinal health status and implementing best practices such as care management.

More experience and much determination have allowed the GCB-THCC integrated care collaboration to increase its capacity to provide quality care for consumers and to do so with greater efficiency. Together, GCB and THCC are surmounting two major barriers to integrating behavioral health and primary care: 1) lack of funding for staff from the two agencies to work together to integrate care and 2) the challenges faced by separate organizations attempting to collaborate, each of which has a culture and mission that may not easily mesh.

Despite these and other barriers, GCB and THCC leaders, including GCB Chief Medical Officer, Dr. Tracey Skale, and staff members from both partner organizations, have made strong commitments to integrated care, and they are seeing success by improving access to health care and the health outcomes of the people whom they serve.

Centerpoint Health and the Health Care Connection

Centerpoint Health is a comprehensive behavioral health care provider with sites throughout Hamilton County. The Health Care Connection (HCC) is a Federally-Qualified Health Center (FQHC) and a leader in providing primary care to low-income, underinsured and uninsured people in northern Hamilton County. It has a similar partnership with Greater Cincinnati Behavioral Health. HCC has co-located primary care staff, Dr. Julia Beatty and two nurse practitioners, Lillian Link and Deb Johnsen, at two of Centerpoint Health's sites. Centerpoint Health hopes to expand primary care services to all five of its locations.

Centerpoint Health serves 4,000 consumers affected by severe mental illness. These consumers made 1,009 visits, including return visits, to the primary clinic during 2008. The need for care increased in 2009; within the first six months, there were more than 852 visits to the clinic.

Centerpoint also has 3,000 consumers affected by less severe mental illness. It responds to more than 34,000 hotline calls annually and provides other prevention services as well.

When consumers first come to Centerpoint Health, staff members administer a self-reporting tool to screen for behavioral health and primary care problems. Information from the screening tool is available to both the behavioral health and primary care staff members.

The success of this integrated care project can be seen in a 47-year-old male consumer who came for a follow-up appointment after an ER visit. At his first visit, he weighed 260 lbs, had a body mass index of 37, a blood pressure of 140/94, an elevated low-density lipoprotein cholesterol LDL level of 161 and impaired glucose tolerance, suggesting a pre-diabetic condition. A year later, after a course of medication and health education provided by HCC, he had lost more than 60 pounds, lowered his blood pressure to 115/71, significantly lowered his glucose readings, achieved a BMI of 28 and reduced his LDL to 59. As a result, he was able to stop taking diabetes and cholesterol medications.

This is just one example of the many successes that is a result of HCC and Centerpoint Health collaboration. In fact, HCC has found that, for a number of primary care indicators, including hypertension and LDL levels, its primary care consumers at Centerpoint and the other behavioral health clinics it serves have exceeded the national averages for reaching recommended benchmarks. Consumers served by this collaboration have better changes of living longer, healthier lives.

The HCC-Centerpoint Health partnership is successful for a number of reasons. One of the most important reasons is that the Centerpoint case managers and the HCC primary care staff members appreciate, respect and value each others' work. Because the services are co-located, staff can stop by each others' offices and share information about consumers face-to-face.

Another valuable aspect of the partnership is an on-site pharmacy, which allows behavioral health, primary care and pharmacy providers to communicate and collaborate. Pharmacy staff members also help manage medication and reimbursement. As a result of the HCC-Centerpoint Health collaboration, consumers have a safe and familiar health care home and

can build relationships with clinicians whom they trust. Prior to the partnership, a majority of the consumers now served by HCC-Centerpoint Health had no health care home.

Behavioral health consumers benefit from having a health care home in two significant ways: 1) it shortens the time between when consumers are referred for care and when they receive it, and 2) they are more likely to follow up on appointments and referrals because they are familiar with the providers to whom they are being referred. Often, consumers are literally sent across the hall for services, significantly reducing the problem of attrition between referral and treatment. Being part of health care home can also reduce the number of unnecessary and expensive visits to the Emergency Department.

MODULE 9

Single Provider Organization for Behavioral Health and Primary Care

Key Point

The key point in this module is:

- The Integrated Care Program Development Tools in this module will help leaders implement and improve fully integrated health care homes within a Single Provider.

Tools

- Integrated Care Program Development Framework
- Levels of "Single Provider" Integration Checklist
- Primary Care, Behavioral Health and Needed Specialty Care Checklist
- Disease and Risk Identification Checklist
- Monitoring Identified Health Conditions Checklist
- Provider Identification, Utilization Monitoring and Referral Checklist
- Routine Information / Frequency / Person Responsible
- Patient Registry
- Collaboration Protocols
- Partnership Prevention and Wellness Services Checklist
- Services Checklist
- Mission and Vision Process Checklist
- Potential Partner Resources Checklist
- Leadership Checklist
- Problem Identification and Monitoring Checklist
- Management Oversight Checklist

- Operations Task 3: Collaboration and Consultation Checklist
- Management Oversight Checklist
- Physical Plant / Resources Checklist
- Operations: Collaboration and Consultation Checklist for Readiness Assessment
- Finance Checklist

Integrated Care Program Development Framework

(Clifford and Thom, 2009)

This module focuses on the integrated care program development areas shaded below.

	Coordination, Referral and Consultation	Partnered-Care with a Specific Resource	Single-Provider Care
Services			
Leadership			
Operations			
Finance			

Organizations may choose to develop internal resources to provide primary care services. There are many reasons why an organization may choose to do this, including consumer problems, access, collaboration and utilization of health care. Many behavioral health providers have expertise in engaging and retaining difficult-to-engage populations in treatment. By extending health care services, they are able to provide all the needed services to a population that is difficult to engage in primary care. Organizations may also find that collaboration, even with partnered organizations, can be more effective within a single provider framework. Regardless of the reason for single provider integrated care, developing this type of program can be very complex.

Many of the clinical activities, organizational practices and compliance requirements will be new for an organization that is seeking to become a single provider of integrated behavioral health and primary care.

Use of the Tools in this Module

This module contains tools that will improve the integration of health care. These tools offer a significant amount of information, and many groups may find that they will save time and gain more from using these tools if they use them in collaboration with an integrated care consultant trained to facilitate teams in using these tools.

The Core Activities of a Single Provider

- ***Services***: Provide or ensure access to a full range of behavioral health and primary care services, including collaboration with and access to specialty care.
- ***Leadership***: Develop the mission, vision and talent necessary to create new clinical services and comply with new regulatory requirements.
- ***Operations***: Operate new services, fiscal compliance and quality improvement initiatives; hire and manage new staff and positions while clearly maintaining a role as a specialty care provider for people who receive their primary care services elsewhere.
- ***Finance***: Develop new payer sources, contracts, billing infrastructure and expertise – which are essential and requires time.

Possible Changes

Some possible changes may include:

- Comprehensive primary care services
- Payer relationships
- Consumer group assignment mechanisms
- Internal, medical and decision-making infrastructures
- Data for oversight
    - Insurance status
    - Utilization
- Physical plant changes

- Health record changes
- Customer flow
- Marketing

Services

One of the key decisions an organization must make is the scope of service it is going to provide. We suggest organization review the literature and frameworks for the health care home to assess if they meet these criteria. Please refer to the National Committee for Quality Assurance (NCQA) The Patient-Centered Medical Home standards at http://www.ncqa.org/tabid/631/Default.aspx.

When an organization is a single provider, it provides both behavioral health and primary care services. This implementation guide describes areas for attention as behavioral health organizations develop their role in providing access to all health care services. This guide does not yet describe the levels of integration. There are a number of resources available from The National Council of Behavioral Health Providers, the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) Model Project and experts such as Kathy Reynolds, now with the National Council, and William Dorety et. al, who wrote The Five Levels of Primary Care / Behavioral Health Care Collaboration Paper in 1996. (*Behavioral Health Care Tomorrow*, October 1996, 25-28).

Providers should think about the level of integration they wish to achieve if they are pursuing single-provider care. The evidence base is not yet established to suggest if a specific level of organizational integration provides better or more specific outcomes.

Note: The Level of “Single Provider” Integration Checklist is not a program development tool. However, assessing the level of integration using the following checklist may be helpful for program development.

Levels of "Single- Provider" Integration Checklist

(*Clifford and Thom, 2009*)

	None	Partial	Fully Combined
• **Consumer (experience):**	☐ Separate	☐ Sometimes combined	☐ No experiential differences
• **Pt. flow (intake, access, collaboration processes):**	☐ Separate	☐ Sometimes combined	☐ No experiential differences
• **Services (BH and PC staffing and consumer perception of "to whom they need to go"):**	☐ Separate	☐ Sometimes combined	☐ No experiential differences
• **Services (availability)**			
○ Clinical direct:	☐ Partial	☐ Intermittent	☐ Routine
○ Collaboration:	☐ Partial	☐ Intermittent	☐ Routine
○ Prevention and wellness:	☐ Partial	☐ Intermittent	☐ Routine
• **Organization (inclusion):**			
○ Funding (billing, contracting, compliance):	☐ Operationally separate	☐ Operationally combined	☐ Operationally vertical
○ Decision making (clinical decision making):	☐ Operationally separate	☐ Operationally combined	☐ Operationally vertical
○ Oversight (board / leadership / clinical direction setting):	☐ Operationally separate	☐ Operationally combined	☐ Operationally vertical
○ Staff competency (cross-trained staff in basic assessments, EBPs for both):	☐ Operationally separate	☐ Operationally combined	☐ Operationally vertical
○ Information (charting, data, productivity management) access:	☐ Operationally separate	☐ Operationally combined	☐ Operationally vertical
○ QA (compliance, improvement efforts):	☐ Operationally separate	☐ Operationally combined	☐ Operationally vertical

Direct Clinical Service 1: Primary Care, Behavioral Health and Needed Specialty Care

This area offers the organization an opportunity to specify which services are being provided. In the Single Provider point along the health care home continuum, leaders should identify which of services they are going to provide for which populations.

Primary Care, Behavioral Health and Needed Specialty Care Checklist *(Clifford and Thom, 2009)*

Services	Provider	Population	Location
• **Behavioral health**			
○ Psychiatry			
○ Specialty behavioral health care (case managers, psychiatric nurses, therapists)			
○ Lab			
○ Other			
• **Physical health conditions (besides behavioral health)**			
○ Primary care			
○ Specialty care (cardiologist, endocrinologist)			
○ Labs			
○ Other			
• **Pharmacy**			
• **Dental**			
• **Other**			

Direct Clinical Service 2: Disease and Risk Identification

Identification of need is a critical service. Ensuring a comprehensive and accurate picture of the health status and needs of the population served is key in shaping the focus of integrated care implementation efforts.

Disease and Risk Identification Checklist

(*Clifford and Thom, 2009)*

	Specific Disease	Provider	Frequency	Charting
Assessment Point				
Information collected				

Direct Clinical Service 3: Monitoring Identified Health Conditions

Monitoring chronic health conditions and treatment is essential to ensuring quality care. Establishing an understanding of monitoring responsibilities and data is helpful.

Monitoring Identified Health Conditions Checklist

(*Clifford and Thom, 2009)*

Chronic Illness	**Tool/Value**	**Provider**	**Frequency**	**Charting**
Behavioral Health				
Psychotic Disorder				
Mood Disorders				
Anxiety Disorders				
Personality Disorders				
Substance Use				
Other:				
Primary care				
Diabetes				
Cardiovascular				
Obesity				
Other:				

Collaboration Services 1: Provider Identification, Utilization Monitoring and Referral

Although covered in Operations and Leadership, there are clinical services and processes that are utilized to identify consumer access and health needs. This may be a straightforward area of program development, as an organization may already be attending to consumer needs and connection to services. Identifying current needs for access and a means of tracking utilization are essential program development steps.

Provider Identification, Utilization Monitoring and Referral Checklist (*Clifford and Thom, 2009)*

	Target Population	Assessment Info	Referral Process	Utilization Monitoring
Primary Health Clinic				
Outside Primary Care				

Collaboration Services 2: Collaboration Protocols

Clarifying the process means and the frequency of collecting routine clinical information is critical.

Routine Information / Frequency / Person Responsible

(*Clifford and Thom, 2009)*

Means	Diagnosis	Medication	Course / Prognosis	Clinical Change	Lab Values	Other
Electronic info						
Paper charting						
Mgt. report						
Screening / outcomes tools						
E-mail						
Phone / VM						
PRN (also see consult)						
Other						

** Please check the means by which the items above are tracked. Please also indicate the frequency at which each item is tracked and who is accountable for collecting this information.*

Developing a registry for specific information sharing (such as for specific diseases) is quickly becoming a standard practice in chronic care disease management. A registry is an information database of consumer-specific clinical information that clinicians may access to improve care. An organization may access the registry data in aggregate to conduct improvement activities. Many organizations are considering developing a registry to use to collect information for chronic illnesses and to promote organization-wide collaboration. There are many resources for disease and population-specific registries online. Organizations may also wish to consider combining registries and electronic health records.

