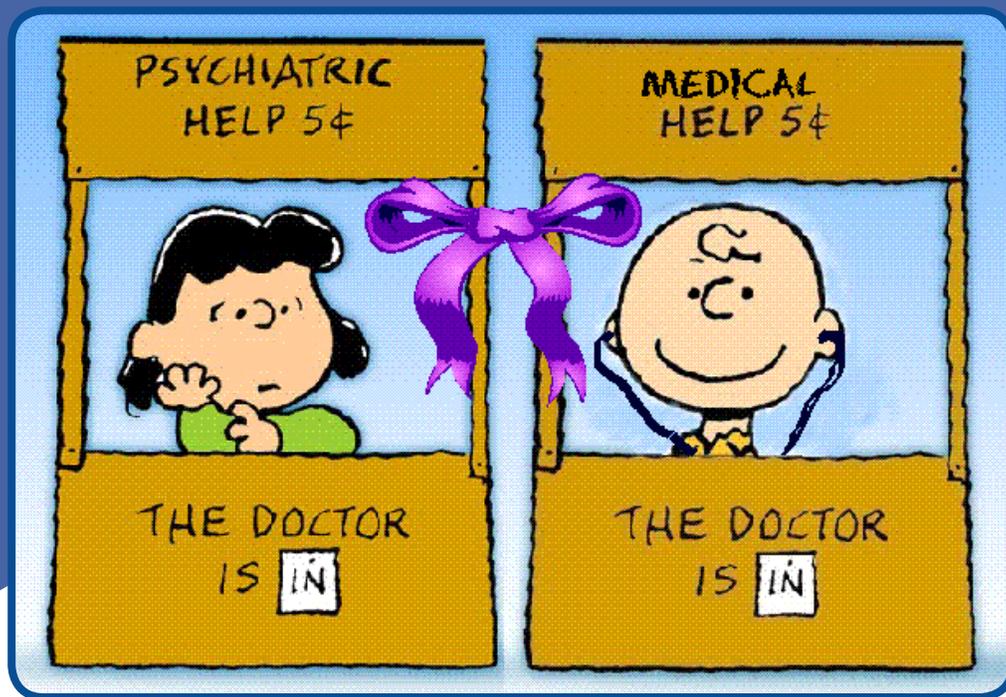


Partners in Health

Primary Care / County Mental Health Collaboration



Tool Kit

First Edition • October 2009



IBHP

Integrated Behavioral Health Project



INTRODUCTION

Integrated behavioral care acknowledges the mind's inextricable connection to the body and fully recognizes that what happens to one profoundly impacts the other. The purpose of this *Collaborative Care Tool Kit* is to help primary care clinics, mental health agencies and substance abuse programs work together seamlessly, coordinating needed care for the whole person, not just a portion, for easier access, greater consumer satisfaction and better outcomes.

This County Mental Health-Primary Care Tool Kit has been developed by the Integrated Behavioral Health Project (IBHP), a strategic initiative of The California Endowment and Tides Center to accelerate the integration of behavioral health services and primary care throughout California. Our ultimate goals are to enhance access to behavioral treatment services, improve treatment outcomes for underserved populations, and reduce the stigma associated with seeking such services.

Much has been written about integration of mental health and primary care as a promising vehicle for improving both accessibility and quality of mental health services, and what should be done to achieve it. IBHP's objective is to turn the "shoulds" into action, to coax the transition of these recommendations from paper to practice throughout California.



Launched in 2006, the Integrated Behavioral Health Project (IBHP) is a four-year initiative to accelerate the integration of behavioral health services into primary care settings in California. Our ultimate goal is to enhance access to

behavioral treatment services, improve treatment outcomes for underserved populations, and reduce the stigma associated with seeking such services. IBHP, a joint project of Tides Center and The California Endowment, has funded nine demonstration projects and subsequently awarded 27 grants to community care clinics and clinic consortia to broaden and deepen their work. We have also established a learning community; co-hosted a web-based training series; established a mentoring program; developed program and systems policy; conducted outcome and process research; and advocated for collaboration between the mental health, primary care, and substance abuse systems for better client care.

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TIDES

Tides partners with philanthropists, foundations, activists and organizations to promote economic justice, robust democratic processes, and the opportunity to live in a healthy and sustainable environment where human rights are preserved and protected.

www.tides.org



The California Endowment awards grants to organizations which support their mission “to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians.”

www.calendow.org

Acknowledgements

This Tool Kit was developed and written by IBHP’s Barbara Demming Lurie based on the valuable contributions of many key players in the collaborative care arena. Questions and comments may be directed to her at barb@ibhp.org.

Our gratitude and appreciation go to all the people whose information and advice fill these pages. Among them:

Alfredo Aguirre, San Diego County Behavioral Health; Peter Van Houten MD, Sierra Medical Center, Nevada City; Marty Adelman and Nicole Howard, Council Of Community Clinics, San Diego; Brenda Goldstein, Lifelong Medical Care, Oakland; Julie Ohnemus MD, Open Door Community Health Centers, Humboldt County; Sally Hewitt, Humboldt Department Of Health And Human Services; Celia Moreno MD, San Mateo Behavioral Health and Recovery Services; Mark Montgomery, Shasta County Mental Health Services; Marta McKenzie, Health and Human Services Agency, Shasta County; Barbara Garcia, San Francisco Department of Community Behavioral Health Service And Primary Care; John Gressman, President and CEO, San Francisco Community Clinic Consortium; Deb Borne MD, Tom Waddell Health Center, San Francisco; Doreen Bradshaw, Shasta Consortium of Community Health Centers; Steve Chamblin, Mental Health Division, Tehema County; Lynn Dorroh, Hill Country Community Clinic, Shasta; Jonathan Porteus, The Effort Community Health Center, Sacramento; Marcia Jo, Behavioral Health, Solano County; Barbara Mauer, MCPP Healthcare Consulting; Alex Barnes, South of Market Mental Health Services, San Francisco; Annie Linaweaver, Clinical Supervisor, Mono County Mental Health; Brenda Reiss-Brennan, Intermountain Healthcare, Utah; Christina Kraushar, Merced Department of Mental Health; Lynn Tarrant, Placer County Mental Health Department; Kathleen Reynolds, formerly of Washtenaw County Michigan Mental Health; Tina Zoppel, Community Health Clinic Olé, Napa; Kirk Strossahl, Mountainview Consulting; Jurgen Unutzer, IMPACT; and Dennis Freeman, Cherokee Health Systems, Tennessee.

Layout and Design by Tempra Board & Associates



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WHAT is Integrated Health Care?

What is Integrated Health Care?

Simply put, it's a coordinated system that combines medical and behavioral services to address the whole person, not just one aspect of his or her condition. Medical and mental health providers partner to coordinate the detection, treatment, and follow-up of both mental and physical conditions. Combining this care allows consumers to feel that, for almost any problem, they've come to the right place.*

Mental Health System



Physical Health System



Simply put, collaborative care is rediscovering the neck.

**Alexander Blount, Clinical Professor, Family Medicine and Psychiatry, University of Massachusetts Medical School.*



WHY Primary Care - Mental Health Collaboration

- Because integration of services means a more cohesive service delivery system and better continuity of care.
- Because many mental and physical disorders are co-occurring, especially depression and chronic medical conditions.
- Because research has shown that integrated behavioral care produces significant positive results, including decreases in client depression levels, improvement in quality of life, decreased stress and lower rates of psychiatric hospitalization.
- Because people with serious mental health conditions are dying on average 25 years earlier than the general population.
- Because improving mental status and functioning often positively impacts physical conditions.
- Because there are often better mental health outcomes when physical problems are managed.
- Because studies have shown that initially most people turn to primary care providers, not specialty mental health clinics, with their emotional problems.
- Because health care visits often have psychosocial drivers; psychosocial stress is a major factor in triggering physical illness and exacerbating existing chronic illnesses.
- Because both medical and behavioral professionals can get the “full picture” about the clients they’re treating.
- Because there is the opportunity for quality improvement of care within the primary care and specialty behavioral healthcare settings.
- Because many people being served by public behavioral health services need better access to primary care.
- Because community health centers serve people who need better access to behavioral healthcare.
- Because behavioral health clinicians are a resource for assisting people with all types of chronic health conditions.
- Because addressing psychosocial aspects of problems presented in primary care often results in lower overall health costs.
- Because clients like the convenience of “one-stop shopping.”
- Because primary care is often the first-line intervention and only access for many people with mental health problems.

- Because offering behavioral health services in non-traditional settings encourages participation by people wanting to avoid the stigma surrounding mental health treatment.
- Because it presents an opportunity to intervene early and prevent more disabling disorders.
- Because more people, who cannot or will not access specialty behavioral health care, can be reached.
- Because the primary care network is a main provider of services to minority populations and culturally diverse communities.
- Because it will improve the skills of primary care clinicians in recognizing and treating persons with mental health conditions.
- Because it will improve the skills of mental health professionals in recognizing and treating the psychological effects of physical conditions.
- Because it increases the use of behavioral interventions in primary care.
- Because primary care physicians' knowledge, skill-sets and comfort-zone are expanded as a result of collaboration with mental health professionals.
- Because underlying behavioral or emotional conditions can increase unnecessary medical utilization and inappropriate referrals.
- Because many primary care physicians – faced with increased administrative demands and time constraints – are ill-equipped to manage patients who present with mental health or substance abuse related issues.
- Because subclinical and clinical depression is frequently misdiagnosed or under-diagnosed in general medical populations.
- Because substance abuse problems often go unrecognized but trigger or exacerbate conditions such as accident-related injuries, gastritis, diabetes and hypertension, liver abnormalities, and cardiac problems.
- Because depression is a frequent complication of cancer, post-cardiac surgery, diabetes, post-partum, and in the treatment of any chronic and debilitating physical illness.
- Because emotional factors are thought to play a role in triggering asthma attacks and exacerbations of autoimmune diseases.
- Because though mental health and substance abuse screening and referral are essential components in a primary care setting, medical staff often has little time or expertise available to perform these functions.
- Because many clients transfer the trust and rapport they share with their physicians to the behavioral specialist he or she designates.
- Because primary clinics are often easier for consumers to access than mental health facilities.

- Because some studies indicate that integrated care leads to a reduction of inappropriate use of medical services and a cost-savings in big-ticket items like emergency room visits and hospitalization.
- Because by referring clients with mental health issues to those specially trained to deal with them, physicians free up their time up to handle more medically-oriented problems.
- Because physicians report increased satisfaction when they have easily available back-up care for their clients' mental health needs.
- Because, according to research, client compliance with medical regimens like diet and smoking cessation are increased when behavioralists provide training and guidance.
- Because management of emotional/behavioral disorders may positively impact adherence to treatment of physical disorders.
- Because in a general care atmosphere, terms like “psychiatric problems” and “mental illness” can be replaced by more universal, less stigma-laden terminology, like “coping skills”, “counseling” and “stress”.
 - Because the primary care network serves a primarily poor and underserved population.
 - Because primary care providers have been shown to have a high level of client adherence and retention in treatment.
 - Because behavioral health care in primary care settings isn't simply psychological counseling; it's teaching coping skills, self-management, adherence to medical regimen, and promoting healthier lifestyles by behaviorally addressing smoking, drinking, poor diet, and other unhealthy choices.