Does the organization have a database of clinical information that can be queried by the consumer or by the organization (de-identified) with specific clinical information from all clinicians?

- Disease-specification (or one large database that includes this category)

- Disease-specific lab values
- Satisfaction
- Consumer demographics
- Service provider identification
- Service utilization information

Patient Registry

(Clifford and Thom, 2009)

A patient registry is a critical database about consumers used to improve health outcomes.

KEY: A1c Hemoglobin DFE Dilated Fundoscopic Exam BMP Basic Metabolic Panel BP Blood Pressure						
	Patient ID	Patient ID	Patient ID	Patient ID	Patient ID	Patient ID
Demographics						
Co-morbidities						
Provider						
PH Clinical / Utilization						
A1c						
Date of last A1c						
Date of last DFE						
Date of last foot exam						
Date of last BMP						
LDL						
Date of last lipids test						
Systolic BP						
Diastolic BP						
Date of last BP						
Meds						
Behavioral Health Clinical / Utilization						
Date of last PYSCH appt.						
PSYCH goals						
Date of last CPST appt.						
CPST goals						
MH outcomes						
MH Outcomes						

Partnership Services 3: Collaboration

Many organizations have informal relationships between both internal and external health service providers. The difference between collaboration and common practices is that collaboration focuses the organization on specific processes and expectations for clinicians to seek input on medical decisions. In collaboration, the information is shared consistently to inform routine practice. The following chart lists policy and protocol categories that promote collaboration.

Collaboration Protocols

(*Clifford and Thom, 2009*)

	Who (staff) collaborates?	What information?	How information is shared (means)?	How Often (frequency)
Internal (Behavioral Health):				
Across Departments				
Within Medical				
Partner:				
Primary Care				
Outside:				
Pharmacy				
Specialty Care				
Emergency Department				
Hospital - Inpatient				
Other				

Prevention and Wellness Services

Prevention and wellness services are critical to managing chronic conditions and promoting the goal of all health care providers: wellness. With additional primary care resources and expertise, there are several areas for consideration for program development—specifically, cross-training and cross-availability of the services.

Partnership Prevention and Wellness Services 1: Education

- General wellness information
- Disease: Specific information for frequently noted chronic health conditions
    - Symptoms /course / cause
    - Treatment options / prognosis
- Advanced Directive information for both medical and psychiatric services
- Consideration of training behavioral health staff on all of the above

Partnership Prevention and Wellness Services 2: Empowerment / Activation

- Communication skills
- Assertiveness (communicating with HCPs / Ads)
- Support / universality / social
- Self-management
- Training of primary care staff on recovery

Partnership Prevention and Wellness Services Checklist

(Clifford and Thom, 2009)

	Service	Primary Care Provider	Behavioral Health Provider	Partnership	Outside Provider
Education	General wellness				
	Disease information: symptoms / course / cause				
	Disease information: treatment options / prognosis				
	Advance Directive information / assistance				
	Self-management				
Empowerment / Activation	Communication skills (see Education)				
	Assertiveness (communicating with HCPs/Ads)				
	Support / universality / social				

Resources:

- Prevention and Wellness Paper
- Electronic Health Records (EHR)
- Current collaboration protocols
- Registry Info: see http://www.aafp.org/fpm/2006/0400/p47.html

Services Checklist

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source		Action Plan
Services	*Content Focus:* Direct Clinical Services					
	DCS1	*Direct Clinical Service 1:* primary care, psychiatry, and needed specialty care		Provider / partners provide	% of consumers receiving these services	
	DCS2	*Direct Clinical Service 2:* disease and risk identification		Provider / partners provide	% of consumers receiving these services	
	DCS3	*Direct Clinical Service 3:* monitoring health conditions		Provider / partners provide	% of consumers receiving these services	
	Content Focus: Collaboration					
	CC1	*Collaboration Services 1:* provider identification, utilization monitoring and referral		Provider / partners provide	% of consumers receiving	
	CC2	*Collaboration Services 2:* collaboration		Provider / partners provide	% of consumers receiving	
	CC3	*Collaboration Services 3:* consultation		Provider / partners provide	% of consumers receiving	
	Content Focus: Prevention and Wellness Services					
	PW1	*Prevention and Wellness Services 1:* education		Provider / partners provide	% of consumers receiving	
	PW2	*Prevention and Wellness Services 2:* empowerment / activation		Provider / partners provide	% of consumers receiving	

Leadership Task 1: Develop a vision that includes collaboration and fit

The leadership of an organization may consider amending its core vision, mission and policies to reflect promotion of wellness through ensuring access and collaboration with local health care resources. The Mission and Vision Process Checklist includes some specific areas to consider.

Mission and Vision Process Checklist

(Clifford and Thom, 2009)

	Question	Vision/Mission
Wellness	How does access to and collaboration with existing health care assist the organization's vision for consumer wellness?	
Organization as a Medical Home	Is the organization seen as a health care home by primary care providers?	
	How does the organization see itself in relation to other local health services?	
Services	What comprehensive services is the organization going to provide?	
	What services does the organization provide to promote collaborative care with local health care resources?	
Ensuring Access	How does the organization ensure access to needed health care services?	
Population	Which consumers go to the clinic, and which ones use other local resources?	

Leadership Task 2: Find and Maintain Partner Resources for Consumers' Access to Health Care

Even in the single-provider point along the health care home continuum, an organization needs partners for consultation, supervision, specialty care, pharmacy care, dental care, laboratory services, hospital collaboration, care management in managed care organizations, etc.

We believe that many adults served by behavioral health providers need to find and develop relationships with other health care providers. As an organization seeks to develop partnered resources, finding the right partners is one of the main tasks. The right partners will become easier to find as a behavioral health provider develops better collaboration with other health care providers, identifies consumer needs and articulates its vision for how it fits within the local health care continuum. An organization's Community Leadership Forum will help to identify potential partners. Resources for finding and building partnerships include current health care utilization by consumers, local safety net resources, payers and local access initiatives.

Potential Partner Resources Checklist

(*Clifford and Thom, 2009*)

	Number of Consumers Utilizing	Contact and contact information	In Community Leadership Forum?
Health Care			
Primary Care Connection			
Medical Home Connection			
Inpatient. Hospital (primary care)			
Inpatient. Hospital (psychiatric /crisis)			
Community Safety Net Resources			
Free Clinics			
Federally Qualified Health Centers (FQHCs)			
School-Based Health Centers			
City/County Health Departments			
Other			
Payer			
Behavioral Health Board			
Managed Care			
Insurers			
Local Access Initiatives			
Community Specific			

Leadership Checklist

(Clifford and Thom, 2009)

Focus Area	Item Number	Content Focus	Description of Current Practice	Data Source			Action Plan
Leadership	L1	*Leadership Task 1:* Develop a vision that includes collaboration, fit and wellness		Vision	Mission	Policies	
	L2	*Leadership Task 2:* Find and maintain partner resources for consumers' access to health care		Vision	Mission	Policies	

Operations

Implementation of any integrated care service should build on an organization's current resources and practices. It is suggested that organizations start by reviewing current practices, identifying the type of care they wish to provide working to close the gap between the two by creating process goals, administrative processes and resource plans.

Some areas for consideration:

- *Processes:* Intake and medical appointment processes, as well as information captured on progress notes and current workflows
- *Human Resources:* Responsibilities and monitoring expectations of current job descriptions / staff responsibilities, including intake workers, medical workers and other clinical staff
- *Data:* Existing EMR and management data, current chart review process, current billing / utilization data and processes
- *Resources:* Health Assessment, Diagnostic Assessment and management reports

- *Oversight*: Current management oversight process and staff, program, leadership levels, current ISP and QA processes

Operations Task 1: Problem Identification and Monitoring

Identification and monitoring of consumer health status and conditions are suggested services for all behavioral health providers. The following is a checklist for the key operational areas that assist an organization in identifying practices related to problem identification and monitoring. It is important to identify the organization's policies and practices for the topics in the Problem Identification and Monitoring Checklist. Clearly defining the organization's data, processes, resources, staff and oversight for health status problem identification and monitoring will improve the effectiveness of implementation.

Problem Identification and Monitoring Checklist (*Clifford and Thom, 2009*)

	Problem Identification			**Ongoing Monitoring (when health condition identified)**		
	Current	Goal	Needs	Current	Goal	Needs
Processes						
Human Resources						
Data						
Resources						
Oversight						

Operations Task 2: Access/Referral and Utilization

Ensuring access to health care for all consumers served is critical. Developing an oversight mechanism and data sources are important. The Management Oversight Tool can assist organizations in promoting access to and utilization of health services.

Management Oversight Checklist

(***Clifford and Thom, 2009***)

		Number of consumers	Data Source	Frequency	Oversight
Problem Identification	Identified chronic health conditions				
Monitoring	% monitored (of ID conditions)				
Access	Internal primary care				
	External primary care				
	No show (internal)				
Specialty Access	As needed				
	Hospital / ED (if used)				
	Prevention and wellness services				
Utilization	Primary care				
	ID consultation utilization				
	Monthly-annual contacts				
Collaboration	# of ISPS with collaboration?				
Other					

Resources:

- Process
- Human Resources
- Data
- Resources
- Oversight

Partnership Operations Task 3: Collaboration and Consultation

As in the previous module, implementing collaboration and consultation processes involve multiple staff members from throughout an organization. Partnerships provide more resources for collaboration. Reviewing current processes, data and electronic health records can lead to potential resources for facilitating ongoing clinical collaboration and consultation between organizations.

Operations Task 3: Collaboration and Consultation Checklist

(Clifford and Thom, 2009)

	Collaboration				**Consultation**			
	Current Behavioral Health	Current Primary Care	Goal	Needs	Current Behavioral Health	Current Primary Care	Goal	Needs
Processes								
Human Resources								
Data								
Resources								
Oversight								

Management Oversight Checklist

(Clifford and Thom, 2009)

The following tool is meant to assist in developing operational processes and data management to assist with management oversight. If an organization has the data necessary to implement this tool, the organization has a pathway to implement the necessary administrative processes.

		Number of consumers	Data Source	Frequency	Oversight
Problem Identification	Identified chronic health conditions				
Monitoring	% monitored (of ID conditions)				
Access	Internal primary care				
	External primary care				
	No show (internal)				
Specialty Access	As needed				
	Hospital / ED (if used)				
	Prevention and wellness services				
Utilization Collaboration Other	Primary care				
	ID consultation utilization				
	Monthly-annual contacts				
	# of ISPS with collaboration?				

Operations Task 4: Develop the "Physical Plant" Infrastructure and Resources

Depending on the type of services that the organization will provide, a provider should consider the following in relationship to physical plant and resources:

Physical Plant / Resources Checklist

(Clifford and Thom, 2009)

		Needs	Resources	Timeframe	Maintenance
Space	Build out				
	Office				
	Exam				
	Records				
	Other				
Pt. flow	Front window				
	Sick / Well Space				
		Needs	Resources	Timeframe	Maintenance
	Waiting room				
	Other				
Staff Flow	Charting				
	Congregate area				
	Other				
Tools	Supplies				
	Equipment				
	Other				

Operations: Collaboration and Consultation Checklist for Readiness Assessment

(Clifford and Thom, 2009)

		Processes	Human Resources	Oversight	Available Data
O 1	*Operations Task 1:* problem identification				
O 2	*Operations Task 2:* problem monitoring				
O 3	*Operations Task 3:* access				
O 4	*Operations Task 4:* referral				
O 5	*Operations Task 5:* utilization				
O 6	*Operations Task 6:* collaboration and consultation Protocols				
O7	*Operations Task 7:* develop a physical plant, resources and infrastructure				

Finance

At this point along the health care continuum, a provider must have or develop the infrastructure and knowledge to make informed decisions and to meet compliance requirements for billing for services rendered.

- Behavioral Health (Community) Medicaid: Rehabilitative in nature
    - Medically necessary
    - For the exclusive benefit of the Medicaid beneficiary
    - Must address needs identified in the assessment and treatment plan

- Indirect Costs
    - Review of the organization’s current indirect cost formulas to ensure they include all of the appropriate services
- Behavioral health (limits/coverage)
- Other funding (limits / coverage)
- Compliance (documentation / charting and prerequisites)

Finance Checklist

(Clifford and Thom, 2009)

Focus Area	Item #	Content Focus	Description of Current Practice	Services with Payers	Services without Payers	Certification/ Accreditation	Action Plan
Finance	F1	*Finance Task 1:* current funding					
	F2	*Finance Task 2:* potential funding					
	F3	*Finance Task 3:* compliance					

Profiles: Interviews with Executives

Below are two examples of mental health organizations that are in the process of implementing the single provider approach.