Some of these thoughts were taken from "Behavioral Health/Primary Care Integration Models, Competencies and Infrastructure" by Barbara Mauer, prepared for the National Council for Community Behavioral Healthcare.

The Reviews Are In...

WHAT KEY PLAYERS ARE SAYING ABOUT PARTNERSHIPS BETWEEN COUNTY MENTAL HEALTH AND PRIMARY CARE IN CALIFORNIA

We've had a significant decline in psychiatric hospitalizations and I attribute that directly to our contract with Hill Country [a primary care clinic]. And the collaboration has prevented lots of people from having to come into the public mental health system. It's been enormous.

- Mark Montgomery, Director, Shasta County Mental Health Services

Behavioral Health collaboration is a journey well worth the struggle since ultimately it's about changing a more welcoming environment that honors the patients' physical, mental, developmental and spiritual health.

-Alfredo Aguirre, Mental Health Director, San Diego County

This collaboration has been the most amazing, most precious work I've ever had the privilege of doing as a clinician.

-Deb Borne, MD, Medical Director, Tom Waddell Health Center, San Francisco

For people who may not have serious mental illness, there are so many hurdles to reach a mental health clinic. Treatment in primary care is much easier for them and they are much more accepting of getting it there....It's really met unmet needs. We are seeing a group that was underserved and catching things earlier so we can prevent more intensive services and ER visits.

-Celia Moreno, MD, Medical Director, Behavioral Health and Recovery Services, San Mateo County

Bottom line, it's better patient care. Often the patients with SMI aren't always their own best medical advocates. The improved collaboration will ultimately have a positive impact on their morbidity and mortality.

-Julie Ohnemus MD, Primary Care Provider, Open Door Community Health Centers

The one-stop community-based approach to health care and social needs is extremely valuable to overall health, not just mental health.

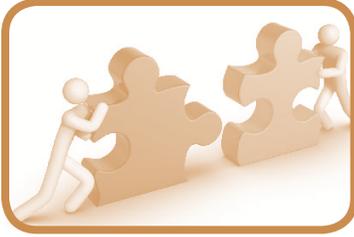
-Lynn Dorroh, CEO, Hill Country Community Clinic, Shasta County

Collaboration with a primary care clinic here is working well. It's enabled us to connect clients to services they may not have originally sought out.

-Annie Linaweaver, Clinical Supervisor, Mono County Mental Health

There is a greatly expanded capacity to respond to the non-medical issues that impact a client's health. What can be better than knowing that the homeless man that you are treating for diabetes is going to receive housing, food assistance and psychiatric care – and you don't have to make 50 phone calls to get information or make referrals?

-Brenda Goldstein, Psychosocial Services Director, Lifelong Medical Care, Alameda County



WHAT the Research Shows

I. Health care visits often have psychosocial drivers. Mental health problems can stem from physical problems. Integrated care allows for the whole person to be treated, not just a part.

- 70% of all health care visits are generated by psychosocial factors. (*Fries et al., 1993; Shapiro et al., 1985*).
- Primary care is the de facto mental health and addictive disorder service for 70% of the population. (*Reagan et al., 1993*)
- The majority of visits in primary care are related to behavioral needs but not to identified mental health disorders. Many patients respond to psychosocial stress by developing vaguely defined, distressing physical symptoms that have no organic cause. (*Kroenke et al., 1989*)
- An estimated 75% of patients with depression present physical complaints as the reason they seek health care. (*Unutzer et al., 2006*)
- The most frequent psychosocial drivers of medical utilization are mental disorders, alcoholism and drug addiction, deficient social support, lack of coping skills and stressful home/work environment. (*Friedman et al., 1995*)
- Psychosocial factors are positively related to poor general health, functional disability, and long-term health morbidity and mortality. (*Frazure-Smith, 1991; Fawzy et al., 1993*)
- Medical outcome studies reveal that depression results in more functional impairment than chronic diseases such as diabetes, arthritis and angina. (*Wells et al., 1989*)

Behavioral Health collaboration with the primary care health care system has opened up opportunities to increase access to care, re-define what is culturally competent, broadened our understanding of wellness, embraced the term of “medical home” as a basic right for mental health patients, helped us better understand self sufficiency, empowerment and illness management, and in general has humbled us in a variety of ways.

–Alfredo Aguirre, Mental Health Director, San Diego

II. Addressing these psychosocial aspects often results in lower overall health costs.

- A meta-analysis of 91 studies found that with active behavioral health treatment, patients diagnosed with a mental disorder had a reduced overall medical cost of 17%, while controls who did not receive behavioral treatment increased an average of 12.3%. (*Chiles et al., 1999*)
- Adding integrated services in one study added \$250 per patient to overall costs, but saved approximately \$500 in additional medical costs. (*Katon et al., 1996*)
- An integrated primary care model for homeless individuals and injection-drug users in Santa Clara County found that emergency and urgent care visit rates decreased from 3.8 visits in

Our mental health clients are more satisfied, less frustrated and are getting better quicker than they were in the mental health system.

The collaborative arrangement with Shasta County Mental Health has given us financial support to fill the hole created by treating large numbers of indigents and for the County, it's stretched their dollar.

–Lynn Dorroh, CEO, Hill Country Community Clinic, Shasta County

the 18 months prior to the clinic's opening to 0.8 visits in the first 18 months of the clinic's operation. (*Kwan et al., 2009*)

costs declined by 21% at 18 months compared to a rise of 22% for those not receiving any treatment. (*Pallak et al., 1995*)

- A review of 57 controlled cost offset studies found an average of 27% cost savings with integrated care. (*Chiles et al., 1999*)
- A targeted psychosocial intervention with high-utilizing Medicaid primary care outpatients found that medical costs declined by 21% at 18 months compared to a rise of 22% for those not receiving any treatment. (*Pallak et al., 1995*)
- Depression management for depressed primary care clients resulted in a \$980 cost decrease for those who complained of psychological symptoms, but there was a \$1,378 cost increase for those who complained of physical symptoms only. (*Miriam Dickinson et al., 2005*)
- The addition of psychological interventions for Kaiser clients with serious medical disorders resulted in a 77.9% reduction in their average length of hospitalization; a 66.7% reduction in hospitalization frequency; a 48.6% decrease in number of prescriptions written; a 48.6% decrease in physician office visits, a 45.3% decrease in emergency room visits, and 31.2% decrease in telephone contacts. (*R. Lechnyr, 1999*)

III. The stigma of being identified as a “mental patient” prevents many people from seeking help in specialty mental health services. Even if they do seek such services, many will not be accepted for treatment unless they meet strict criteria of being seriously mentally disordered.

- A national survey found that 32% of undiagnosed, asymptomatic adults would likely turn to their primary care physician to help with mental health issues; only 4% would approach a mental health professional. (*National Mental Health Association, 2000*)

- A total of 71% elderly clients assigned to integrated care in the primary care setting engaged in treatment, compared to just 49% of the group who received outside referrals. (*Stephen Bartels et al., 2004*)
- Sixty-one percent of all primary care clients surveyed and 69% of depressed clients desired counseling, but relatively few desired a referral to a mental health specialist. (*D. Brody et al., 1997*)
- In a poll conducted by the American Psychological Association, 30% of the adults responding expressed concern about other people finding out if they sought mental health treatment, and 20% identified stigma as "a very important reason not to seek help" from a mental health professional. (*J. Chamberlin, 2004*)

Most of the projects are serving clients who are considered extremely high risk and who are often labeled as non-compliant in the primary care setting. The collaborations with mental health programs enable our providers to go to where the population is located and in a setting where they feel safe and supported. For providers interested in working with this population this is a model that promotes success for the patient.

–Brenda Goldstein, Psychosocial Services Director, Lifelong Medical Care, Alameda County

IV. Primary care is the first-line intervention for many. Folding behavioral health care into this setting improves access and accelerates prevention and early intervention.

- By 2003, 54% of people with mental health issues were served in the general medical sector only, rather than within or in combination with the specialty mental health sector. (*B. Mauer, 2007*)
- 69% of clients approved for services in San Diego primary clinics as part of a MHA-

Having mental health personnel stationed at primary care streamlines to process of getting patients access to more intensive services should they need it. I think it's worked quite well. We're seeing over 1,000 distinct clients and managing most in the primary care settings with only a few being referred to specialty mental health. The physicians like our service and are clamoring for more.

–Celia Moreno, MD, Medical Director, Behavioral Health and Recovery Services, San Mateo County

sponsored program, all diagnosed with serious mental illness, had not been seen previously in the county mental health system. (*Council of Community Clinics, San Diego*)

- Primary care physicians (i.e., family physicians, general internists, and

obstetrician-gynecologists) serve as the initial health care provider for between 40% and 60% of individuals with depressive disorders. (*Virginia Boney, 1998*)

- Service utilization studies suggest that 70-80% of the general population will make at least one primary care visit annually. The conclusion is that approximately 65-70% of patients with mental disorders are cycling through the general medical sector, whether they are recognized and treated or not. These patients, as a rule, do not seek specialty mental health care to address their behavioral health needs.

(Kirk Strosahl, 1997)

- The prevalence of borderline personality disorder in primary care is about four times higher than that found in studies of the general community.

(Raz Gross, 2002)

- A study of antidepressant utilization in a national managed care organization and its behavioral health subsidiary found that 77% of all antidepressant prescriptions were written by primary care providers. *(Karen Way, 1999)*

- Fifty percent of all care for primary care patients with mental disorders is delivered solely by general medical practitioners (based on other cited epidemiological studies). *(Kirk Strosahl, 1997)*

It's very humbling to be involved in a project that has made so much difference in people's lives. We've really helped people who are so marginal that they hadn't gotten any medical care before.

–Deb Borne, MD Medical Director, Tom Waddell Health Center, San Francisco

- Although only a minority of people affected by depression seek professional help, depressed people are significantly more likely than others to visit physicians for other reasons. *(Surgeon General's Mental Health Report, 1999)*

- A national survey of over 20,000 adults found that slightly more were likely to receive mental services from general medical physicians than from specialists in mental health or addiction, leading authors to conclude "Primary Care is a de facto mental health system responsible for care of more patients with mental disorders than the specialty mental health sector." *(D. Regier, 1993)*

- Two-thirds of primary care physicians could not access mental health services for their patients, a rate that was at least twice as high as for other services. *(P.Cunningham et al., 2009)*

V. On the flip side of the equation, people with serious mental disorders die much younger than the general population and many are in dire need of medical intervention.

- People with serious mental illness treated by the public mental health system die on the average 25 years earlier than the general population; they live to 51, on average, compared

Collaboration with a primary care clinic here is working well. It's enabled us to connect clients to services they may not have originally sought out.

–Annie Linaweaver, Clinical Supervisor, Mono County Mental Health

with 76 for Americans overall. According to the data, they are 3.4 times more likely to die of heart disease, 6.6 times more likely to die of pneumonia and influenza, and 5 times more likely to die of other respiratory ailments. (C. Colton, based on 1997-2000 data)

Integrating with primary care has worked out very well. Our clients now have a doctor who can handle their problems and medication side effects. A lot of patients who didn't know they had a health problem found out about it in time to get treatment for it.

–Alex Barnes, South of Market Mental Health Services, San Francisco

- Sixty percent of premature deaths in persons with schizophrenia were due to medical conditions such as pulmonary, infectious and cardiovascular diseases. (J. Parks et al., for Nat'l Association of State Mental Health Directors, 2006)

- Seven of the ten leading causes of death (heart disease, cancer, stroke, chronic lower respiratory disease, accidents, diabetes and suicide) have a psychological and/or behavioral component. (Centers for Disease Control and Prevention, 2005)
- Based on analyzed insurance claims over a six year period, persons with bipolar disorder were significantly more likely to have medical co-morbidity, including three or more chronic conditions (41% versus 12%), compared with controls. (C.P. Carney et al., 2006)

VI. Primary care-based behavioral health has been shown in several studies to result in positive clinical outcomes and high client satisfaction.

- An analysis of 37 randomized studies of collaborative depression treatment in primary care found significantly improved outcomes at six months compared with standard treatment, and evidence of longer-term benefit for up to 5 years. (Simon Gilbody et al., 2006)

- Primary care clients with panic disorder randomly assigned to a collaborative care intervention experienced an average of 74.2 more anxiety-free days during the one-year

We found that being stationed in the primary care setting is a good way to reach low income and minority populations, particularly Hispanic and Asian. Our original impetus was to satisfy primary care doctors contracting for our services and we do have survey results of their satisfaction level – and it's high. The survey also shows that the doctors' expertise and comfort level have gone up for persons with less severe psychiatric disorders.

–Marcia Jo, Research and Planning Director, Behavioral Health, Solano County

intervention than clients receiving usual primary care. (Wayne Katon, 2002)



- Older adults are more likely to have greater satisfaction with mental health services integrated in primary care settings than through enhanced referrals to specialty mental health and substance abuse clinics. (*Hongtu Chen et al., 2006*)

VII. Primary care is the health mainstay of the underserved from diverse cultures.

- California's health care clinic population is 53% Latino, 30% non-Latino White, 6% Black, 6% Asian/Pacific Islander, and 2% American Indian. A total of 47% have limited or no English proficiency. (*California Primary Care Association, based on 2004 OSHPD data*)
- 2.1 million community clinic patients are below 200% of the federal poverty level and 1.3 million are uninsured. (*California Primary Care Association, 2006*)



LEVELS of Integrated Behavioral-Medical Care

Integrated behavioral care isn't an all-or-nothing proposition. Rather, it is practiced on a continuum, based on the level of collaboration between health care and behavioral health care professionals.

Level One: Minimal Collaboration

Mental health and other health care professionals work in separate facilities, have separate systems, and rarely communicate about cases.

- **Where practiced:** Most private practices and agencies.
- **Handles adequately:** Cases with routine medical or psychosocial problems that have little biopsychosocial interplay and few management difficulties.
- **Handles inadequately:** Cases that are refractory to treatment or have significant biopsychosocial interplay.

Level Two: Basic Collaboration at a Distance

Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. All communication is driven by specific patient issues. Mental health and other health professionals view each other as resources, but they operate in their own worlds, have little understanding of each other's cultures, and there is little sharing of power and responsibility.

- **Where practiced:** Settings where there are active referral linkages across facilities.
- **Handles adequately:** Cases with moderate biopsychosocial interplay, for example, a patient with diabetes and depression where the management of both problems proceeds reasonably well.
- **Handles inadequately:** Cases with significant biopsychosocial interplay, especially when the medical or mental health management is not satisfactory to one of the parties.

Level Three: Basic Collaboration On-Site

Mental health and other health care professionals have separate systems but share the same facility. They engage in regular communication about shared patients, mostly through phone or letters, but occasionally meet face to face because of their close proximity. They appreciate the importance of each

other's roles, may have a sense of being part of a larger, though somewhat ill-defined team, but do not share a common language or an in-depth understanding of each other's worlds. As in Levels One and Two, medical physicians have considerably more power and influence over case management decisions than the other professionals, who may resent this.

- **Where practiced:** HMO settings and rehabilitation centers where collaboration is facilitated by proximity, but where there is no systematic approach to collaboration and where misunderstandings are common. Also medical clinics that employ therapists but engage primarily in referral-oriented collaboration rather than systematic mutual consultation and team building.
- **Handles adequately:** Cases with moderate biopsychosocial interplay that require occasional face-to-face interactions between providers to coordinate complex treatment plans.
- **Handles inadequately:** Cases with significant biopsychosocial interplay, especially those with ongoing and challenging management problems.

Level Four: Close Collaboration in a Partly Integrated System

Mental health and other health care professionals share the same sites and have some systems in common, such as scheduling or charting. There are regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases, and a basic understanding and appreciation for each other's roles and cultures. There is a shared allegiance to a biopsychosocial/systems paradigm. However, the pragmatics are still sometimes difficult, team-building meetings are held only occasionally, and there may be operational discrepancies such as co-pays for mental health but not for medical services. There are likely to be unresolved but manageable tensions over medical physicians' greater power and influence on the collaborative team.

- **Where practiced:** Some HMOs, rehabilitation centers, and hospice centers that have worked systematically at team building. Also some family practice training programs.
- **Handles adequately:** Cases with significant biopsychosocial interplay and management complications.
- **Handles inadequately:** Complex cases with multiple providers and multiple larger systems involvement, especially when there is the potential for tension and conflicting agendas among providers or triangling on the part of the patient or family.

Level Five: Close Collaboration in a Fully Integrated System

Mental health and other health care professionals share the same sites, the same vision, and the same systems in a seamless web of biopsychosocial services. Both the providers and the patients have the same expectation of a team offering prevention and treatment. All professionals are committed to a biopsychosocial/systems paradigm and have developed an in-depth understanding of each other's roles and cultures. Regular collaborative team meetings are held to discuss both patient issues and

team collaboration issues. There are conscious efforts to balance power and influence among the professionals according to their roles and areas of expertise.

- **Where practiced:** Some hospice centers and other special training and clinical settings.
- **Handles adequately:** The most difficult and complex biopsychosocial cases with challenging management problems.
- **Handles inadequately:** Cases where the resources of the health care team are insufficient or where breakdowns occur in the collaboration with larger service systems.



This description of collaboration levels was put forth by William J. Doherty, Ph.D. Susan H. McDaniel, Ph.D. and Macaran A. Baird, M.D., and summarized in *Behavioral Healthcare Tomorrow*, October, 1996, 25-28:



DIFFERENCES Between Mental Health & Primary Care

Be mindful of differences between mental health and primary care cultures...

While their mutual goal is improved mental health and functioning, primary care-based behavioral services and specialty mental health often go down substantially different roads to get there. The fast-paced, cognitively-oriented, short-term aspects of primary care often contrast with the more in-depth, longer-term treatment offered by many mental health clinics. The contrast in operational approaches and professional orientation can make partnership adjustment challenging. The following chart highlighting some of the differences was taken from *The Primary Behavioral Health Care Services Practice Manual, 2.0*, Air Force Medical Operations Agency, 2002.

PRIMARY CARE BEHAVIORAL CARE COMPARED TO SPECIALTY MENTAL HEALTH TREATMENT

Primary Care Behavioral Care	Specialty Mental Health
population-based	client-based; specific requirements for service acceptance
often informal client inflow	formal acceptance process; requires intake assessment, treatment planning
treatment usually limited; one to three visits in typical case	often long-term treatment; number variable, related to client condition
mental health seen as just one component of overall health care	focus on mental health care
treatment afforded to persons with mild impairments, those coping with situational stress and sometimes stabilized persons with serious mental disorders	treatment restricted to persons experiencing or at risk of serious mental disorders
informal counseling session, vulnerable to frequent interruption	more formal, private interchange

Primary Care Behavioral Care	Specialty Mental Health
visits typically 15-30 minutes	visits usually 50 minutes
low intensity treatment usually	higher intensity usually, involving more concentrated care
treatment often encompasses behavioral aspects of healthcare, like pain management, smoking cessation, etc.	treatment emphasis is on mental health interventions
between session interval often longer	between session interval shorter
therapeutic relationship generally not primary focus	establishment of therapist-client relationship important
visits often timed around medical provider visits	mental health is reason for visit
long-term follow-up rare, reserved for high risk cases	long-term follow-up more commonplace
case management (i.e., linkage to community resources, etc.) often minimal due to lack of reimbursement	emphasis often on psychosocial aspects of care
marriage and family therapists (MFT's) usually absent because not Medi-Cal reimbursable	MFT's often available as providers
stigma often minimal due to normalization of setting	stigma high usually
intervention supports medical provider decision-making	intervention generally not tied to medical healthcare
referrals mainly from medical provider	referrals made by self, family, other community agencies
behavioral counselor part of healthcare team	counselor relationship often nonaligned with team
fewer clients eligible for Medi-Cal	more clients eligible for Medi-Cal

Primary Care Behavioral Care	Specialty Mental Health
care responsibility returned to medical provider once behavioral treatment is concluded	therapist remains contact point if needed
intervention relies heavily on patient education model	face-to-face contact is primary treatment vehicle; education model usually ancillary
primary care provider almost always involved in behavioral treatment	primary care provider rarely involved in behavioral treatment
behavioral records often integrated with the medical treatment chart	mental health records stand-alone
treatment approach usually encompasses motivational interviewing and focused cognitive behavioral intervention	treatment often varies with individual clients and/or preference of clinician
frequent consultation with medical provider for clients with co-occurring health and mental health conditions	often little or no interaction with medical provider regarding medical conditions
clients often seen, at least briefly, on same day as referral	often substantial wait-time for services in non-emergency cases
therapist workday often involves jumping from one activity to another	therapist can focus on one-to-one client interaction



OPERATIONAL Q & A

Questions and Answers About Primary Care Behavioral Health Services

How many behavioral sessions, on average, do clients have in primary care?

The number of sessions varies from clinic to clinic, but most fall within the range of two to eight visits. Some clinics allow clients with more complex problems to exceed their usual limit.

How long is the average behavioral visit?

Most behavioral providers say they spend between 20 and 30 minutes per client, though exceptions are made.

How many clients do behavioral health providers see in a given day?

Based on an informal survey, behavioral staff sees an average of 8-12 clients per day. Many agreed that 10 per day was an optimal number.