Shawnee Mental Health Center

Shawnee Mental Health Center (SMHC) serves Adams, Scioto and Lawrence counties in South Central Ohio. We talked to Don Thacker, the Executive Director of SMHC, and Cynthia Holstein, Project Director for SMHC’s integrated care project, about the program described in this example.

Individuals affected by chronic, severe mental illness make up SMHC's target population. Currently, SMHC's staff members serve between 2,000 and 3,000 consumers that are affected by severe mental illness annually. All consumers are eligible for primary care services.

SMHC behavioral health staff refers consumers to primary care, if they feel that the consumer would benefit from these services and he/she has no health care home. This is done especially when a consumer needs immediate medical attention.

Primary care is provided by SMHC's own full-time staff: a certified nurse practitioner, a nurse care manager (an LPN) and a support person. These staff members travel to see consumers at SMHC clinics in West Union, Portsmouth and Coal Grove.

The primary care nurse care manager assesses whether the consumer is appropriate for primary care treatment. If so, the nurse practitioner sees the consumer and completes an assessment. If the consumer's health problem is within the nurse practitioner's scope of practice, she will do a complete physical health history, including measuring blood pressure, glucose, lipids and body mass index and screening for tobacco and substance use. If the consumer has health problems that fall outside practitioner's scope of practice, she will refer the consumer to a community physician.

As a part of the organization practice, the nurse practitioner consults with a community physician once a week. Occasionally, the physician will see a patient with the nurse practitioner. Because the physician's time is very limited, SMHC plans to hire a staff physician in the near future.

In addition to treating acute problems, the primary care team provides wellness and prevention programs, such as tobacco cessation. By late summer of 2010, SMHC plans to hire a nutritionist to do meal planning with high-risk consumers.

Holstein and Thacker shared this success story:

"Joe," who has bi-polar disorder, came to the primary care clinic with a non-healing skin lesion that had been bothering him for two years. He had been unable to get help with this due to insurance problems. SMHC's nurse practitioner, working with her consulting physician, identified basal cell carcinoma. He is now receiving appropriate treatment for his illness.

SMHC received initial funding for its primary care project from The Health Foundation of Greater Cincinnati, and the program is currently receiving funding through a four-year grant from Substance Abuse and Mental Health Services Administration (SAMHSA). This grant will allow SMHC to hire two additional full-time care managers, three part-time peer wellness coaches (who are also behavioral health consumers) and one full-time primary care physician or a part-time physician and a second full-time nurse practitioner.

In addition to grants, SMHC receives payments for its primary care consumers through three Medicaid-managed care contracts, as well as Medicare, some private insurance and a limited amount of self-pay.

Now in its second year of the Health Foundation grant funding, SMHC has been serving 125 primary care consumers per month, with a target of serving 450 individuals during the year. It has set a target of serving 1,150 consumers during the course of the four-year SAMHSA grant.

SMHC has found that providing primary care with behavioral health care works well. This arrangement reduces problems with confidentiality, makes it clear who owns the consumers' charts, helps to eliminate billing problems and circumvents the problem of two organizational cultures that might not mesh very well. Just as importantly, consumers feel more comfortable seeing both behavioral care and primary care staff in a familiar and safe environment.

Behavioral health and primary care staff continue to work at building a collaborative approach to care. To that end, they have regular staff meetings and occasionally shadow each other as they go about their daily work.

Finally, Cynthia and Don state that it is crucial for agencies planning to develop integrated care programs to identify sources of funding and, in particular, grants and Medicaid and Medicare

payment streams. They offered to share their experience with any agencies that are considering starting integrated care projects.

Talbert House

Talbert House also has an integrated care program that it runs in-house at its community corrections facilities. Talbert House nurse practitioners provide primary care to residential consumers. Dr. Bob Donovan of the Cincinnati Health Network is available as a collaborating physician, and a psychiatrist is available for consultation.

Since its beginning, 30,000 consumer visits have been provided, with averages of 4,000 to 5,000 per year. A 1.6 full- time equivalent (FTEs) nurse practitioners and one support staff member have provided these services and they serve 13 sites in the county.

The nurse practitioners routinely diagnose illnesses such as cancer, hepatitis C and sexually transmitted diseases. In some cases, the consumers were previously unaware of their conditions. Early diagnosis has lead to more timely and effective treatment. Part of the success has been achieved because the nurses can ensure the consumers receive regular treatment and can monitor for compliance since they are working with a residential population. As a result, consumers have met or exceeded treatment targets for several common health problems. For example, 80% of consumers with a hypertension diagnosis have achieved an outcome of normal blood pressure, which compares strongly against national performance numbers. In addition, the program resulted in an 18.1 percent reduction in Emergency Department visits by consumers in the first six months, 32 percent reduction in the first year and a more than 40 percent within 18 months following implementation.

Part of the success of the program comes from the fact that Talbert House has been able to provide medication for consumers, as well as utilize screening tools for several common health problems among its consumers. Glucometers and training for their use and in-house A1C hemoglobin screenings have helped reduce diabetes-related problems. In-house hepatitis C and liver function screenings have reduced wait times for treatment considerably.

Dr. Oberdoester pointed out that little of the funding for this program has come from public sources, and fewer than 10% of consumers served have health insurance. The ability to obtain funding from other sources has been critical to the program's success. In 2002-2003, the project received a planning grant from the Health Foundation of Greater Cincinnati. It has also received important additional funding from the Fifth Third Foundation and the Foundation for Talbert House. The foundation board has been particularly generous, providing funding for the in-house diabetes and liver disease screening tools as well as medications.

MODULE 10

Case Study: Integrated Care in Akron, Ohio

Key Points

The key points in this module include:

- It is important for providers to share what they have learned openly about integrated care in order to improve health outcomes and eliminate avoidable deaths.
- The team in Akron, Ohio, identified numerous learning points that are applicable to many other integrated care approaches. The top lessons the team learned are discussed in this module.

Description of Integrated Care at Community Support Services, Inc.

The lessons the team that developed The Margaret Clark Morgan Integrated Care Clinic at Community Support Services, Inc. in Akron, Ohio, learned will be discussed in this module. The Integrated Care Clinic represents an approach to integrated care that is more robust than approaches taken by other organizations, but many of the lessons learned are applicable to other circumstances. The purpose of this module is not to promote a specific model, but to share information that may be helpful to others initiating integrated care programs.

Akron, Ohio, is fortunate to have many strong health care resources, universities and The Margaret Clark Morgan Foundation, a leader in innovative mental health-related initiatives. Key stakeholders worked together to implement The Margaret Clark Morgan Integrated Care Clinic, at Community Support Services, Inc. The clinic offers the following services:

Clinical collaboration

- Referral to specialty and dental care
- Direct Clinical Services
  - Behavioral health care
  - Primary care
  - Pharmacy services
  - Laboratory services
- Teaching of nursing and pharmacy students and psychiatry residents

A number of regional organizations joined to establish an integrated care clinic that focused on improving the overall health of individuals served by the public mental health system. The partner organizations were:

- The Margaret Clark Morgan Foundation
- Best Practices in Schizophrenia Treatment (BeST) Center
- Community Support Services, Inc. (CSS)
- The University of Akron College of Nursing
- Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM)
- Internal Medicine Specialists
- Klein's Pharmacy
- Pathology Laboratory
- County of Summit Alcohol, Drug Addiction and Mental Health Services Board
- Buckeye Managed Medicaid
- Ohio Department of Mental Health
- Summit County Department of Job and Family Services

Foundation Support

The Margaret Clark Morgan Foundation provided funding to renovate a section of Community Support Services' facility to deliver integrated behavioral health and primary care. The renovations included new primary care exam rooms, a new onsite pharmacy and changes to the entrance, lobby and front desk. The foundation's chairwoman lent her expertise to ensure that the clinic space was welcoming and recovery-oriented. The Margaret Clark Morgan

Foundation funded the services of a consultant, who lead two planning meetings, and the services of a nurse practitioner for the first year. The Foundation also funded the Best Practices in Schizophrenia Treatment (BeST) Center in NEOUCOM's Department of Psychiatry, and BeST Center staff members provided project management assistance and other support for the integrated care clinic.

Lessons Learned

A key lesson learned was the importance of updating integrated care action plans when the approach changes significantly. Initially, the team developed a detailed action plan to implement a Partnered-Care approach to integrated care. The proposed approach included a primary care organization that would deliver services onsite. The primary care organization planned to bill for services using its existing infrastructure and processes. However, plans changed significantly, and the proposed changes were very complicated. The lesson learned here is that when significant changes in the direction of an integrated care program occur, the team needs to reconvene to revise the detailed action plan.

Teaching/Workforce Development

The Community Support Services' integrated care program differs from other programs because of its very strong focus on teaching and workforce development. Developing the next generation of health care providers to provide integrated care is a key focus. While training and mentoring students is a significant investment, it results in the development of students who understand the complex and chronic needs of individuals affected by mental illness and who will advocate for integrated care in the future.

The integrated care clinic is one of the most popular practice sites for nurse practitioner students from The University of Akron's College of Nursing, and nursing students from UA have been involved in special projects at the integrated care clinic. A faculty member from the Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM) works with students at the integrated clinic to improve consumers' overall wellness. The clinic's nurse practitioner and pharmacist devote portions of their day to training and mentoring students.

The team plans to increase the number of hours the physician spends at the integrated care clinic in the future, so the clinic can serve as a training site for medical residents in NEOUCOM residency programs.

Primary Care Clinicians

A part-time nurse practitioner and a part-time primary care physician provide primary care services onsite at The Margaret Clark Morgan Integrated Care Clinic. Community Support Services has a contract with The University of Akron's College of Nursing for the advanced nurse practitioner's services and a contract with Internal Medicine Specialists, a private physicians group, for the primary care physician's services. The primary care physician and the advanced nurse practitioner collaborate to provide services, and nursing students assist in the primary care clinic.

Pharmacy

Initially, Community Support Services explored the possibility of owning its own onsite pharmacy, but subsequently decided to collaborate with Klein's Pharmacy. Barry Klein, R.Ph., CEO of Klein's Pharmacy, established a Klein's Pharmacy at Community Support Services. Pharmacists from Klein's work with NEOUCOM pharmacy students to improve the integration of behavioral health and primary care. Pharmacy students also complete consumer medication histories in the primary care clinic and help with special projects.

Community Support Services also has a contract with a NEOUCOM pharmacy practice faculty member to provide medication management services. She meets with consumers, particularly following discharge from facility discharge (community or state hospitals, correctional facilities, etc.) and performs medication management reviews, screening for duplication, interactions or medications that may be detrimental in combination. The clinical pharmacist reviews medication regimen with the consumer, makes sure he or she understands it and has sufficient medications supply to last until their follow-up appointments. Klein's Pharmacy bills Community Support Services for medication management services, and Community Support Services bills

insurance companies. In addition, this staff provides training to behavioral health staff about medications and their side effects.

Pharmacy staff members provide strong, practical business and marketing support. For example, pharmacists help plan and implement wellness fairs onsite to engage consumers who have high-risk medical conditions in health promotion activities. Klein's Pharmacy is extremely committed to serving individuals affected by mental illness, and Community Support Services and Klein's Pharmacy had a longstanding partnership prior to the creation of the Integrated Care Clinic. Initially, use of the onsite pharmacy services was somewhat slow, but it gathered steam as the number of consumers served by the integrated care clinic increased.

The integrated care approach used at CSS is much more complex than approaches taken by other integrated care programs, but many of the lessons learned are similar. Unless there is very strong community leadership and financing, the best approach to improving integration of care is to start small and achieve quick successes. After partnerships are strengthened, communities can pursue more robust approaches.

Philosophical shifts and changes in the organization's core identity

The integrated care clinic team learned that developing a health care home for behavioral health consumers required a significant shift in organizational philosophy.

Initially, resolving the tensions inherent in a recovery-oriented behavioral health care and an efficient medical model was challenging. This tension was fueled by the fact that the Medicaid and Medicare funding system for primary care services was not designed for consumers with numerous chronic conditions and multiple barriers to health, such as homelessness, unemployment and/or lack of transportation. Current primary care funding systems promote brief appointments focused only on medical issues. In order to become a health care home for consumers who were not currently receiving primary care services, Community Support Services had to make a major change in its core identity.

Consumers

The importance of actively engaging and listening to the mental health consumers to be served by the integrated care program was an important part of the planning process and a lesson learned. Consumers are an important element in redefining the organization's core identity and ensuring that a recovery focus is integrated into traditional medical models.

The Margaret Clark Morgan Foundation emphasized the importance of involving mental health consumers in the planning of the clinic. Consumers were involved in planning the services, communication strategies and designing the physical space. They helped to design the lobby and exam spaces and voted on the color schemes and floor coverings.

A Recovery Specialist (Peer Support) was engaged to build rapport with consumers in the waiting room and verify printouts that included basic consumer information, such as demographics, diagnoses, medications, insurance status and other important information. The Recovery Specialist reviewed the printout with the consumer, made necessary changes and gave the form to the receptionist to enter updated information into the electronic records system. The most current information could then be available for behavioral health, primary care and pharmacy providers. The Recovery Specialist worked to improve consumer satisfaction, manage the flow of consumers and to reduce waiting times for appointments.

It is exciting to add new services, and it is important to promote them. But it is also vital to maintain consumer choice. If consumers have primary care and pharmacy providers who are serving them effectively, then they should not feel pressure to change providers.

Choosing the Level of Collaboration and Picking the Right Partners

Selecting the right partner can be a challenge. It is very important that all partners have clear expectations the goals for each partner and how goals will be measured and reported. It is also important to articulate expectations for consumer visits and consumer satisfaction and plans for coverage when staff members have time-off.

Community Support Services explored several options before making a final decision about an integrated care partner. They approached a federally-qualified health center (FQHC) about an integrated care partnership, but the FQHC was not able to participate due to other commitments. Several other partnership opportunities were explored as well. Ultimately, the team partnered with a local physician with a successful practice. In the process of selecting partners, the team learned another very important lesson: they needed to ensure all clinicians had active Medicaid numbers and were credentialed with all the managed care providers before they started paying salaries or delivering services.

When selecting primary care clinicians, it is important to find providers who can effectively balance both quality and productivity. Clinicians with strong business expertise about primary care, productivity, scheduling, treatment algorithms, documentation and coding are key to success. And, of course, clinicians should be selected based on his/her alignment with the vision and organizational philosophy of integrated care.

"Organized partnering" is also beneficial. For example, the primary care providers at Community Support Services now participate in the regular, monthly meetings of psychiatrists. Often there is limited time for collaboration during the day, and the monthly meeting helps to promote coordination of care and collaboration among providers.

Another lesson learned is that an algorithm needs to be developed for the time for each visit in order to stress that consumers are often more comfortable with shorter, more frequent visits. Plans for capturing "walk-ins" are also important; the capacity to serve walk-ins was vital in establishing services.

Resources such as the AAAHC accreditation manual is also extremely helpful in setting up practice standards, and it helps to clearly distinguish between a "health care home" and a "physician's office."

Change Management

The team learned that the depth of change management required to implement integrated care was considerable. When implementing significant changes, staff resistance is common. For years, many behavioral health providers did not consider integrating primary care to be within the scope of their work. Heavy caseloads, lack of training about primary care, concerns about productivity and reimbursement and many other issues continue to contribute to this resistance.

Shared records, preferably shared electronic records, are a principal element. Both primary care and behavioral health providers at Community Support Services can review one another's notes and ensure that information about significant changes and needs is shared appropriately. Information is automatically sent to the appropriate providers by simply checking a box on the electronic record.

An extremely dedicated scheduler is also integral to successful integrated care. The scheduler must seek out new referrals, place appointment reminders and manage no-shows.

There also needs to be a system, based on medical need, for prioritizing follow-up with individuals who do not keep their appointments. A mechanism to ensure that appointments with specialty providers are kept, and that the information from specialists is obtained, is also essential.

Individuals affected by mental illness served by the public mental health system often have health care needs that are significantly more complex than others. Primary care providers are often shocked by the severity of their needs and, often, are not prepared to address consumers' resistance to primary care services. Some of the challenges experienced by the Community Support Services' primary care providers include:

- Varied presentations of illnesses
- Multiple co-morbidities

- Consumers’ difficulty articulating an accurate medical history
- Difficulty in making diagnoses
- Challenges articulating symptoms
- Psychosocial issues
- Building trust and a therapeutic alliance with the consumer
- No-shows for appointments
- Vast paperwork requirements
- Failed efforts to secure medications for consumers (prior authorizations, denials, etc.)
- Lack of knowledge about insurance coverage
- Considerable time required to collaborate with case manager, behavioral health nurses, therapists, physicians and other staff
- Required essential, but not billable, services and meetings

Please see Module 3 for numerous tools that can be helpful for implementing breakthrough change.

Next Steps

Integrated care is a journey, not a short-term destination. The Margaret Clark Morgan Integrated Care Clinic team continues to strengthen their integrated care program. They are addressing:

- Billing and fiscal viability
- Collaboration and communication

- Evaluation and developing the business case
- Expansion to include other specialists, such as podiatrists, etc.
- Planning to become a training site for medical and pharmacy residents

MODULE 11

Delivering Behavioral Health Care in Primary Care

Key Points

The key points in this module include:

- It is important to meet people where they are and create bi-directional service delivery between behavioral health and primary care.
- This implementation guide focuses mostly on the delivery of primary care in behavioral health settings, but the delivery of behavioral health in primary care is also important.
- The Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) model is an example of an effective way to deliver behavioral health within a primary care setting.

Resources

The role of behavioral health providers in partnering with or implementing primary care services is the central focus of this guide. However, some behavioral health providers are developing programs and interventions for delivering behavioral health services within primary care settings. We recommend that providers review available resources for integrating behavioral health and primary care. Some examples of online resources include:

- The Hogg Foundation's *Connecting Mind and Body a Resource Guide to Integrated Health in Texas and the United States*
- CareIntegra's online resources
- The Integrated Behavioral Health Project, an initiative of The California Endowment and the Tides Center, report: *Partners in Health: Primary Care / County Mental Health Tool Kit*.
- The University of Washington, Department of Psychiatry and Behavioral Sciences' IMPACT Program

The IMPACT Model

The Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model seeks to improve outcomes for people affected by depression through a structured, collaborative approach to care within a primary care setting. Providers seeking to implement IMPACT should focus on several key areas, including staffing and services, clinical processes and resources.

IMPACT prescribes a Depression Care Manager (who may be a nurse, social worker, counselor or psychologist) who educates and coaches the consumer. The care manager provides education about depression, brief evidenced-based counseling and activation and monitoring and engagement of the consumer in developing a relapse prevention plan. The model requires a consulting psychiatrist and primary care providers who support the care manager.

In addition to staff and services, IMPACT suggests a clear model for clinical processes and resources. IMPACT and primary care providers use systemic screening and outcomes tracking instruments (IMPACT suggests the PHQ9) to facilitate diagnoses and track outcomes. The team also embraces a stepped-care approach that allows for changes in the duration and intensity of treatment as warranted.

IMPACT is a well-known intervention with an abundance of resources and support available for organizations that are interested in learning more.

Behavioral Health Specialists Working in Primary Care

Behavioral health specialists working in primary care should consider the following questions:

- What medical conditions does the consumer have, and how do they affect his/her mental health concerns?
- How do the consumer's mental health concerns affect his/her medical condition?
- What data would be helpful (systematic screening procedures, the PHQ-9 in primary care settings, percent screened, percent detected, etc.)?
- What information would be helpful for the medical provider to know in order to provide the best care?
- How can I, as a behavioral health specialist, support the medical providers best?

The Behavioral Health Specialist's role in evaluation often includes:

- Brief triage assessments
- Diagnostic assessments
- Seeing consumers that primary care providers have identified as needing behavioral health services in exam rooms

The clinical approach for providing behavioral health care in primary care settings is often brief, solution-focused treatment. Treatment plans should identify behavior change goals that medical providers can support.

The psychiatrist's role in primary care settings often includes:

- Following up on medically complex cases
- Seeing consumers who are not responding to typical medications
- Answering calls and consulting with primary care providers
- Educating primary care providers via Grand Rounds or presentations

Profiles from Interviews with Executives

The following are profiles developed from interviews with mental health organization executives who are in the process of integrating behavioral health services in primary care settings.

Summa Health Systems and Coleman Behavioral Health

Summa Health System and Coleman Behavioral Health are collaborating to integrate health care for individuals affected by mental illness. Summa Health System is a multi-campus hospital system serving the greater Akron area. Coleman Behavioral Health, which is part of Coleman Professional Services, is a not-for-profit mental health and rehabilitation services provider serving Portage, Trumbull, Stark and Summit counties in Ohio. We interviewed. Randy Zumbar of Summa and Sandy Myers of Coleman to create this profile. Zumbar is Regional Resource Manager for Summa's Department of Psychiatry and Myers is Vice President and Chief Officer of Behavioral Health for Coleman.

Unlike several of the other integrated care partnerships featured in this guide, this partnership was initiated by the primary care provider, Summa Health System. Summa became aware of the need for integrating behavioral health and primary care because it operates several primary care outpatient clinics for low-income consumers at its Akron City Hospital campus.

These clinics serve approximately 12,000 consumers a year, and about 60% of the individuals served are covered by Medicaid.

Clinic physicians recognized that many of the consumers they saw also needed behavioral health care. While consumers had some access to onsite behavioral health support, this was not adequate for many consumers' needs. As a result, clinic staff referred consumers to community mental health clinics, but there were no systems in place for Summa clinicians to follow up or coordinate care with the behavioral health providers.

Because of the inability to respond adequately to behavioral health needs, clinic directors talked to Dr. Joseph D. Varley, Director of Psychiatry for Summa, about possible solutions. As a result, Summa physicians searched for a behavioral health partner and selected Coleman Behavioral Health as a partner. Summa and Coleman had a several-year-long history of partnerships in other areas of behavioral health.

On February 1, 2010, Coleman opened an outpatient behavioral health clinic in leased space at Summa's St. Thomas Hospital facility. The clinic serves adult Medicaid consumers by providing counseling and psychiatry services, diagnostic assessments and case management. Consumers may self-refer or be referred to the clinic by clinicians or social workers. Appointments are generally set within two weeks of referral.

By late April, the primary care clinics at Summa had referred 131 people to the behavioral health clinic. The behavioral health clinic had served 116. More than half were between 18 and 29 years of age, three-quarters were women, nearly three-quarters were Caucasian and about two-thirds had incomes of less than $16,000 per year. Diagnoses were nearly evenly distributed among bipolar disorder, major depressive disorder and anxiety disorder, while an additional 3% of the consumers were diagnosed with schizophrenia.

To ensure that both behavioral health and primary care clinicians could share information efficiently, Summa and Coleman established protocols for exchanging clinical information at the time that appointments were scheduled. In addition, the two organizations are currently

working to develop a registry of patient assessments that will be available to primary care and behavioral health clinicians. Summa is exploring the expansion of its existing electronic health record system to accomplish this.

This integrated care initiative has been very successful. In the first three weeks of operation, consumer demand exceeded projections. Consumers have kept their appointments at very high rates. Virtually 100% of consumers have kept their appointments with psychiatrists. The high demand and low no-show rate seem to indicate high consumer satisfaction. Many consumers also express their satisfaction with the services to members of the clinic staff.

Patient success stories illustrate the effectiveness of the integrated care program. The Summa Women's Health Clinic referred a woman to the Coleman Behavioral Health Clinic following the birth of her baby. She presented with anxiety and depression. Her previous baby had died at the hands of his father (shaken baby syndrome) while she was attending an Alcoholics Anonymous meeting. The birth of her new daughter triggered flashbacks and nightmares.

When the patient arrived for intake at the clinic, she was unable to work because of anxiety. At present, she is actively working on recovery from addiction and mental health issues and is engaged in therapy, psychiatry and case management with Coleman staff. She is also active with Alcoholics Anonymous, and she is employed. Her treatment team at the behavioral health clinic is in contact with her primary health care providers to ensure her post-partum care and behavioral health care are well-integrated and well-managed.

Although Medicaid pays for the case management, the indirect costs of collaboration are not covered by any payment source. Each of the integrated care collaborations described in this guide faces similar challenges with collaborations. Some states are creating systems to pay for collaboration.

Both Mr. Zumbar and Ms. Myers emphasized the success of the collaboration is built on the trust between the two organizations that has developed as a result of working together for

several years. They suggest that organizations planning similar initiatives might want to start with a small project and develop it by building upon initial successes.

The trust between these two organizations has its roots in a meeting that Dr. Varley called several years ago so that Summa and Coleman could discuss some issues that he had identified. Now Summa and Coleman leaders and staff members work to solve problems by discussing them as they occur. Another important factor in the success of this collaboration is that Coleman's onsite manager, Becky Dempster, has the background and skills to make the collaboration work. Dempster has worked for Coleman for a number of years and, in addition to managing this clinic, she is the Chief Officer of Coleman Access Services.

One of the most important results of this collaboration is that primary care providers are growing increasingly more comfortable in caring for individuals affected by behavioral health illnesses. As a result, primary care clinicians are able to identify people needing services, and the number of referrals from primary care to behavioral health has increased. In addition, as the behavioral health staff stabilizes consumers, primary care staff members are more comfortable with those consumers being released back to them. As the stabilized consumers return to primary care, the behavioral health clinic serves new consumers with severe behavioral health illnesses.