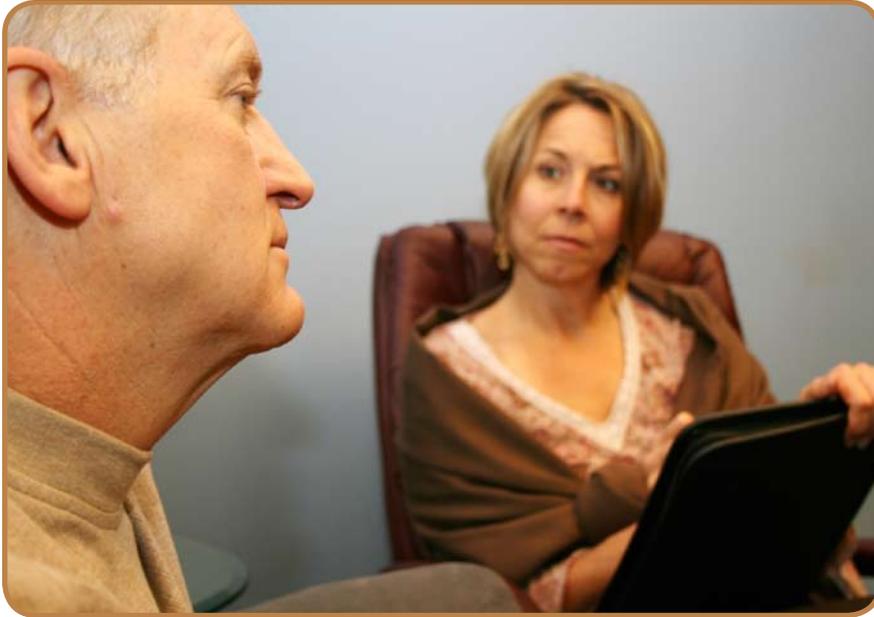
What's the ratio of behavioral specialists to primary care providers at the clinics?

The range given in an informal survey was one behavioral counselor for every three to seven medical providers. Many respondents fell within the 1:3 or 1:4 range and felt that the 1:3 ratio was optimal.

Does offering behavioral treatment in primary care settings really increase access for those having serious mental illness?

Absolutely, according to data collected by the Council of Community Clinics in San Diego. In studying MHSAs-initiated behavioral programs in primary care, they found that 69% of the people who were approved for services – all diagnosed as seriously mentally disordered — had not been seen previously in the county mental health system.

What therapeutic approach is typically used?



Because it's time-limited, structured, and goal-directed, cognitive behavioral therapy meshes well with the problem-solving, fast-paced orientation of the primary care setting and thus has been widely adopted. Behavioral activation, which concentrates on reducing depressive symptoms by gradually increasing enjoyable activities, is used in the IMPACT model, widely embraced to treat depression in primary care. Many therapists rely on motivational interviewing, which emphasizes both feedback and client responsibility for change.

Stepped care – the continual reassessment of client progress and readjustment of treatment levels or approach based on response – is also emphasized.

Do primary care clinics have to provide treatment to uninsured clients?

Yes. Unlike mental health centers, community health centers are federally required to provide services to the uninsured population.

How much does a behavioral session cost?

Based on data gathered by the Council of Community Clinics in San Diego, the average cost for a traditional behavioral session in a primary care setting was \$163, factoring in therapy, medications and medication management. The estimated cost for an entire treatment episode was \$894, which could include up to 12 therapy and medication sessions (the average was 5.5 sessions) and up to three months of medication.

The average cost for an IMPACT model session (a structured approach for treating depression in primary care) was \$107, factoring in therapy, care management and medications. The average cost for an entire IMPACT course of treatment was \$641, including \$369 for therapy, \$187 for medications and \$85 for medication management and a one year supply of medications.

A 2007 study of stepped-care depression treatment among primary care patients with diabetes that involved intervention by trained nurses showed a \$79 cost for each in-person visit (typically 30 minutes) and \$41 for each phone contact (typically 10-15 minutes). These estimates include time required for

outreach efforts and record-keeping (approximately 45 minutes of nurses' time was allowed for each 10-15 minute phone contact). Factored into these costs were salary and fringe benefits plus 30% overhead. (*Simon et al.*)

Several studies have shown that expenditures for behavioral therapy in primary care are offset by cost savings realized through decreased emergency room and hospital visits.

How are behavioral services paid for in primary care?

Primary care clinics can receive reimbursement for behavioral services provided by licensed social workers, psychiatrists and psychologists (but not MFT's) through MediCal and Medicare. Payment for care for uninsured clients can come from a number of sources, including the Expanded Access to Primary Care (EAPC) Program; the County Medical Services Program (CMSP) for rural areas; federal funding under Section 330 of the Public Health Service Act if the clinic is Federally Qualified Health Center (FQHC); various other grants and, of course, self-payment by clients.

Questions and Answers About FQHCs

Much of the following was adapted from the Rural Assistance Center and the National Association of Rural Health Clinics.

Many primary care clinics are considered federally Qualified Health Centers (FQHC). What does that mean?

Federally Qualified Health Centers (FQHC's) are safety net providers, such as community health centers, that receive federal funds to provide care to underserved populations. To qualify, providers must, in addition to providing care to an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. FQHC's receive grants under section 330 of the Public Health Services Act.

What is a Federally Qualified Health Center Look-Alike?

An FQHC Look-Alike is an organization that meets all of the eligibility requirements of an organization that receives a Section 330 grant, but does not receive grant funding.

What types of services do FQHCs provide?

FQHCs must provide primary care services for all age groups. They also must provide preventive health services on site or by arrangement with another provider. Other services that must be provided directly or by arrangement with another provider include: dental services, mental health and substance abuse services, transportation services necessary for adequate patient care, hospital and specialty care.

Are there special staffing requirements for FQHCs?

No, there are no specific requirements for staffing mix at FQHCs. FQHCs are required to have a core staff of full time providers but there is no specific definition of core staff.

Are there minimum hours that an FQHC must be open?

Yes, 32 hours per week is the minimum. FQHCs must also have professional call coverage when the practice is closed, directly or through an after hours care system.

Is a sliding fee scale required?

Yes, FQHCs must use a sliding fee scale with discounts based on patient family size and income in accordance with federal poverty guidelines. FQHCs must be open to all, regardless of their ability to pay.

Can a for-profit clinic be an FQHC?

No. An FQHC must be a public entity or a private non-profit.



MENU of County Mental Health-Primary Care Collaboration Models in California

Collaboration between county mental health departments and primary care clinics to coordinate delivery of both mental and physical health to their clients can come in as many forms as there are county systems. Scan the menu to see which ones mesh best with your own system of care.

- **The county mental health agency out-stations mental health workers at primary care sites and assumes related personnel costs.**

Example: Solano County Behavioral Health began placing mental health professionals in primary care settings in response to physician complaints about the unavailability of mental health services for their clients. The mental health staff stationed at three primary care clinics are full time and serve between 600 and 700 unique clients with an average of two visits per client, according to Marcia Jo, their Research and Planning Director. According to her, the program, now in its fourth year, has proven successful.

Case Study - Tehama County

Through a CMSP grant for services to indigent clients, the Tehama County Mental Health Division outstations a marriage and family therapist twice weekly at the county-operated primary care clinic. A drug and alcohol counselor is also available by appointment when needed. A consumer support worker is on hand at the clinic to help clients reapply for Medi-Cal eligibility and a social worker from the Department of Social Services visits the clinic to assist with eligibility as well. Up to ten treatment sessions for mental health care and 20 for substance abuse counseling are permitted at the primary care clinic under the grant. Clients needing more intensive mental health treatment must be referred to the Mental Health Division by the primary care provider. Direct referrals to Mental Health can also be made by non-county medical providers. The Mental Health Division will refer to primary care clients who have co-occurring behavioral and medical problems, as well as those who are uncomfortable receiving treatment in traditional mental health setting. An intake assessment instrument, incorporating the portions of the CAGE and mental-health related questions, is used at the clinic as a screening tool.

Example: San Mateo County Behavioral Health Services hired and placed clinicians, all supervised and with one exception paid for by them, in each of six primary clinic sites. The clinicians provide treatment and arrange access to more intensive mental health services should clients need it.

Example: Kern County Mental Health Services outstations a therapist/case manager at its Lamont Community Health Center to provide brief treatment services for patients referred by primary care providers.

Example: A marriage and family counselor from the Tehama County Mental Health Division provides assessment and counseling twice weekly at the county-operated primary care clinic there.

Example: Rather than lose the staff to funding reductions, Stanislaus County Behavioral Health chose to outstation four LCSW's at four County-run primary care clinics. The impetus was a finding from their own needs surveys that depression in the community was often going untreated and that the population was amenable to accepting treatment for it in a primary care setting. In addition, their approved PEI plan includes not only outstationing clinicians in health clinics, but advancing the clinics' collaboration with other community resources.

Case Study – San Mateo County

San Mateo County developed an Interface Team eight years ago. The County Behavioral Health Services hired and placed clinicians in each of six primary clinic sites, and, with one exception, absorb much of their cost. Their oversight and supervision is through Mental Health. Clinicians, all bilingual, open mental health charts and bill for their services. They triage, conduct brief (up to eight sessions) solution-oriented therapy, link patients with substance abuse services, offer transitional case management, and provide support and “curbside consultation” with primary care providers. In urgent situations where the clinician is unable to see the patient immediately, a referral is made back to the county psychiatric emergency services. Approximately 800 clients are seen by County Mental Health personnel at the six clinics in a year’s time.

According to Dr. Celia Moreno, Medical Director for the County Behavioral Health Services, “The challenge of primary clinics hiring their own mental health professionals is that they often lack oversight. That’s the advantage of having Mental Health Services take responsibility. Having these people under us also streamlines the process of getting patients access to more intensive mental health services should they need it. It’s an easy process because they’re already in our system. We use the same forms and criteria. The physicians like our service and are clamoring for more.”

On the flip side, to ensure optimal health care for their mental health clients, San Mateo Behavioral Health contracts for nurse practitioner services at some of their regional clinics.

- **County mental health agency contracts with select primary care providers to deliver health screening and basic services at mental health facilities.**

Example: San Mateo County Behavioral Health Services has contracted for 1.3 nurse practitioners to provide health services at three regional mental health clinics.

- **A county-run mental health clinic has a collaborative arrangement with a primary care clinic to provide health services for their clientele.**

Example: A nurse practitioner from Tom Waddell Health Center in San Francisco comes to South of Market County Mental Health Services twice a week to conduct assessments, triage, preliminary treatment and referrals. Persons in need of further treatment are referred to the Health Center. South of Market transports patients to their medical appointments if needed.

Case Study – San Francisco County

Tom Waddell, a primary care clinic that is part of San Francisco County’s public health system, outstations nurse practitioners at two county-operated or contracted mental health clinics - South of Market twice weekly and Tenderloin for one half-day per week. Their objectives are two-fold: address the medical needs of mental health clients unable to access primary care, and encourage them to make the primary care clinic their medical home. Tom Waddell staff also act as consultants to the mental health clinics, designing and implementing health initiatives like smoking cessation and diabetes monitoring. While performing routine medical care like PAP’s, mammograms, etc., they’re concentrating on persons with intensive case management, trying to understand “...what door we can use to get them the treatment they need,” according to Tom Waddell Medical Director Deb Borne. She adds, “I consider all the thousands of clients at South of Market my clients too.”

- **Primary care clinics and county mental health agency agree, via MOU or contract, on which system will be the primary medical home for clients, depending on the level of their physical and mental health needs.**

Example: Humboldt County Department of Health and Human Services is negotiating an agreement with Open Door Community Health Center specifying which agency will be the primary caregiver for identified populations.

- **County mental health agency contracts directly with local primary care consortia who, in turn, coordinates the provision of agreed-upon mental health services by member primary care clinics.**

Example: San Diego County Mental Health Services used MHA funding to contract with the Council of Community Clinics (CCC) who then sub-contracted with nine participating primary care clinics to deliver behavioral services.