One of the primary advantages of basing an integrated care collaborative in a primary care setting is that many consumers who need behavioral health services are already associated with a primary care health care home. Being in a familiar environment that does not have the same stigma that is often associated with behavioral health settings makes it easier to connect consumers to behavioral health care in the same environment.

Butler Behavioral Health Services and the Butler County Community Health Consortium

The partnership between Butler Behavioral Health Services (BBHS) and the Butler County Community Health Consortium (BCCHC) is another example of integrating behavioral health into a primary care setting.

BBHS provides comprehensive behavioral health care services. BCCHC, a federally-qualified health center (FQHC), provides primary care. BBHS and BCCHC both have clinics in Hamilton and Middletown that serve Butler County residents without regard to the consumers' income or insurance status.

Kimball Stricklin, CEO of BBHS, told us that BBHS envisions integrated care as providing a person-centered health care home. To that end, BBHS has co-located therapists at BCCHC for the past three years. Recently, both organizations have sought to expand their collaboration by seeking grants to expand the BCCHC space for behavioral health services. In addition, with the aid of a planning grant from the Health Foundation of Greater Cincinnati, BCCHC has applied to expand its FQHC scope of services certificate to include behavioral health. Ultimately, the two organizations hope to co-locate BCCHC staff at BBHS clinics and BBHS staff at the BCCHC clinics.

Consumers seeking integrated care may enter the program either through BBHS or BCCHC, and BBHS therapists may interact with primary care consumers in a variety of ways. They may join the primary care clinicians in the examining room, primary care providers may consult with therapists after they have seen the consumer or the therapists may assume responsibility for the consumer while the primary care clinician continues to treat his or her physical health problems.

Most of the integrated care consumers are adults affected by severe mental illness, although children are also treated occasionally. The partners are working to expand integrated care for children.

The consumers served are generally low-income, uninsured or under-insured. Although many have a history with the behavioral health system, increasing numbers are seeking behavioral health care for the first time. Stress related to the poor economy has triggered or exacerbated behavioral issues; more consumers are in need of behavioral health care.

Funding for the integrated care program comes primarily from Medicaid and Butler County Mental Health levy dollars. However, only about 35% of consumers are Medicaid-eligible and levy dollars are inadequate for the expanding need.

Because of tight funding, the program has only been able to have two half-time therapists to serve the needs of the approximately 100 consumers in the program.

Stricklin pointed out that investing in expanded funding for integrated care will ultimately help reduce the community's health care costs; early primary care intervention with behavioral health clients can reduce the severity and complexity of their physical health problems.

Kim also offered some advice to organizations considering developing integrated care programs: integrated behavioral health and primary care requires organizational structures that support collaboration. Both organizations need to be fully committed at all levels and to have a clear, written understanding of their relationship.

In addition, both collaborators must be flexible and willing to modify their usual practice models.. Co-located behavioral health and primary care—and the staffs of both disciplines actively talking and working together—is the ideal arrangement for integrated care. The BBHS-BCCHC collaboration is one of only 24 organizations nationwide selected for a pilot program for integrated care hosted by the University of Wisconsin and funded by the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Services Administration (SAMSHA). This is exciting news, and it will lead to more and better information about effective practices of integrated care.

MODULE 12

Payers, Reimbursement and Fiscal Planning

Key Points

The key points in this module include:

- It is critical that leaders working to improve the integration of behavioral health and primary care understand the payers (Behavioral Health (Community) Medicaid, other forms of Medicaid, Medicare, private insurance and other sources of funding), reimbursement system and documentation/compliance system.
- Reimbursement for some key services, such as collaboration, is a challenge.

Tools

- Ohio Medicaid Covered Services
- Prerequisites to Billing Medicaid

Overview of Reimbursement

This implementation guide provides general information only; it is not intended to provide financial or legal advice. Please consult with reimbursement and financial experts before taking any actions associated with finances and billing and refer to the Ohio Administrative and Revised Codes for official rules and policies.

This module provides an overview of reimbursement of primary care services in behavioral health settings in Ohio. The health care coverage of individuals with severe mental illness in Ohio varies based on eligibility criteria. Medicaid fees for service, Medicaid-managed care and Medicare are often used by primary care services in behavioral health centers. Integrated programs also use private third-party insurance and Vocational Rehabilitation physical reimbursement streams when consumers are eligible for these programs. Many people affected by mental illness are uninsured, which is a significant barrier to accessing effective behavioral health and primary care.

This module contains information and resources about:

- Ohio Medicaid
- Medicaid-Managed Care in Ohio
- Community Medicaid Mental Health Program
- Prerequisites to billing Medicaid in Ohio
- Coding systems for health service reimbursement
- Ohio's Medicaid early and periodic screening, diagnosis and treatment for children
- Medical records documentation that supports reimbursement
- Advanced-practice nurses and physician assistants

- Medicare fees for service programs and clinician enrollment
- Medicare preventative services and coding
- Claims, monitoring and the Physician Quality Reporting Initiative
- The Medicare-Medicaid relationship
- Reimbursement for emergency health services to undocumented individuals
- Medicare fee schedule
- E-Prescribing Incentive Program
- Reimbursement policy recommendations
- Financial planning

Sources: CMS, Ohio Department of Job and Family Services, American Medical Association, Medscape and National Guideline Clearinghouse

Ohio Medicaid

Medicaid is one of the most common reimbursement methods for primary care clinics that are co-located at a behavioral health center. A chart listing the groups that are covered by Ohio Medicaid and their required income levels for eligibility is on the following page. Some of these groups are required to pay monthly premiums or co-pays for some services.

Groups Eligible for Medicaid	Income Limit Guidelines
Former foster youth age 18 to 21	No income guidelines. Restrictions apply.
Children to age 19 and Pregnant Women	200% of the federal poverty level (FPL)
Parents	90% FPL
Disabled Persons	~ 64% FPL*
Workers with Disabilities	250% FPL*
Persons 65 and over	~ 64% FPL*
Medicare beneficiaries in need of premium assistance	200% FPL

** Exceptions and calculations will affect final amount counted toward eligibility. Actual determination of eligibility is done at a county department of job and family services office. Some eligibility categories consider resources other than income and health insurance. (Source: Ohio Department of Job and Family Services (ODJFS), 2009)*

For citizens of Ohio who have a disability or who are age 65 or older, gross countable income, as well as their other resources, are taken into consideration for Medicaid eligibility. These resources include savings, cash, investments, etc. If these individuals have an income that is over the Medicaid limit but they meet all the other eligibility criteria, they are eligible to participate in the Medicaid Spenddown program. Medicaid caseworkers in each county identify how much people have to pay before they are eligible for Medicaid in that month *(ODJFS, 2009).* The table listed on the next page the federally mandated Medicaid services and the services that Ohio Medicaid selected as optional services.

Ohio Medicaid Covered Services

Federally-Mandated Medicaid Services

- Ambulatory surgery centers
- Certified family nurse practitioner services
- Certified pediatric nurse practitioner services
- Family planning services and supplies
- Healthchek (EPSDT) program services (screening and treatment services to those younger than age 21)
- Home health services
- Inpatient hospital
- Lab and x-ray
- Medical and surgical vision services
- Medicare premium assistance
- Non-emergency transportation
- Nurse midwife services
- Nursing facility care
- Outpatient services, including those provided by rural health clinics and federally-qualified health centers
- Physician services

Source: ODJFS, 2009)

Ohio Medicaid's Optional Services

- Ambulance / ambulette
- Chiropractic services for children
- Community alcohol and drug addiction treatment
- Community behavioral health services
- Dental services
- Durable medical equipment and supplies
- Home- and community-based service waivers
- Hospice care
- Independent psychological services for children
- Intermediate care facility services for people with developmental disabilities (ICF-MR)
- Occupational therapy
- Physical therapy
- Podiatry
- Prescription drugs
- Private duty nursing
- Speech therapy
- Vision care, including eyeglasses

For additional information about federal regulations governing Medicaid services, see section 1905(a) of the Social Security Act and the Code of Federal Regulations, 42 CFR. Specific regulation citations for key services are below.

Citations for Selected Mandatory Medicaid Services

- Inpatient hospital: 1905(a)(1) and 42 CFR 440.10
- Laboratory and x-ray: 1905(a)(3) and 42 CFR 440.30
- Outpatient hospital services: 1905(a)(2)(A) and 42 CFR 440.20
- Rural health clinic (RHC): 1905(a)(2)(B), 1905(l)(1) and 42 CFR 440.20(b), (c)
- Federally-qualified health center (FQHC): 1905(a)(2)(C) and 1905(l)(2)(B), and 42 CFR 491.1 - 491.11
- Physician services: 1905(a)(5)(A) and 42 CFR 440.50

Citations for Selected Optional Medicaid Services

- Rehabilitation services: 1905(a)(13) and 42 CFR 440.130(d)
- Medical care or remedial care furnished by licensed practitioners under state law: 1905(a) (6) and 42 CFR 440.60
- Prescribed medicines: 1905(a)(12) and 42 CFR 440.120
- Clinic services: 1905(a)(9) and 42 CFR 440.90
- Targeted case management services: 1915(a)(19), 1915(g)

Medicaid-Managed Care in Ohio

In 2005, the Ohio legislature mandated the statewide expansion of the Medicaid-managed care program for the entire Covered Families and Children population and a portion of the Aged, Blind or Disabled (ABD) population. The Ohio Department of Job and Family Services contracts with two to three managed care providers (MCPs) in each of eight geographic regions. In addition to the services within the Medicaid fee for service program, Medicaid-managed care providers offer additional services such as:

- Case management
- 24-hour hotline for medical advice and direction
- Provider directory
- Member handbook
- Grievance resolution system
- Provider network management
- Member services
- Preventive care reminders
- Health education materials and activities
- Expanded benefits, including transportation, vision and incentives (varies among MCPs)
- Extended office hours (varies among MCPs)

(Source: ODJFS, 2009)

Community Medicaid Mental Health Program

The Community Medicaid mental health program in Ohio is managed by the Ohio Department of Mental Health (ODMH). The program is governed by section 5101: 3-27 of the Ohio Administrative Code. Community Medicaid covers the following community mental health services:

- Group and individual behavioral health counseling and therapy
- Pharmacological management services
- Pre-hospitalization screening
- Mental health assessment
- Crisis intervention
- Partial hospitalization
- Community psychiatric supportive treatment
- Free-standing inpatient psychiatric care in psychiatric hospitals (for consumers under the age of 22 or over the age of 64)

Covered, community-based, substance use disorder services include:

- AOD urinalysis screening
- Assessment
- Case management
- Group counseling
- Individual counseling

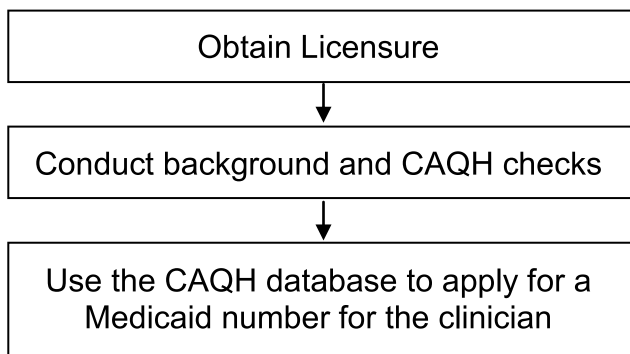
- Crisis intervention
- Intensive outpatient
- Methadone maintenance
- Ambulatory medical and social detoxification
- Medication / somatic

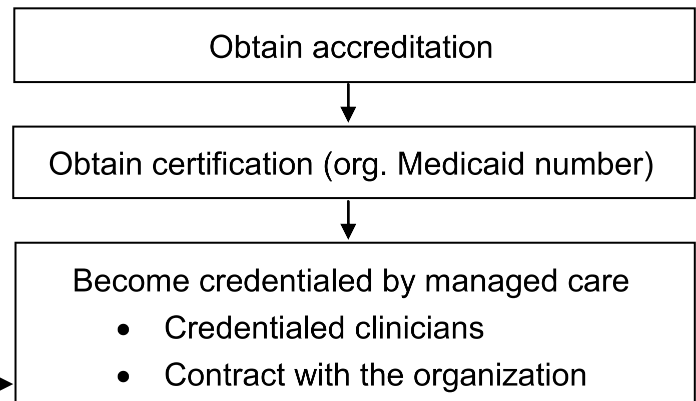
(Source: Office of Medicaid Program Compliance, Ohio Department of Mental Health)

Prerequisites to Billing Medicaid in Ohio

Before a provider can be reimbursed for services by Medicaid, the provider must be enrolled. For more information, please contact the Ohio Medicaid Provider Enrollment Unit at 1-800-686-1516. Before a provider can bill a Medicaid-managed care provider, the provider must be enrolled as a Medicaid provider with the state and approved by the managed care organization. Please contact each managed care organization to obtain information about the application procedure. Below is a high-level picture of the process for billing Medicaid in Ohio. Before initiating this process, please confirm it with the Ohio Department of Job and Family Services.

Prerequisites to Billing Medicaid





Coding Systems for Health Service Reimbursement

(*Sources: CMS and the American Medical Association)*

Coding is very complex and the codes change rapidly. Please consult the Ohio Department of Job and Family Services before initiating this process. The two coding systems that are used most often to bill for health services are the American Medical Association's Current Procedural Terminology (CPT) codes and the International Classification of Diseases (ICD-10) codes. Clinicians must ensure that the services provided, the medical records documentation and the codes selected are accurate and consistent. The amount of time a clinician spends on a consumer's case is usually correlated with the level of the code. Clinicians bill for consultations using evaluation and management (E/M) service CPT codes.

Many different CPT codes are used by primary care clinics co-located at behavioral health centers. Below are the codes for new patient office visits:

- 99201: New patient office visit: problem-focused evaluation and management (E/M)
- 99202: New patient office visit: expanded evaluation and management (E/M)
- 99203: New patient office visit: detailed evaluation and management (E/M)
- 99204: New patient office visit, comprehensive: moderate evaluation and management (E/M)
- 99205: New patient office visit, comprehensive: high evaluation and management (E/M)

Below are the codes for established patient office visits:

- 99211: Established patient office visit: low level evaluation and management (E/M) services
- 99212: Established patient office visit: focused evaluation and management (E/M)

- 99213: Established patient office visit: expanded evaluation and management (E/M)
- 99214: Established patient office visit: detailed evaluation and management (E/M)
- 99215: Established patient office visit: comprehensive evaluation and management (E/M)

It is important that clinicians review the CPT code definitions carefully before using them. Many clinicians find that listing the CPT codes on a smart phone is very useful. People affected by severe mental illness often have other very complicated and serious health issues. Clinicians are tempted often to address all these health issues during the initial visit. Unfortunately, this is not usually realistic. Individuals affected by mental illness often require more time to diagnose and treat. Co-located primary care clinics often need to use the more comprehensive codes for these individuals. Administrators of co-located primary care clinics are concerned this may trigger red flags and additional audits.

For more information about coding, please visit:

- Evaluation and Management (E/M) Coding
- Pocket Guide for the 1997 E/M Documentation Guidelines

The second coding system often used is the International Classification of Diseases (ICD) coding. Currently, ICD-9 codes are in effect, but everyone is required to transition to IDC-10 codes on October 1, 2013. Please see http://www.cms.gov/ICD10/ for the most up-to-date information.

- Other CPT and ICD-10 codes are listed in the prevention section of this guide.

- Ohio's Medicaid Early and Periodic Screening, Diagnosis and Treatment for Children

Healthchek, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medicaid program, is an initiative designed to promote the health of Ohioans who are less than 21 years

of age. Rule 5101:1-38-05 of the Ohio Administrative Code describes Healthchek and its services, which include:

- Screening services
- Vision services
- Hearing services
- Dental services
- Behavioral health and other rehabilitative services
- Other services that are deemed medically necessary, including further diagnosis and/or treatment.

(Source: http://codes.ohio.gov/oac/5101%3A1-38-05 and Ohio Department of Job and Family Services)

Medical Records Documentation that Supports Reimbursement

Accurate, efficient patient medical records are essential for providing effective treatment, improving outcomes and accurately billing for services provided. Some key information that needs to be included in records:

- Date and location of the service
- Reason for the visit
- Health history
- Health risk factors
- Results of the exam and test results

- Rationale/medical necessity of tests and services provided
- Previous and current diagnoses
- Treatment plan
- Progression of the patient and outcomes

(*Source: CMS)*

Advanced Practice Nursing and Physician Assistants

- The roles of advanced practice nurses (APNs) and physician assistants (PAs) are increasing. See more information about CMS and their work with APNs and PAs.

Medicare Fee for Service Program and Clinician Enrollment

- See an overview of the Medicare Fee for Service Program Fee Schedule.
- To access reimbursement for different payer sources, clinicians must be properly enrolled. See Medicare Fee for Service Physician Enrollment Reporting Responsibilities.
- See Non-Physician Fee for Service Physician Enrollment Reporting Responsibilities.
- See Fee for Service Provider Enrollment Reporting Responsibilities for Group Practices.

Medicare Preventive Services and Coding

- The Medicare Preventive Services document describes preventive services covered under Medicare in detail.
- During the first 12 months that a person is enrolled in Medicare Part B, he/she is entitled to a face-to-face Initial Preventative Physical Examination. See A Medicare Preventive Services Eligibility Determination.

- The Update to the Initial Preventive Physical Examination (IPPE) page provides detailed information about this benefit.
- The Smoking and Tobacco Use Cessation brochure summarizes the services Medicare covers to help people quit using tobacco.
- The Medicare Part B Immunization and Billing overview summarizes the services covered and the appropriate billing codes.
- The Medicare Preventative Services Summary information about preventive services, correct coding and frequency.
- See http://www.cms.gov/DiabetesScreening/ for additional information.
- Provider resources about diabetes self-management may be found at http://www.cms.gov/DiabetesSelfManagement/02_ProvResources.asp

Medicare, Federally Qualified Health Centers and Rural Health Centers

- See information about Medicare and Federally Qualified Health Centers.
- See information about Medicare and Rural Health Centers.
- See information about Medicare Billing for Rural Health Providers, Suppliers and Physicians.

Claims, Monitoring and the Physician Quality Reporting Initiative

- See a Medicare Form CMS 1500 fact sheet for the limited situations where paper claims are appropriate.
- See an overview of the Medicare Claims Review Programs.
- See information about the Physician Quality Reporting Initiative, an approach for reducing inappropriate billing.

- See information about the Preventative Care Measures Group and the Physician Quality Reporting Initiative.
- See information about Medicare Overpayments.

Medicare-Medicaid Relationship

- See a brochure describing the relationship between Medicare and Medicaid.

Reimbursement for Emergency Health Services to Undocumented Individuals

- See information about federal Reimbursement for Emergency Health Services to Undocumented Individuals.

Medicare Fee Schedule

- See the Medicare Clinical Laboratory Fee Schedule.
- See the Medicare Physician Fee Schedule fact sheet.

E-Prescribing Incentive Program

- As the trend toward electronic medical records continues, electronic prescribing is more prevalent. See information about the E-Prescribing Incentive Program.

Reimbursement Policy Recommendations

The current health care reimbursement system in the U.S. does not encourage—in fact, it often discourages—integrated behavioral health and primary care. Policies that unintentionally deter collaboration must be reexamined and changed. Currently, existing reimbursement rates make it extremely difficult to cover all the costs for a co-located primary care clinic. There are many opportunities to remove the barriers to integrated care including:

- **Collaboration**

- Promote collaboration among behavioral health, primary care, dental, housing, vocational rehabilitation and other social services at the federal, state and local levels.
- Provide reimbursement for appropriate collaboration between behavioral health and primary care clinicians for shared consumers.
- Ensure contract language, quality assurance and funding promotes collaboration and clearly articulated wellness goals.

- **Realistic Reimbursement Rates**
  - Ensure reimbursement rates for fee-for-service and managed care programs are consistent with the cost, time and intensity of care required for appropriate treatment. This is especially important when treating individuals affected by severe mental illness who have complex health care needs and who are not able to clearly articulate symptoms or follow up on treatment recommendations.
- **Consumers**
  - Promote policies, practices, clinician training and tools that encourage consumers to manage their overall wellness, make healthy choices and develop good health habits.
  - Create reimbursement for effective peer support wellness and transportation services within a co-located primary care clinic.
- **Clarification**
  - Clearly define what is an allowable service covered under Medicaid.
  - Communicate what is allowable for same-day billing for behavioral health and other health care services.

- **Workforce**
  - Address workforce shortages that make it difficult to provide certain services due to licensing restrictions.
- **Outcomes**
  - Reward clinicians who achieve significant positive outcomes - instead of only reimbursing for activity.
- **Audits**
  - Ensure that clinicians who are serving individuals with the most complex health care needs are not penalized with excessive audits and prior authorizations.
- **Start-up**
  - Provide funding to cover the initial expenses of co-located primary care clinics within behavioral health centers for programs that commit to demonstrating significant improvement in overall wellness outcomes.
- **Information-sharing**
  - Encourage collaboration via the appropriate use of electronic health records.
  - Clarify how to promote appropriate information sharing without violating privacy laws.

Health care funding systems across the U.S. are not promoting—and sometimes even undermining—behavioral health and primary care collaborations. Most primary care clinics co-located at behavioral health centers require funds from the government, grants, foundations or other sources to cover construction, equipment, administrative time and other start-up costs. Supplemental funding is often required to sustain integrated care clinics because current reimbursement rates do not cover the cost and effort required to provide adequate health care.

Premature deaths of people served by the public mental health system can be reduced by improving public policies and spending government tax revenues more efficiently.

Fiscal Planning

Financial planning is very important when selecting and implementing integrated care. Managers and clinicians need to have a clear understanding of the required clinical quality and productivity expectations. Financial data, break-even analyses, payer mixes, expected productivity, forecasted service demand, staffing mix and other factors should be considered during the planning process. Integrated care planning teams should develop an initial budget and evaluate the effects of staffing, consumer flow / productivity and payer mix assumptions on profitability.

Module 13

Evaluation and Business Case Development

Key Points

The key points in this module include:

- Information about the need, process measures, fiscal impact and consumer outcomes is imperative for improving quality, increasing efficiency, leading change, influencing policy changes and articulating the value of integrated care projects.
- At first, less is more. Start collecting a small number of outcome and fiscal measures and expand the number of metrics as needed.

Tools

- Integrated Care Business Case and Evaluation Measurement Selection Tool

Business Case and Evaluation Template for Integrated Care

The annual, indirect economic cost of mental illness is approximately $79 billion in the United States (Rice, 1996). These costs include lost productivity due to premature death. These staggering statistics and the human tragedy associated with them must be improved. The purpose of this section is to provide a draft business case / behavioral health services research template that can be modified for different integrated care programs. The function of a business case and evaluation is to measure results, improve quality and influence public policy.

As demand grows for limited health care resources, there are two opposing needs: the need to streamline data collection and the need to provide business cases and evaluations that influence funding and other policy decisions. The challenge is to collect enough information at an appropriate frequency for an effective business case, at the same time, to keep the time and effort spent collecting and reporting to a minimum.

Questions for an Effective Business Case and Evaluation (Clifford, 2001)

- How were consumer outcomes impacted as a result of the integrated care clinic?
- How were processes and outcomes impacted as a result of the integrated care clinic?
- What is the cost versus the benefit of implementing an integrated care clinic?
- What additional information should be collected to monitor implementation effectiveness? What are the critical success factors and learning associated with the implementation of an integrated care clinic?

Categories of Business Case Information (Clifford, 2001)

- How were consumer outcomes impacted as a result of the integrated care clinic?
  - Demographic and health history
  - Consumer health outcomes
- How were processes and outcomes impacted as a result of the integrated care clinic?
  - Recovery and consumer functioning outcomes
  - Consumer health habits
  - Satisfaction
  - Teaching and workforce development outcomes
  - Service outcomes
- What is the cost versus the benefit of implementing an integrated care clinic?
  - Economic outcomes
  - Integrated care clinic fiscal analysis
- What additional information should be collected to monitor implementation effectiveness? What are the critical success factors and learning associated with the implementation of an integrated care clinic?
  - Integrated care clinic process and access to care measures
  - Social supports
  - Barriers and lessons learned

The National Association of Mental Health Program Directors (NAMHPD) recommends that behavioral health organizations collect the following primary care information.

NAMHPD Health Indicators

1. Personal History of Diabetes, Hypertension and/or Cardiovascular Disease
2. Family History of Diabetes, Hypertension and/or Cardiovascular Disease
3. Weight / height / body mass index (BMI)
4. Blood pressure
5. Blood glucose or HbA1C
6. Lipid Profile
7. Tobacco use / history
8. Substance use / history
9. Medication history / current medication list with dosages
10. Social supports

Process Indicators

1. Screening and monitoring of health risk and conditions in behavioral health settings
2. Access to and utilization of primary care services (medical and dental)

The Integrated Care Business Case and Evaluation Tool provides a menu of the type of information that should be considered for an integrated care business case. This template can be used to add and delete information so the key information in a business case can be prioritized. Some of the items with a **+** are usually very important to funders and policy makers. Most of the data should be collected at baseline (entry into the integrated care clinic) and at

key milestones so that changes can be monitored. Some data elements, such as date of birth and other items that do not change, need to be measured only at baseline.