Example: The county mental health program in Alameda County contracts with the clinic consortium there for behavioral health services to the senior population.

Case Study – San Diego County

Using MHA Community Service and Support funds, San Diego County Mental Health Services awarded a contract to the Council for Community Clinics (CCC), a consortium of primary care clinics, to provide assessment and short-term services for seriously mentally ill adults without other source of payment. CCC in turn subcontracted with nine primary care organizations having 15 individual sites throughout the county. In addition to coordinating traditional mental health care at clinic sites, CCC implemented the IMPACT model, an evidence-based intervention for treating depression in primary care. The IMPACT model requires preliminary screening, in-house care coordination, brief activation therapy, frequent outcome measurements to assess progress, stepped care, and follow-up.

CCC handles authorization and payment for services provided by these community clinics on a fee-for-service arrangement, paid at Medicare rates. For the IMPACT programs, these funds cover: the cost of part-time depression care managers; depression medication for up to one year; up to four primary care physician visits involving medication prescription and/or monitoring; prescription medication; consulting psychiatry services; and other consulting and technical assistance. The agreement provides that SMI clients in need of longer term treatment and/or medication management be referred, within four months, to County providers through the County's Access and Crisis Line. Though finalizing the agreement took considerable time, services were provided within two months of the contract being signed.

- **College or university supplies student behavioral health staff as part of their training program.**

Example: While not involving the county mental health department, the Social Action Community Health Services in San Bernardino County trains students in Loma Linda University's MFT program, who in turn provide behavioral services at the clinic.

Example: In San Francisco, the UCSF Nursing Program places nursing students in Glide Clinic, a primary care facility.

Example: In Los Angeles, the USC School of Social Work sends trainees to St. John’s Well Child and Family Center.

- **Primary care clinics purchase behavioral services from county mental health.**

Example: A primary care clinic in San Mateo assumes the cost of a mental health provider stationed there by County Behavioral Health Services.

- **Primary care clinics have an arrangement with the county mental health agency to be reimbursed through mental health, rather than via the usual primary care funding streams.**

Example: Behavioral Health Services of the San Francisco Department of Public Health is developing a program whereby primary care providers will be reimbursed for their services under Short-Doyle funding.

A similar approach has been adopted by primary care clinics in other states which allow primary care to bill Medi-caid under the auspices of the mental health system. The advantages of this arrangement are that both the services provided by MFT’s and care management services become reimbursable, whereas they are not under rules pertaining to primary care. In addition, it may be easier to bill for same-day medical and mental health services, currently disallowed by Medi-Cal in primary care.

- **County mental health makes assessment and triage services available to primary care providers.**

Example: In response to a primary care physician referral in Santa Cruz County, a licensed clinician based in the County Mental Health’s Access Team evaluates the client and performs initial telephone screening, triage, and face-to-face assessment, as indicated. Based on the evaluation, the Access Team develops a treatment plan, recommending specialty mental health services if established medical necessity is met. If so, these services are provided by managed care network clinics and therapists in the Santa Cruz community. The referring primary care physician is supposed to receive a report summarizing the assessment and recommendations.

- **County mental health provides free psychiatric consultation services to primary care providers.**

Example: San Francisco County Behavioral Health Services funds a part-time psychiatrist to provide primary clinics with medication management. The program is now in its third year.

Example: Nevada County Behavioral Health is making a psychiatrist available for consultation two hours per week in-person at one primary clinic, and via telemedicine at another, more remotely located clinic.

Example: Santa Cruz County Mental Health allows primary care providers to access a psychiatrist for consultation and on-going psychiatric management. Their MOU calls for the consultant to “...report back to the primary care provider in a timely manner with a specific plan and recommendations for further care. Follow-up will always be in writing although the primary care physician may also request a telephone review of the consultant’s findings and recommendations.”

Example: Solano County Mental Health Division pays for a psychiatrist to be available to Petaluma Health Center, a primary care clinic, for consultation and direct services.

- **County mental health contracts with primary care to provide services to a circumscribed target population (e.g., seniors, children, substance abusers, high utilizers, etc.).**

Example: Los Angeles County has contracted with select primary care clinics for depression intervention geared to seniors. It also contracted with a primary care clinic, Eisner, to deliver Medi-Cal mental health outpatient services to children, including individual and family therapy, psychiatric services, rehabilitation, and case management.

Example: Kern County Mental Health Department contracts with a primary care provider, Clinica Sierra Vista, to provide substance abuse outpatient services for residents in specified geographical areas within the county.

Example: San Diego County contracted with primary care providers, through their professional consortium, to deliver direct care to severely emotionally disturbed children.

Example: Alameda County Behavioral Health provides Early Periodic Screening, Diagnosis, and Treatment (EPSDT) contracts to all the primary care clinics in the county.

- **Clinics are given contracts by the county mental health agency specifically to perform a special service or to address an identified problem.**

Example: In Alameda County, primary care clinics have received MHSA funding earmarked for hiring more bilingual staff, thus reducing disparities in treatment access.

Example: The Council of Community Clinics, a consortium of primary care clinics, received funding from County Behavioral Health agencies through their emergency preparedness Regional Special Projects program to enhance mental health response in a disaster throughout San Diego, Imperial, and Riverside Counties. Funding will enhance the clinics’ existing

telemedicine network, enabling the availability of mental health services at multiple clinic sites via video-conferencing during a disaster.

Example: In San Diego, the Council of Community Clinics, received MHSAs funding for a senior peer “promotora” program implemented at four clinics. Members of the Hispanic community are hired to conduct outreach programs to seniors, providing mental health-related training and linkages to community-based resources.

■ **County mental health services make select primary care providers full-service partners.**

Example: Using initial MHSAs funding, Shasta County Mental Health has contracted with Hill Country Community Clinic, a primary care provider, for full-service partnership care.

Example: In Los Angeles, Tarzana Treatment Center has become a full service partner as part of the continuum of care established through an MHSAs contract.

Case Study – Shasta County

As a full-service partner, Hill Country Community Clinic, a primary care provider, was awarded initial MHSAs funds to deliver “whatever-it-takes” services to ten persons with serious mental disorders and intensive services to 25 others with a high degree of need. In addition to a case manager for this subpopulation (originally supplied by County Mental Health, but now a direct clinic employee), Hill Country has two full-time and three part-time clinicians offering services both on-site and at local schools. A psychiatric nurse practitioner is also available twice monthly. A separate contract between County Mental Health and Tri-County Community Network allows that organization, in concert with Hill Country’s case manager, to intensively work with select clients in obtaining housing, employment and other community support.

The clinic is medical home to approximately 100 mental health clients, offering them a spectrum of mental health, medical and dental services. In addition to traditional services, the clinic operates a wellness program for mental health clients and their families, encompassing support groups for young adults, a grief support group for women, classes in employment preparation, arts and crafts and games among other activities.

Through a MHSAs contract, the clinic also initiated their WRAP program (Wellness Recovery Action Plan) to help mental health clients identify resources, strengths, and stress triggers. They hope to expand the program, now open to anyone at no cost, to others with chronic health problems. Two experienced staff members head this program, along with four consumer employees who act as coaches and helpers.

Their contract with County Mental Health requires Hill Country to demonstrate outcomes and collect required data. Their new electronic records system will incorporate responses to screening questions, though no systematic screening currently takes place. The clinic bills third-party payers for their services and the county makes up the difference.

- **County mental health provides personnel at primary care site to directly deliver care management (i.e., helping clients access community resources) or provides funding for the clinic to hire a case manager for the clinic’s seriously mentally ill population.**

Example: Nevada County Mental Health has awarded a small contract to Sierra Family Health, a primary care clinic, for case management services. Though crucial to the recovery process, care coordination of services outside the clinic is generally not Medi-Cal reimbursable in community care facilities.



Example: Shasta County Mental Health assigned and paid for case managers at select primary care clinics to leverage and arrange support services and linkages to inpatient care and substance abuse as needed

- **County mental health enters into an agreement with primary care providers to deliver services to stabilized clients with serious mental illness and, in return, offers support services, consultation and ease in transitioning the client back to the mental health system when needed.**

Example: Del Norte County and Open Door Community Health Center, a primary care clinic, have hammered out an MOU wherein Open Door agrees to accept referrals from Del Norte County for general medical, mental health, and medical management of their most stable patients. In return, Del Norte agrees to assess the “...most severe cases that fall under our target population within available resources and processes.” Both agencies agreed to share records with client consent to the extent allowed by HIPAA.

- **Staff from the county drug and alcohol agency outstation staff at primary care to assist with assessment and resource linkages.**

Example: San Mateo County Behavioral Health, which outstations clinical personnel at primary care sites, also has members of the AOD (Alcohol and other Drugs Services) on site to help with drug and alcohol screening and support.

- **Staff from both the primary care clinics and the county drug and alcohol agency co-host therapeutic group sessions together.**

Example: Through a SAMHSA grant, Mendocino Community Health Clinic has partnered with the county Office of Alcohol and Other Drug Programs to conduct group counseling for persons with substance abuse problems.

- **Staff from primary care clinics and the county mental health agency meet informally to discuss individual cases and problem-solve.**

Example: Every three weeks, Petaluma Health Center staff meets with the Medical Director of the Sonoma County Mental Health Division for case management and issue-resolving.

- **County mental health directly schedules primary care appointments for clients.**

Example: Shasta County Mental Health Services is finalizing an arrangement to directly book clients into assessment slots provided by Shasta Community Health Center – not as referrals, but as set appointments. These appointments will primarily be reserved for persons with mental health problems not serious enough to warrant admission into the county mental health program.

- **Persons with behavioral health problems are referred by the county mental health agency to primary care for both physical check-ups and psychiatric medication.**

Example: If clients are agreeable to it, Mono County Mental Health refers clients with CMSP funding to Sierra Park Clinic where a psychiatrist/general practitioner performs physical check-ups and prescribes medication as needed.

Case Study – Mono County

Clients funded through CMSP seeking services at Mono County Mental Health are asked to complete a questionnaire asking if they would like a physical check-up and/or a psychiatric medication assessment at a primary care clinic. If so, Sierra Park Family Medicine then provides them with physical health services as well as medication prescriptions and monitoring, based on an assessment done by a physician on staff who practices both family medicine and psychiatry. At the same time, these clients can receive up to ten mental health therapy sessions and 20 drug and alcohol sessions at the county mental health center, funded through a CMSP pilot project.

- **Primary care clinics can directly access 23-hour crisis intervention services provided by county mental health.**

Example: Hill Country Community Health Clinics, which has a full-service partnership contract with Shasta County Mental Health Services, can take decompensating clients directly to their Crisis Resolution Unit, thereby avoiding 5150's, police intervention, etc.

- **County mental health contracts with primary care for mental health services and with a third party for case management support.**

Example: Shasta County Mental Health Services awarded a full service partnership contract to Hill Country Community Clinics, but since they were not fully prepared to help clients with community resources for housing, jobs, etc., a contract was given to a nonprofit organization to handle that aspect of the clients' care.