Integrated Care Business Case and Evaluation Measurement Selection Tool (Clifford, 2009)

Potential measures	**Check the information that is currently being collected**	**Check the information that the group wants to collect initially** *(start with a small number of measures)*
Demographic and Health History		
Age		
Gender		
Race		
Education		
Income		
Personal history of diabetes		
Personal history of hypertension		
Personal history of cardiovascular disease		
Personal history of substance use		
Personal history of tobacco use		
Family history of diabetes		
Family history of hypertension		
Family history of cardiovascular disease		
Family history of substance use		
Family history of tobacco use		
Medication history/current medication list, with dosages		
Diagnosis (behavioral and physical)		
Personal history of trauma		

Potential measures	Check the information that is currently being collected	Check the information that the group wants to collect initially *(start with a small number of measures)*
Social Supports		
Social supports		
Living situation		
Income/financial stability		
Supports for food		
Consumer Health Outcomes *(it is important to monitor both behavioral health and other primary care outcomes so that neither is optimized without consideration for the other)*		
Waist circumference +		
Height		
Weight		
Body Mass Index +		
Fasting HbA1c (blood glucose) +		
Systolic blood pressure +		
Diastolic blood pressure +		
Lipid Profile +		
Heart attacks +		
Strokes +		
Urine test results		
Asthma / breathing challenges		
Cancer		
Health risk factors		
Death (preventable with effective health care)		
Mood		
Depression +		
Mania +		
Psychosis/thoughts +		

Potential measures	Check the information that is currently being collected	Check the information that the group wants to collect initially *(start with a small number of measures)*
Anxiety +		
Motivation +		
Somatic symptoms		
Attention/concentration +		
Pain		
Sleep		
Recovery and Consumer Functioning		
Recovery **+**		
Employment +		
Quality of Life +		
Functioning +		
Independent Living +		
Social interactions		
Family relationships		
Consumer Health Habits *(some of these are difficult to measure because some rely on self-reported data)*		
Participation in integrated care clinic's wellness activities		
Cigarettes per day +		
Glasses of water per day		
Amount of exercise per week		
Changes in diet		
Use of alcohol		
Substance abuse		
Adherence to behavioral health treatment recommendations		
Adherence to primary care treatment recommendations		

Potential measures	Check the information that is currently being collected	Check the information that the group wants to collect initially *(start with a small number of measures)*
Integrated Care Clinic Process and Access to Care		
Date of consumer's first integrated care clinic appointment		
Number of unduplicated consumers served by the behavioral health center per year		
Number of unduplicated consumers on active status at the behavioral health center on the date this report is run		
Number of unduplicated consumers served in the integrated care clinic per year +		
Number of consumer visits to the integrated care clinic per year +		
Number of new consumer visits/month +		
Number of returning consumer visits/month +		
Number of consumers served/month +		
Number of consumers returning after their initial visit/month +		
Number of consumers who visited the clinic at least five times/year +		
Average number of visits per consumer per month +		
Average length of time between repeating consumer visits +		
Average duration of a new consumer visit +		

Potential measures	**Check the information that is currently being collected**	**Check the information that the group wants to collect initially** *(start with a small number of measures)*
Average duration of a returning consumer visit +		
Consumer show rate for the Nurse Practitioner		
Number of missed appointments for the Nurse Practitioner for each reason (consumer cancel, staff cancel, no show, etc.) +		
Productivity of the Nurse Practitioner +		
Consumer show rate for the MD +		
Number of missed appointments for the MD for each reason (consumer cancel, staff cancel, no show, etc.) +		
Productivity of the MD +		
Average waiting time for an appointment (from “request” to “being seen by a clinician”) +		
Satisfaction		
Consumer satisfaction with services		
Staff satisfaction with the integrated health clinic		
Administrator satisfaction		
Satisfaction of funders		
Satisfaction of partners		
Student’s satisfaction with learning experience		
Services Outcomes (at the co-located primary care clinic)		
Number of behavioral health consumers receiving primary care services anywhere		

Potential measures	Check the information that is currently being collected	Check the information that the group wants to collect initially *(start with a small number of measures)*
Number of behavioral health consumers receiving primary care services at the integrated care clinic		
Number of behavioral health consumers screened for hypertension		
Number of behavioral health consumers screened for obesity		
Number of behavioral health consumers screened for diabetes		
Number of behavioral health consumers screened for co-occurring substance use disorders		
Number of behavioral health consumers screened for tobacco product use		
Teaching and Workforce Development Outcomes		
Number of each type of student trained in integrated care via grand rounds and conferences (pharmacy, nursing, primary care / family practice residents, psychiatric residents, etc.) **+**		
Number of each type of student trained at the integrated care clinic (pharmacy, nursing, primary care/family practice residents, psychiatric residents, etc.) **+**		
Average number of hours of training at the integrated care clinic for each type of student **+**		
Number of hits to the Web site with resources about the learning from the integrated care clinic **+**		

Potential measures	Check the information that is currently being collected	Check the information that the group wants to collect initially *(start with a small number of measures)*
Economic Outcomes		
Number of emergency department utilization +		
Number of hospitalizations +		
Estimated cost avoidance: avoidance of adverse events and expensive medical procedures due to prevention and intervention (heart attacks, strokes, amputations, hospitalizations, significant cancer treatment, infections, etc.) [*Note: this is difficult to quantify in some cases, but is very powerful if done correctly*.] +		
Reduced risk factor rate +		
Consumer employment income (and taxes paid) +		
Cost of behavioral health care +		
Cost of primary care +		
Cost of physical health specialists (besides behavioral health) +		
Integrated Care Clinic Fiscal Analysis		
Total expenses of the integrated care clinic +		
* Physician		
* Nurse practitioner		
* Medical assistant		
* Management time (project management, supervision, issues resolution, etc.)		

Potential measures	Check the information that is currently being collected	Check the information that the group wants to collect initially *(start with a small number of measures)*
* Administrative support (scheduling, front desk, quality assurance, etc.)		
* Facilities		
* Equipment		
* Supplies		
* Labs		
* Information technology (hardware, staff, etc.)		
Total revenues from the integrated care clinic +		
* Revenues from nurse practitioner visits		
* Revenues from primary care physician visits		
* Revenues from nurse practitioner student visits		
* Revenue from family practice/primary care resident visits		
* Other revenue		
Total profit or loss (total revenue minus expenses) +		
Additional fiscal information		
* Payer mix for all behavioral health center consumers (Medicaid, Medicaid Managed Care (separate by plan), Medicare, Private 3rd party insurance, vocational rehabilitation, no insurance, etc. +		
* Payer mix for integrated care clinic consumers +		

Potential measures	Check the information that is currently being collected	Check the information that the group wants to collect initially *(start with a small number of measures)*
* Average reimbursement rate of a new consumer +		
* Average reimbursement rate of a returning consumer +		
Barriers and Lessons Learned +		

* *Note: each person involved in the project should keep a list of barriers and learning as the project progresses*

After the list of information is prioritized, each specific data element needs to be clearly defined. This critical step is needed so that clinicians, administrators, information technology staff members and evaluators are aligned about exactly what will be collected. Taking the time to define data elements up front will avoid excessive, costly retrospective data collection and/or analysis after the study is completed. In order to minimize administrative burden, evaluators should ask for the definitions of data elements that are already being collected by the organization and use them if appropriate.

Building collaboration between behavioral health, primary care and each Medicaid-managed care provider is a way to begin to develop a business case. Identify a number of mutual consumers who meet the following criteria:

- Have not seen a primary care provider in the last six months
- Meet the managed care organization’s definition of high need
- Make high use of emergency departments and/or hospitals for non-behavioral health conditions

If possible, agree up front about how the cost savings will be used to improve the health of additional mutual consumers. Conduct joint case reviews of each of the selected mutual

consumers and agree on an action plan to improve their health. Using the template of information as a menu, prioritize and select the information that will be tracked. Collect and analyze the information as the joint action plan is implemented. Track the costs and other available information about the mutual consumers who did not choose to participate in the integrated care clinic. This will not be an unbiased control group, but will provide useful information. If possible and medically appropriate, identify a match-pairs control group for comparison.

A strong business case and evaluation is a critical tool for influencing public policy and funding decisions. Behavioral health consumers, advocates and providers must increase their knowledge and capability to build effective businesses cases in order to reduce human suffering and the inefficient use of tax dollars that result in premature death of individuals affected by mental illness.

Appendix

This section of the implementation guide concludes with numerous tools, resources and references that will increase impact and effective implementation.

The Need for Change

Appendix A: Reclaiming 25 Years of Life: Integrating Physical and Mental Health Care to Reduce Disparities for People with Severe Mental Illness

Organizational Change

Appendix B: Root-Cause Analysis and Strategies for Overcoming the Barriers to Integrated Behavioral Health and Primary Care

Additional Resources

Appendix C: Integrated Care Annotated Bibliography

Appendix D: Webography on Behavior Health and Primary Care Integration

Services

Appendix E: Prevention and Wellness Bibliography

Appendix F: Prevention and Wellness in Integrated Care Settings

Appendix G: Medical Diagnosis and Monitoring Protocols

Appendix H: NAMI Hearts and Minds

Appendix I: Fact sheet: Enhancing the Continuum of Care: Integrating Behavioral Health and Primary Care through Federally Qualified Health Centers

Appendix J: Federally Qualified Health Center Reporting Requirements

Information/Measurement

Appendix K: OCCIC Measurement Tool Resource List

Appendix L: Integrated Care: Confidentiality and Release of Information Fact Sheet

Appendix M: Information Technology and Electronic Health Records for Behavioral Health Providers

Operations

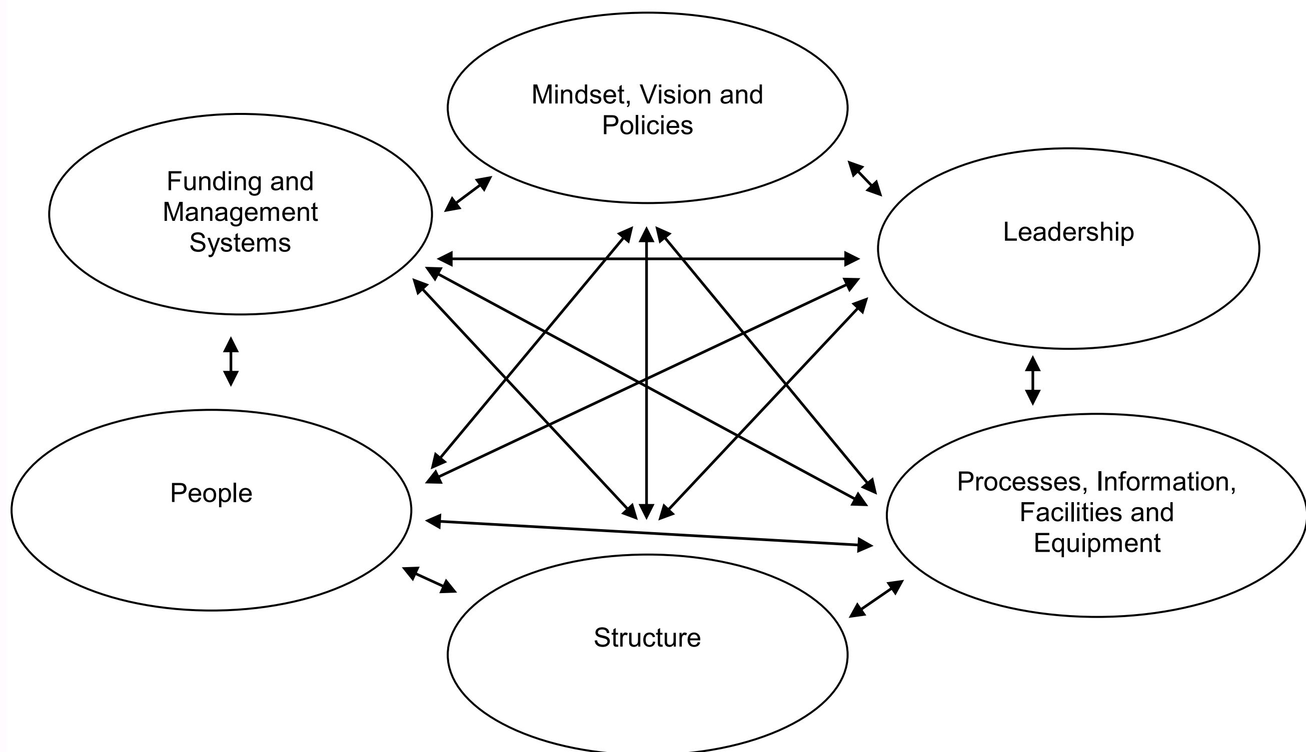
Appendix N: OCCIC Amended Job Descriptions for Behavioral Health Providers in Primary Care

Finance

Appendix O: Profiles of Integrated Care: Working with Federally Qualified Health Centers (FQHCs)

Appendix B: Root-Cause Analysis and Strategies for Overcoming the Barriers to Integrated Behavioral Health and Primary Care

Many of the causes of premature death among individuals served by the U.S. public mental health system are preventable medical conditions (NASMHPD, 2006). This section explores the root causes that make it difficult to integrate behavioral health and primary care. This framework of six interconnected design elements was used to conduct a root cause analysis of the U.S. public health and social service system. The detailed root-cause analysis may seem overwhelming at first glance, but it is much better to understand the root causes prior to implementing a change than to be blind-sided during implementation.



Source: Clifford, 1994

- **Mindset, vision and policies***:* The way that key stakeholders view the world and the system; transformation cannot occur without challenging at least one assumption and shifting mindsets; and the direction and priorities of the system

- **Leadership**: Individuals who are able to challenge inaccurate assumptions, shift mindsets, set direction and lead change
- **Processes, information systems, facilities and equipment**: The flow of work, people, products and information; the facilities and equipment needed to achieve the work
- **Structure**: The way the system is organized including authority, responsibilities and roles; it is important to recognize that formal and informal structures impact a system
- **People**: The key stakeholders within the system; this includes the individuals served by the system, working in the system, influencing the system and impacted by the system; the interests, skills and knowledge of the people should be considered during system design / redesign
- **Funding and management systems**: The fiscal and non-fiscal incentives, recognition, performance feedback and monitoring systems

Examining a system using this framework may initially seem complicated. However, when stepping back to examine how systems and their subsystems are misaligned, numerous opportunities for improvement emerge. The overall public health and social service systems are not designed or funded to promote integration. Below are some examples of how behavioral health and primary care sub-systems are not aligned and the challenges that they face when they try to integrate.

- **Mindset, vision and policies**
  - Many people's lack of belief that individuals with mental illness can recover and lead productive lives
  - Lack of vision or commitment to the vision
  - Lack of clear policies about integrated care or policies that are not supported by the funding system

- Conflicting philosophies of care
- Differing cultures and assumptions between mental health, primary care, dental, housing, vocational rehabilitation and other social services
  - Public primary care organizations such as Federally-Qualified Health Centers serve people based on their financial need and are focused on being the health care safety net
  - Public mental health organizations are often guided by Medicaid and limited eligibility criteria.
- Integrated health care for people affected by severe mental illness as a non-priority for many primary care and mental health organizations
- Lack of shared outcome expectations for patients
- Lack of clarity about how managed care and mental health providers should collaborate
- Lack of Memoranda of Understanding to ensure clear expectations for all partners
- Lack of joint planning regarding desired outcomes, finances, productivity, staffing / roles, information sharing, marketing, facilities, proximity, client flow, staff flow, safety, security, contracts, supplies, equipment, housekeeping, procedures, referrals, parking and other important details

- **Leadership**
  - Lack of champions to articulate the importance of improving overall outcomes
  - Lack of support, commitment and collaboration between the leaders of key health and social service organizations

- Lack of strong executive, clinical, financial and operational leaders to remove barriers and align the system toward the shared goal of wellness
- Lack of commitment by one or more of the partner organizations
- Lack of strong skills and knowledge about driving transformational change

- **Processes, information systems, facilities and equipment**
  - Limited evidence-based practices focused on integrated behavioral health and primary care
  - Poor marketing and referral processes
  - Lack of a robust approach for reducing no-shows for appointments
  - Perceived and actual barriers to sharing patient information with other clinicians
  - Inefficient facility layouts that slow down productivity
  - Unclear office support processes
  - Ineffective client insurance verification processes
  - Lack of strong formal and informal communication processes
- **Structure and roles**
  - Separate sub-systems for behavioral health, primary care, dental, housing, vocational rehabilitation and other social services that are often not well coordinated
  - Unclear roles and expectations regarding integrated care
  - People given the responsibility without the authority to get things done
- **People**

- All stakeholders
    - Stigma
    - Lack of effective advocacy skills, including building a compelling case for transformation
    - Lack of communication to all key stakeholders about the importance of integrated care
- Consumers
    - Complex needs for behavioral health, primary care, dental, housing, vocational rehabilitation and other social services
    - Lack of feeling of empowerment to manage their own health care and collaborate with primary care providers
    - Multiple co-morbid conditions
    - Variable ability and willingness to adhere to treatment
    - Lack of knowledge about what he or she wants
- Staff
    - Poor relationships among implementing parties
    - Lack of primary care clinicians who are comfortable and interested in serving people with severe mental illness
    - Lack of training about mental illness, early identification and effective treatment for primary care clinicians and other non-mental health specialists

- Lack of training about primary care screening and effective treatment for mental health clinicians
- Lack of training and expertise of clinicians about how to help patients adhere to treatment
- Workforce shortages
- Staff burnout
- Lack of knowledge about mental health, primary care, dental, housing, vocational rehabilitation and other social service resources in the community
- Stigma and paternalistic approach
- Lack of champions at all levels of the organization

- **Funding and management systems**
  - Lack of capacity and narrow eligibility criteria for public mental health services
  - Fragmented funding and subsystems for mental health, primary care, dental, housing, vocational rehabilitation and other social services
  - Lack of funding for many types of coordination between mental health and primary care clinicians
  - Inadequacy of Medicare and Medicaid coding and reimbursement rates to treat patients with complex healthcare needs, resulting in unrealistic productivity expectations and an inadequate amount of time to effectively serve patients
  - In some situations, a lack of clarity about what is an allowable service covered under Medicaid

- Confusion about limitations on same day billing for mental health and other healthcare services
- Reimbursement licensing restrictions for certain services
- Medicare and Medicaid coding and reimbursement rates that are not always adequate for patients who are not able to clearly articulate symptoms or follow up on treatment recommendations due to their mental illness
- Lack of funding for key elements of evidence-based practices
- Reimbursement for activities vs. outcomes
- Reimbursement rates that limit clinical time to address complex mental health and other physical health needs
- Lack of affordable transportation
- Client's inability to pay a co-pay or Medicaid spend down
- Lack of strong outcomes data collection necessary to develop impactful business cases to influence change

The critical root causes of a lack of integration between behavioral health and primary care include:

- Fragmented funding streams and organizations that often unintentionally discourage integrated care
- Lack of a shared mindset about the importance of treating the whole person and helping each individual move on with their life
- Lack of leadership reinforcing the goal of improving overall outcomes
- Misalignment within the system

Many federal and state policy issues need to be addressed in order to promote integrated care and better outcomes for individuals affected by mental illness. However, some communities are not waiting for federal and state transformation. These communities are taking matters into their own hands and transforming their local systems. Successful integrated care initiatives tend to have the following characteristics:

- The collaborators challenge current assumptions in order to develop a shared mindset and focus on the health and social service outcomes of the whole person.
- Many of the projects leverage start-up funds from government, foundations or other funding sources to cover construction, equipment, administrative time and other start-up costs.
- Executive, operational and clinical leaders commit significant time and energy to:
    - Make wellness a priority
    - Shift the mindset of their staff by identifying out-dated assumptions and promoting new thinking and behaviors
    - Align their organizations to promote integrated care and overall wellness

Addressing the root causes and realigning the system to promote the integration of behavioral health and primary care can improve quality of life and reduce premature deaths in the public mental health system.

Appendix D: Webography on Behavioral Health and Primary Care Integration

Federal

- **CMHS/ NIDRR/SAMHSA:** Wellness Summit: http://www.bu.edu/cpr/resources/wellness-summit

  The Web site, hosted by Boston University's Center for Psychiatric Services in conjunction with an NIDRR / SAMHSA-funded Rehabilitation Research and Training Center, is designed to provide information on promoting wellness for people affected by mental illnesses. The "Pledge for Wellness" also appears there.

- **HHS:** http://www.healthypeople.gov/hp2020/default.asp

  Healthy People 2020: provides science-based, 10-year, national objectives for promoting health and preventing disease and will reflect assessments of major risks to health and wellness, changing public health priorities, and emerging issues related to our nation's health preparedness and prevention. The initiative is led by the Department of Health and Human Services (HHS) and leverages scientific insights and lessons learned from the past decade, along with new knowledge of current data, trends and innovations.

- **AHRQ:** http://www.ahrq.gov/populations/chroniccaremodel

  Also within HHS, the Agency for Healthcare Research and Quality (AHRQ) has introduced a Toolkit for Implementing the Chronic Care Model in an Academic Environment. This toolkit aims to help improve care for consumers who need chronic care, and it presents a range of materials for implementing the Chronic Care Model in academic health care settings. Designed to transform service delivery, the Chronic Care

Model creates a unique, multidisciplinary team approach that empowers consumers to become active participants in their own care.

National

- **IMPACT: University of Washington:** http://impact-uw.org/

  Focuses on depression screening and treatment in a primary care setting. In one of the largest treatment trials for depression to date, a team of researchers led by Dr. Jürgen Unützer followed 1,801 depressed, older adults from 18 diverse primary care clinics across the United States for two years. The 18 participating clinics were associated with eight health care organizations in Washington, California, Texas, Indiana and North Carolina. The clinics included several Health Maintenance Organizations (HMOs), traditional fee-for-service clinics, an Independent Provider Association (IPA), an inner-city public health clinic and two Veteran's Administration clinics.

- **The National Council: Business and Practice Areas: Integrated Health Care:** http://www.thenationalcouncil.org/cs/integrated_healthcare

  Overall well-being is a function of both mental and physical health. Just as screening and evaluation for mental illnesses and addictions is increasingly available in primary care settings, screening and evaluation for general health problems must be available in behavioral health settings. Despite funding and staffing barriers and confusing liability and confidentiality issues, many community behavioral health care organizations have implemented innovative clinical and financing models to address the comprehensive health care needs of those they serve. The National Council offers resources to support the replication and adaptation of models of effective comprehensive care.

- **Bazelon:** http://www.bazelon.org/issues/general/publications/RoundtableReport.pdf

  This publication presents major points from a 2004 roundtable convened to discuss strategies for integration of primary care and behavioral health in the context of private health insurance. Roundtable participants included health care leaders with expertise in primary care, mental health and substance abuse services and public and private-sector health plan policy, purchasing and administration. [Item IN-3 $4, shipping and handling included] (Feb. 2005)

- **Health Management Associates:** http://www.healthmanagement.com/files/rwjfreport.pdf

  Several state and local health policymakers, managed-care organizations and providers have recently implemented programs designed to address both the behavioral (mental and substance abuse disorder) and physical health needs of individuals. As the topic of integrated physical and behavioral health garners increasing attention, The Robert Wood Johnson Foundation sought assistance in understanding the facets of existing integrated services initiatives in order to have knowledge of the approaches, treatment models and services used to achieve integration. The aim of the *Integrating Publicly Funded Physical and Behavioral Services: A Description of Selected Initiatives* report is to identify and describe existing models of publicly-funded integrated service programs.

- **NASHPD:** http://www.nasmhpd.org/

  National resources, including NASMHPD Medical Directors Council Technical Report, Measurement of Health Status for People with Serious Mental Illnesses, and NASMHPD Medical Directors Council Technical Report, Obesity Reduction and Prevention Strategies for Individuals with Serious Mental Illness, October 2008.

Ohio

- Ohio Coordinating Center for Integrated Care: http://www.occic.org
- Interface Network: https://interfacenetwork.grouphub.com/login
- Wellness Management and Recovery: http://www.wmrohio.org/wmrovw.html
- Tobacco and Recovery: http://www.ohiotobaccorecovery.case.edu/
- Health Policy Institute of Ohio: http://www.healthpolicyohio.org/publications/mentalhealthintegration.html

Appendix E: Prevention and Wellness Bibliography

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Appendix J: Federally Qualified Health Center (FQHC) Reporting Requirements

Sources: HHS, HRSA, and 45 CFR Part 74

Federally-Qualified Health Centers (FQHCs) are required to use their federal funding in order to increase access to underserved individuals in need of health care. Reporting requirements for FQHCs include:

- Uniform Data System (annual data submission about services and patient demographics – see attached)
- Quarterly financial reports
  - SF 269 or SF 269A. The SF-269 must be used if income was earned. The awarding agency may waive the SF-269 or SF-269A requirement if the PMS-270 (Request for Advance or Reimbursement) or the PMS-272 (Report of Federal Cash Transactions) provide the information that the awarding agency needs. When the project is complete, a final SF-269 or SF-269A is required.
- Performance reports
  - Comparison of accomplishments vs. goals / objectives for the period (use quantitative data when possible)
  - If established goals were not met, specification of reasons
  - Include other pertinent information as needed (i.e. analysis and explanation of cost overruns, etc.)

There are additional reporting requirements for health centers who received American Recovery and Reinvestment Act (ARRA) grants. In addition to the annual Uniform Data System reporting requirements, health centers must submit quarterly reports that include a standard set of ARRA information and a set of specific health center program information.