- **The County mental health agency designates a liaison for the primary care system to handle problems, facilitate access to the mental health system, shepherd referrals, act as a systems consultant and resource.**

Example: Humboldt County Department of Health and Human Services provides a staff person to interface with primary care providers and assist them in accessing the system.

- **The County mental health agency refers clients to primary care based on their mental health level of need as determined by initial screening.**

Example: The Level of Care Utilization System (LOCUS), a screening/rating instrument, is administered to clients seeking services at Sacramento County Mental Health. Those with a comparatively low level of need (i.e., whose scores fall in levels 1 and 2) are asked if they'd like to receive mental health treatment at The Effort Community Health Center, which generally has less wait time for an appointment.

Training and Cross-Education Models

- **County mental health and primary care providers engage in cross-training and conferences to enhance mutual understanding and knowledge.**

Example: In Alameda County, quarterly meetings are held between the County Department of Mental Health (DMH) and clinic consortium members. Clinic providers are given access to county DMH training regarding access to DMH services and clinic physicians can partake in psycho-pharmacology training.

- **County mental health contracts with primary care provider to educate other providers about the integrated model.**

Example: Nevada County Mental Health has used MHPA funds to pay for the medical director of Sierra Family Health Center, a primary care clinic, to conduct training for other providers in the area about how integrated behavioral care works in primary care settings.

- **Both the county mental health agency and the primary care providers collaborate in work-force development by working with schools of social work, nursing, psychology and medicine.**

Example: San Mateo County Behavioral Health has established a psychiatric residency training program in which new residents are rotated through primary care clinics every six months. According to Dr. Celia Moreno, Medical Director for the County Behavioral Health Services, “We get a great response; many of them stay with us once their training is completed.”

- **County mental health offers on-going behavioral health education for primary care providers or vice versa.**

Example: Santa Clara County Mental Health provides on-going continuing education for select primary care providers based upon an assessment of their training needs and interests.

Example: Venice Family Clinic has provided free training to Los Angeles County Mental Health staff regarding primary care issues.

- **County mental health provides funding for primary care clinics to conduct in-house staff training regarding mental health assessment, psychotropic medication, and behavioral treatment.**

Example: Redwood Health Community Coalition, a consortium of primary care clinics in Northern California, received funds from County Mental Health which partially supported a five-part mental health educational series they conducted monthly for primary clinic staff.





CHECKLIST for MOUs/ Contracts

MOU/CONTRACT CHECKLIST

Suggested by IBHP for agreements between county mental health, primary care and substance abuse services.

	INCLUDE?	
	YES	NO
Principles and/or vision statement		
Goals and objectives		
Effective start date and period covered by MOU/contract/ agreement		
Standards for success		
Definitions (including “primary care provider” and “county mental health services”)		
Target population(s) <i>(What will be the population to be served by each agency and what, if any, population will the agency not serve?)</i>		
Scope of work for each partner		
Productivity standards <i>(Will there be quotas or expected numbers of persons to be treated and/or units of service to be delivered?)</i>		
Professional credentialing and standards <i>(Are the qualifications of staff delivering services to be specified and, if so, what will they be?)</i>		
Funding sources <i>(What is the anticipated payer mix for services delivered (e.g., Medi-Cal, Medi-Care, uninsured, etc.?)</i>		

	INCLUDE?	
	YES	NO
Costs, billing and reimbursement <i>(What kind of administrative overhead is involved and how will this cost be handled? How many billable visits are anticipated? How will billing be handled? What are anticipated cost off-sets, if any?)</i>		
Ancillary service expenses, including cost and time for <ul style="list-style-type: none"> • planning • case-related phone calls • professional training • conference attendance • business-related travel • case-conferencing • other staff meeting time • assisting clients in accessing community resources 		
Staff support <i>(What support staff and equipment will be provided by the collaboration partner and what is expected to be self-supplied?)</i>		
Referral criteria and procedure from primary care to county mental health		
Referral criteria and procedure from county mental health to primary care		
Criteria and procedure for transfer of clients back to referral source and source's obligation to accept them for treatment		
Documentation needed for between-agency referral (e.g., diagnosis, medications and dosages; history; recommended treatment plan; recommended follow-up consultation)		
Client follow-up information needed by referral source (e.g., services provided, diagnosis, treatment plan, etc.)		
Expected documentation to be maintained in treatment record		
Expected timelines for initiation of services after referral		
Client consents needed		

	INCLUDE?	
	YES	NO
Handling of client preferences		
Criteria for termination of client services		
Client information-sharing between agencies and access to records		
Confidentiality provisions <i>(What regulations and policies apply and how will they be followed?)</i>		
Provisions for out-stationed staff (if any):		
<ul style="list-style-type: none"> • Who will be responsible for hiring? 		
<ul style="list-style-type: none"> • Who will provide clinical supervision? 		
<ul style="list-style-type: none"> • Who will oversee nonclinical matters like work hours, absences, etc? 		
<ul style="list-style-type: none"> • How will payment for their services be handled? 		
<ul style="list-style-type: none"> • Where and when will work space be provided for them? 		
<ul style="list-style-type: none"> • What level staff are needed to perform the needed functions? 		
<ul style="list-style-type: none"> • How will staff support be handled? 		
<ul style="list-style-type: none"> • Who will be responsible for their data entry? 		
<ul style="list-style-type: none"> • Who will order and pay for supplies for them? 		
Expected outcomes and timelines to reach them		
Outcome measures to be used (e.g., Global Assessment Scale, PHQ-9, Duke Health Profile, client satisfaction surveys, etc.) and frequency of implementation		
Process measures to be used (e.g., numbers of clients served; length of time before initial visit; staff training; rate of client participation, etc.)		
Reporting requirements to partner agencies		

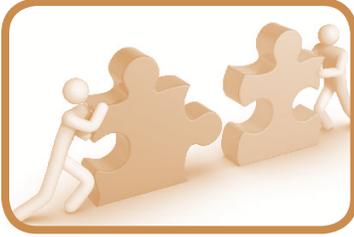
	INCLUDE?	
	YES	NO
Program reviews - frequency and scope <i>(How will accountability be handled? What is expected in terms of auditing and reporting? If one agency is paying for another's services, how much access will that agency have to the contractor agency's records and documentation?)</i>		
Psychiatric consultation available to primary care providers (type, times available, method of access, etc.)		
Physical medicine consultation available to mental health providers (type, times available, method of access, etc.)		
Ancillary medical services available to county mental health clients		
Ancillary mental health services available to primary care patients		
Communication expectations (case conferences, joint meetings etc.)		
Treatment approach and policies <i>(Does there need to be agreement on treatment approaches—e.g., clinical methods, length of individual treatment offered; session length, etc.—and, if so, what approaches are mutually agreeable?)</i>		
Professional training needs and requirements <i>(What will staff training needs be—both clinical and administrative—and how will cross-training be provided?)</i>		
Responsibility for provision of and/or linkage to substance abuse treatment services		
Language capability of each agency and cultural competency approach/handling		
Emergency response availability		
Community outreach responsibility		
Special considerations for children/youth		
Medication procurement, management and dispensing responsibilities		
Provision of care management/coordination within the clinic/agency		

	INCLUDE?	
	YES	NO
Provision of care management outside the clinic agency (e.g., helping the client with accessing community-based services and resources)		
Forum and procedure for resolving operational problems and/or disagreements		
Criteria for termination of contract or Memorandum of Understanding, including advance notice timeframe		
Other: _____		

QUESTIONS FOR INTEGRATED BEHAVIORAL CARE PREPARATION

Dr. Jurgen Unutzer, a leader in the IMPACT depression treatment model and research, posed several fundamental questions clinics needed to ask themselves to prepare for implementation of the model. These questions apply equally to clinics contemplating all types of integrated behavioral care programs:

- How will clients be identified?
- Who will prescribe psychotropic medication?
- Who will provide counseling/psychotherapy?
- Who will provide mental health back-up?
- Who will track clinical outcomes and how?
- How will treatment changes be initiated?
- How will team members communicate?
- What is the overall implementation strategy?
- Who will lead/coordinate the effort?
- What kind of provider/staff training is needed?
- What structural/program changes are needed?
- What are anticipated barriers and challenges?
- How will we measure success?
- How can the model be sustained?



ISSUES Worth Considering in Forging Partnerships

ISSUES WORTH CONSIDERING IN FORGING PARTNERSHIPS BETWEEN PRIMARY CARE AND MENTAL HEALTH

CARE MANAGEMENT NEEDED BUT NOT FUNDED

Linking clients to needed community resources for housing, jobs, etc. is often crucial to their recovery, but this kind of care management is usually not a reimbursable function within community care clinics. Nor are activities such as monitoring clients' response and adherence to treatment or phone consultation considered a reimbursable service by most payers. Collaborative agreements should consider how and where clients will receive these types of service.

MFT'S NOT MEDI-CAL REIMBURSABLE

Exacerbating the shortage of mental health professionals in California is the fact that Marriage and Family Therapists (MFTs), are not recognized as reimbursable providers in primary care clinics. Currently, only psychiatrists, licensed clinical psychologists, and licensed clinical social workers are mental health providers recognized by Medi-Cal as billable mental health providers at federally-qualified health centers and rural health clinics.

RACE FOR SPACE

To be truly integrated, it is imperative that behavioral health services operate in close proximity to medical services, but space at primary care clinics is often at a premium. The issue of who will work where needs to be resolved early on or the entire collaborative effort may be lost in space.

SAME-DAY SERVICES NOT MEDI-CAL REIMBURSABLE

Allowing clients to see behavioral staff on the same day as their medical visit not only facilitates access, particularly for those with transportation difficulties, but a "warm hand-off" by the physician to the behavioral counselor helps confer the trust and rapport developed between client and provider to the counselor. Moreover, research has shown that initial face-to-face contact, however brief, helps ensure that subsequent appointments will be kept. However, as of this writing, same-day visits are not reimbursable under Medi-Cal in California, though federal Medicaid laws permits this arrangement if states approve. The California Primary Care Association (CPCA) is spearheading a legislative effort to allow primary care clinics to bill for same-day services, but if legislation does not come to fruition, designers of collaborative agreements may want to consider possible resolutions for this issue.

A CULTURAL DIVIDE TO BE BRIDGED

Like countries operating side by side, the mental health, substance abuse and health systems may all have commerce together and co-exist well, but each has its own distinct culture and language, making system integration difficult. Bridging this cultural gap may be thorny for providers unfamiliar with the operations, approaches, knowledge base and treatment philosophies of other systems of care. Mental health professionals may, at first, feel uncomfortable with the fast-clipped pace of primary care, just as primary care may be frustrated with the slower, more in-depth approach often taken by behavioral professionals. Even the respective terminology may take adjusting. For example, the word “patient,” while commonplace in health care, can have a negative connotation in the mental health community, where the medical model is sometimes seen as a throw-back to less enlightened care and “client” or “consumer” is the preferred term for persons receiving care.



PRIMARY CARE FUNDING DISCOURAGES GROUP SESSIONS

Conducting therapy or education via group sessions makes practical sense in many instances and often allows consumers to interact with one another in a positive and constructive way. However, Medical funding does not encourage this approach for behavioral issues in primary care.



ADVICE from Those Who've Been There

- Whenever possible, try to collaborate with the other partner when hiring personnel. If they can't be at the interviews, at least try to get their input. When hiring, choose people who are flexible and can roll with the changes
- Make sure staff at all levels have bought into the model. Try to attend partner staff meetings and other functions ahead of time to build personal relationships. It's great if administrators think the arrangement is a good idea, but if ground level staff isn't on board, you have problems.
- Determine how much provider time is non-billable, like case conferences, planning, staff meetings, etc. and consider these expenses when determining costs.
- You should figure out what the expected revenue for the primary care provider would be if they were working at an FQHC clinic and see if the partner agency can provide the difference between normal productivity and productivity at a community-based program.
- You need to be as clear as possible around role definitions and responsibilities. What does staff understand each others roles to be? What is mental health's understanding of primary care and how does primary care intersect with mental health? For example, are primary care providers expected to provide medical case management?
- Flexibility is a must.
- There should be a formal communication structure to monitor collaboration – like how does clinic staff communicate with collaborative partner staff on-site and how does larger oversight/problem-solving happen?
- You've got to recognize the differences in agency culture: how each partner operates; their communication style; their understanding of each other's role; and their approach to serving their clients.

**BRENDA GOLDSTEIN, PSYCHOSOCIAL SERVICES
DIRECTOR, LIFELONG MEDICAL CARE, ALAMEDA**

- I recommend both parties participating, as we did, in quarterly problem-solving meetings to share each other's dirty laundry – and mutually clean it. If there are differences, challenge each other with respect. We used case conferencing to discover, and sometimes to illustrate, problems in the system.
- If you're going to complain, be part of the solution. And you need to own your own shortcomings.
- Start with meeting the administrators, become acquainted, get people on board with the idea and listen to the other system's concerns.
- There should be boundaries—and a clear understanding about what you can and can't do—but with flexibility. I think setting boundaries is more difficult for primary care providers, considering that they are expected to provide all-around care and be their patient's medical home.
- There should be an equal partnership: you need to meet each other half-way. Both sides need to take risks. View each other as colleagues ultimately wanting the same things you do for your clients.
- You need to learn each other's lingo and definitions and study each other's services, policy and procedures for admissions, philosophy (wellness recovery action plans, evidence-based approaches, admission policies, etc.).
- It's a good idea to have meetings on each other's turf.
- Agreements on certain definitions should be established. For example, the working definition of a "stable patient" for purposes of referral could be someone who: has had no medical change for six months; had had no hospitalizations for the past year; has not had multiple SDS visits in the last six months; and doesn't require case management.
- It's a good idea to circulate a contact "health tree" to the other partner: how to get a hold of key staff, what their responsibility is and where they are in the organization.
- The bottom line is be patient and look for opportunities to interface on a continuum.
- Learn to live with uncertainty but not necessarily build your whole behavioral program around them.
- Continue to strive for preventative services.

**JULIE OHNEMUS MD, PRIMARY CARE PHYSICIAN, OPEN DOOR
COMMUNITY HEALTH CENTERS, HUMBOLDT COUNTY**

- The single biggest stumbling block was that we had no training period before services were to begin. The expectation was that we'd start on Day One with no ramp up. That turned out to be completely unreasonable. We had to develop policies and procedures on the fly and that was tough. You need to build in planning, training, and implementation time beforehand.
- Cross-training our depression care managers on medical issues like diabetes and chronic pain was important because they really need to speak the language to be able to dialogue with the primary care doctors and communicate with the patients. For example, it's important for them to understand what a hemoglobin count is and what blood sugar levels mean.
- One important lesson we learned is that, in order to train primary care providers, you have to go where they are and do it when they want you. You can't hold training in a hotel somewhere and expect them to turn up. They definitely want the training, but they're so swamped, it has to be done within their timeframe.
- There's a huge variation among primary care providers in their knowledge about, and interest in treating mental health problems. So you have to tailor your training to the knowledge base and receptivity of the target audience.

**MARTY ADELMAN, COUNCIL OF
COMMUNITY CLINICS, SAN DIEGO**

- Psychiatrists might be the key as a check and balance to make sure medications are appropriately prescribed [by primary care providers].
- There is a need to foster communication between primary care providers and a consulting psychiatrist.

**NICOLE HOWARD, DIRECTOR OF PROGRAMS,
COUNCIL OF COMMUNITY CLINICS, SAN DIEGO**

- Primary care doctors are not comfortable in dealing with persons with serious mental illness and they have a very different opinion about what serious mental illness is and what the mental health system should be treating. Their threshold is much lower than the county mental health providers. Primary care doctors don't like being told they're a bunch of wusses any more than mental health likes being told they're not doing their job. You need to reach a common understanding.
- There's a huge population who isn't getting served: they're not psychiatrically ill enough for acceptance by county mental health, but they're deemed too ill to be seen in primary clinic settings. The disparity of expectations between mental health and primary care can get in the way (of a collaborative arrangement).
- Folks really have to agree on standards for acceptance and when the person will be taken back (by the referring source). Otherwise, there might be a gap in understanding of who is an eligible candidate for services.
- If you bring primary care into a mental health setting, at least when patients are cycled from primary care to mental health when their mental condition gets worse, you won't lose the continuity of care.
- A piece that's crucial is to have a staff person within mental health responsible for communication who primary care providers can contact if things go wrong. There needs to be someone, preferably someone who can also deliver services, who can function as an interface between the mental health and primary care systems.
- It would really be helpful to convene a meeting between the medical directors of both primary care and mental health clinics to form relationships and hash out operations, but both are difficult to spare for meetings like this.
- We already had a nurse practitioner on staff who does health screening activities and lab work, but there's been no place to refer our clients. We're delighted to have a system of care for our clients with medical problems

**SALLY HEWITT, PROGRAM MANAGER FOR CLIENT
CULTURAL DIVERSITY, HUMBOLDT DEPARTMENT
OF HEALTH AND HUMAN SERVICES**

- It's vital as you begin collaborations to have up-front discussions about important issues. For example, we didn't give much importance to space [for mental health staff out-stationed at primary care sites] at the beginning, but it became a labor-intensive problem later on. We should've negotiated it at the beginning.
- Screening is important, but we haven't been able to accomplish it [at primary care sites] because there's a shortage of primary care doctors and they're all so busy. We need to look for ways of handling it without imposing on the doctors' time.
- The psychiatric consultation piece is critical.

**CELIA MORENO M.D., MEDICAL DIRECTOR, SAN MATEO
BEHAVIORAL HEALTH AND RECOVERY SERVICES**

- In a small county like ours, folks don't really trust the government. Hill Country [primary care clinic] was already providing services for them, already their medical home. So we just purchased access to psychiatric care in their clinic. It really worked out well.
- Our arrangement wasn't a sell job on either side. We went to the table with both mental health and primary care being equal partners working for the general good of the community. That's important.
- It's really important to learn the other side's language. Learning about the financial piece [for primary care] was crucial, but along with billing mechanisms, we needed to get in the game by learning about their licensure requirements and philosophical approach. Likewise, once we understood the rules of their game, it was essential to educate the FQHC's about what we [county mental health] can and can't do.
- Take the time up front to figure out how this is going to work. Learn about geographical locations, transportation issues and things like who steps in when someone decompensates.

**MARK MONTGOMERY, DIRECTOR, SHASTA COUNTY
MENTAL HEALTH SERVICES**

- The glue [that holds the collaboration together] is psychiatric consultation.
- The primary care system has to be convinced of the financial incentive for treating people with serious mental disorders. Since many of them have Medi-Cal, there's financial revenue maximization for the clinics – more so than treating indigents with no insurance.
- The problem may be that mental health workers in primary care aren't connected to the mental health system, so they often don't get needed clinical supervision. It helps if they report to [county] mental health to get the benefit of that system. It probably works out best if they report administratively to primary care and clinically to county mental health.
- It's good to have a primary care liaison [within the county mental health system] for any problems that bubble up. If a patient is too much for primary care to handle, the liaison can make sure that he or she gets the next level of care.
- It's really important to have cross-training to learn about each other's systems.
- You've got to identify the needs of clients so the system reflects the type and level of need.

BARBARA GARCIA, DEPUTY DIRECTOR OF HEALTH, DIRECTOR OF COMMUNITY PROGRAMS, SAN FRANCISCO DEPARTMENT OF COMMUNITY BEHAVIORAL HEALTH SERVICE AND PRIMARY CARE

- Psychiatric consultation often is important, but primary care providers often won't take advantage of it unless they have a working relationship with, and trust in, the psychiatrist. They're very protective of their patients and want to make sure they're getting the best advice and psychiatric service. So to build up both trust and relationships, it's a good idea to have the psychiatrist come to the clinic in advance to conduct trainings and answer questions.
- Take it slow and develop a relationship. Establish what you're willing to take on and what support you'll need. Cultivate trust and really understand what the other system's internal themes and culture are.
- Training about the ins and outs of each other's systems is absolutely necessary.

JOHN GRESSMAN, PRESIDENT AND CEO, SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM

- If you don't have case management, like most primary care clinics, tracking patients can be difficult. To help with this, we arranged to have the mental health provider follow up with our no-shows. They have responsibility for maintaining patient engagement.
- Having one central person be the coordinator between the two systems is invaluable. Someone has to own all of this. We're lucky that our mental health liaison is a nurse who can easily bridge the two systems.
- Both systems need to decide on a few specific goals together, then look at the barriers that might impede reaching them, being as concrete as possible.
- You need to figure out the pharmacy and medications piece and lots of communication is needed around that issue to make sure there's proper coordination.
- It's important to know all the different funding streams fueling these systems, and all the mandates and philosophies they bring with them.

**DEB BORNE MD, MEDICAL DIRECTOR, TOM WADDELL
HEALTH CENTER, SAN FRANCISCO**

- To do a good job for their patients, the clinics need to know what resources are out there besides mental health services. You have to have other support services to keep your patients moving forward.
- There's a level of animosity that sometimes develops between the two systems over time. You really need to get over that and do some relationship-building if collaboration is going to work. You have to get people to see the bigger picture.



**DOREEN BRADSHAW, EXECUTIVE DIRECTOR, SHASTA
CONSORTIUM OF COMMUNITY HEALTH CENTERS**

- You have to be willing to sit down at the table and take your licks. A lot of it is just listening. If you're going to work together, you need to learn what to expect from each other, what's worked well in the past and what hasn't. You have to work on the scar tissue – hash over the past with the future in mind. Just take little steps forward.

**STEVE CHAMBLIN, CLINICAL SUPERVISOR, MHSA
COORDINATOR, MENTAL HEALTH DIVISION, TEHEMA COUNTY**

- The building blocks are all about relationships and putting in the time needed to develop them – and the willingness to take risks and create innovations.
- The primary care clinic needs to be able to hire their own people to avoid the gap between orientation and organization values.
- The transparency of the contractual process helped us move forward. We needed to convince mental health that they weren't going to be taken to the cleaners.
- You need to put cynicism aside. Avoid bashing. You need to take the approach that the people on the other side of the table want our patients to get better as much as we do.

**LYNN DORROH, CEO, HILL COUNTRY
COMMUNITY CLINIC, SHASTA**

- The system works best if the medically indigent first go to the mental health agency for determination of need and benefits acquisition. The people who are found to need a lesser level of behavioral care can then be triaged to primary care.
- The county doesn't need to pay providers for services that clinics may be able to bill for independently. They could use that savings to in-fill with case management services, for example.

**JONATHAN PORTEUS, THE EFFORT
COMMUNITY HEALTH CENTER, SACRAMENTO**



FOUR QUADRANT Clinical Integration Model

The well-known and widely adopted Four-Quadrant Model is conceptual system-wide framework for health and mental health services developed by Barbara Mauer under the auspices of the National Council for Community Behavioral Healthcare. It serves as a guideline for assigning treatment responsibility between specialty mental health agencies and primary care providers. The model divides the general treatment population into four groupings based on behavioral and physical health risks and status, and suggests system elements to address the needs of each particular subpopulation.

Meant as a population-based planning tool, the Model recognizes that both mental and physical health needs may change over time and thus the constellation of services must be flexible enough to meet individual need at any given point in time. It also acknowledges and incorporates consumer autonomy: “The ‘clinical home’ should be based on consumer choice and the specifics of community collaboration. The primary care and specialty behavioral health systems should develop protocols, however, that spell out how acute behavioral health episodes or high-risk consumers will be handled.”

The individual quadrants in this conceptual design are as follows (as excerpted from *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities* by Barbara Mauer, 2005):

Quadrant I: Low Behavioral and Physical Complexity/Risk – A population most likely to exhibit depression and anxiety, though it may include some with more severe mental disorders. If selected by the consumer, this population can be served in primary care with behavioral health staff on site.

Quadrant II: High Behavioral Health, Low Physical Health Complexity/Risk – Most individuals with severe mental illness, children/youth with serious emotional disturbance or those with co-occurring disorders. This population would likely be served in a specialty behavioral health system that coordinates with the primary care provider, or in more advanced integrated systems that provide primary care services within the behavioral health setting.

Quadrant III: Low Behavioral, High Physical Health Complexity/Risk – Large percentage of patients with chronic medical illnesses (e.g., diabetes, cardiovascular conditions) that are at risk of or have evidence of behavioral disorders (e.g., mild to moderate depression, anxiety), some of which may be related to their primary medical conditions. This population can be served in the primary care/medical specialty system with behavioral staff on site in primary or medical specialty care, coordinating with all medical care providers including disease care managers. Access to behavioral specialists with expertise in treating persons with co-morbid chronic medical illnesses is advisable.



Integrated Behavioral Health for Persons with Health Problems

Research has clearly shown that improving mental health often leads to improvements in physical health, just as successful medical interventions often raise mental health status and functioning. But there's an area where the two realms directly overlap: addressing behaviorally modifiable behaviors that contribute to poor health. While changing these behaviors is important for everyone, the startling statistic that persons with serious mental illness die on average 25 years earlier than the general population underscores the importance of closely monitoring this sub-population's physical well-being. Their early deaths are often due to modifiable risk factors, like smoking, obesity and poor nutrition.

Some behaviorally modifiable behaviors that contribute to poor health which can be addressed in either mental health or primary care settings:

- Smoking
- Alcohol Consumption
- Drug Abuse
- Unsafe sex practices
- Poor nutrition
- Obesity
- Sedentary lifestyle
- Stress
- Failure to seek medical treatment when needed
- Poor adherence to medical treatment plan
- Sleep disorders

Some Physical Conditions Commonly Addressed By Behavioral Health Professionals in Primary Care Settings

Asthma

Studies have shown that stress can trigger and exacerbate asthma attacks. Behavioral professionals can help clients alleviate the stress by teaching relaxation techniques and offering counseling on how to reduce or avoid stressors.

Hypertension

Behavioral interventions may include teaching the clients stress and anger management skills and coaching them in lifestyle changes like sodium intake reduction, weight reduction and smoking cessation.

Chronic Pain

Many studies have found that depression and pain are closely linked. Mental health problems may be the cause or, as is often the case, the result of chronic pain. Behavioral intervention may help clients deal with it by using bio-feedback and relaxation training and by working to address negative thoughts associated with the pain.

Coronary Artery Disease

Long-term stress and strong emotions, particularly anger, have frequently been linked in the literature to blood vessel damage and precipitation of heart attacks. Behavioral health consultants can work with the clients not only to address stress levels but to implement lifestyle changes, like increasing exercise, making better dietary choices, alleviating stress and quitting smoking.

Diabetes

Several studies have linked depression to diabetes and though it may not be a causative factor, depression can contribute to the condition by negatively impacting diet, help-seeking, and self-maintenance. Thus, targeting depression is an important component of treating the disease. Factors contributing to diabetes, like poor diet and obesity, can also be addressed using behavioral techniques.

It's a well-known and well-researched fact that many physical problems can be ameliorated through physical activity. Promotion of exercise, both to improve physical health and alleviate psychiatric disability, can be accomplished by both mental health and physical health professionals.



Some Types of Primary Care Behavioral Services

The following description of a consultation service model was taken, with slight modifications, from the Primary Behavioral Care Services Practice Manual 2.0, 2002 by Kirk Strosahl:

- **Triage/Liaison Services** – Initial screening visits usually of 30 minutes or less to determine appropriate level of need for mental health care.
- **Behavioral Health Consultation** – Intake visits of usually 15 to 30 minutes for clients referred for general evaluation. The focus is typically on diagnostic and functional evaluation, problem-solving, and recommendations for treatment and forming limited behavioral change goals. The visit may involve assessing clients at risk because of some life stress event, educating clients about community and/or clinic resources, or referring them to more appropriate treatment resources. In all cases, the visits will result in consultative feedback given to the client's primary care provider.
- **Behavioral Health Follow-up** – Secondary visits by a client to support a behavioral change plan or treatment started by a primary care provider on the basis of earlier consultation – often occurring in tandem with primary care visits.
- **Compliance Enhancement** – Visits designed to help the client adhere to an intervention initiated by the primary care provider – often spaced at longer intervals.
- **Behavior Medicine** – Visits designed to assist clients in managing a chronic medical condition or to tolerate invasive or uncomfortable medical procedures. The focus may be on lifestyle issues or health risk factors among clients at risk (i.e., smoking cessation, weight loss) or may involve managing issues related to progressive illness such as end-stage COPD, etc.
- **Specialty Consultation** - Consultative services rendered over time to clients whose situation requires ongoing monitoring and follow-up. This service is applicable to patients with chronic psychosocial issues and/or physical problems requiring longer term management. While the visits are structured like regular behavioral health consultations, they are less frequent and spread out over a longer period of time. The focus should be on restoring adaptive functioning rather than eliminating an acute mental disorder.
- **Disability Prevention/Management** - Visits designed to assist clients on medical leave from job to return to work quickly. The focus is on coordinating care with primary care provider, job site and client with emphasis on avoiding “disability building” treatments.

- **Psycho-educational Classes** - Brief group treatment designed to promote education and skill-building that either replaces or supplements individual consultative treatment. Often a psycho-educational group can serve as the primary psychological intervention, as many behavioral health needs are best addressed in this type of group treatment.
- **Conjoint Consultation** - Visits with primary care provider and client designed to address an issue of concern to both, often involving a conflict between them.
- **Telephone Consultation** - Planned, scheduled intervention contacts or follow-ups with patients that are conducted by the behavioral health counselor via telephone, rather than in-person.
- **On-Demand Behavioral Health Consultation** - Usually unscheduled, primary care provider-initiated contact, either by phone or face to face, generally in an emergent situation requiring immediate or short-term response.
- **On-Demand Medication Consultation** - Usually unscheduled, primary care provider-initiated contact regarding a medical or medication issues, either by phone or face to face, generally in an emergent situation requiring immediate or short-term response.
- **Care Management** - Designed to coordinate delivery of medical and/or mental health services through multi-disciplinary involvement. Can also involve assisting the client with resources in the community.
- **Team Building** - Conference with one or more members of the health care team to address peer relationships, job stress issues, or process of care concerns.
- **Medical Provider Consultation** - Face-to-face visits with the primary care provider to discuss client care issues; they often take the form of “curbside” consultation.
- **Team Education** - Training provided to the primary care providers and other clinic staff about identification and treatment of mental disorders; the relationship of medical and psychological systems; and the services and procedures offered by the behavioral health program, including appropriate candidates for referral.

The Washington Association of Migrant and Community Health Centers, in their “*Providing Behavioral Health Services in a Community Health Center Setting*” Manual, 2002, framed behavioral functions in the following grid, offered here as an example of how services could be rendered:

Behavioral Health Service Type	Estimated % of Patient Contacts	Key Service Characteristics
General Behavioral Health Consultation Visit	60-70%	<ul style="list-style-type: none"> • Brief, general in focus; oriented around a specific referral issue from health care provider. • Visit length (15-30 min) matches pace of primary care. • Designed to provide brief interventions and support medical and psychosocial interventions by the primary care team member. • May involve conjoint visit with primary care provider • May involve primary focus on psychosocial condition or working with behavioral sequelae of medical conditions.
Behavioral Health Psycho-education Visit	10-20%	<ul style="list-style-type: none"> • Employs psycho-educational approach in classroom or group modality. • Program structure is often manualized, with condensed treatment strategies; emphasis on patient education and self-management strategies.
Telephone Visit	10-20%	<ul style="list-style-type: none"> • Same parameters as the General Behavioral Health Consultation Visit, but handled via telephone.
Behavioral Health Case Conference	10%*	<ul style="list-style-type: none"> • Reserved for high-utilizers and multi-problem patients. • Emphasis is on developing and communicating a health care utilization plan to contain excessive medical utilization, and on giving primary care providers effective behavioral management strategies and community resource case management. • Goal is to maximize daily functioning of patient, not necessarily symptom elimination.
Medication Consult	30%*	<ul style="list-style-type: none"> • Reserved for use by consulting psychiatrist. • Provides assessment and review of pharmacological regimen.

*These services do not necessarily involve direct client contact



IMPACT MODEL for Treating Depression in Primary Care

Because depression is prevalent in our senior population (nearly 5 million of 31 million Americans over 65 have clinically depressive syndromes) and many elderly are reluctant to seek out help for it in specialty mental health settings, primary care has become a mainstay for providing treatment for this condition.

Given its evidence-based track record – there are more than 30 published articles substantiating its effectiveness – many primary clinics are implementing the IMPACT model to improve outcomes for this population. Mental Health Departments in several California counties, including Los Angeles and San Diego, have used MHSAs funds to initiate the IMPACT approach, via contractual arrangements, in primary care clinics in their local communities. Some have generalized the model to apply to all adults, not just seniors. While there are numerous models for both integrated behavioral care and for treating depression in primary care, IMPACT is highlighted here because of its wide acceptance and implementation throughout the State.

The IMPACT website (<http://impact-uw.org>) lists the five essential components to the approach:

1. Collaborative Care

Collaborative care is the cornerstone of the IMPACT model and is manifest in two fundamental ways:

- The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)
- The care manager and the primary care provider consult with the psychiatrist to change treatment plans if patients do not improve

2. Depression Care Manager

This position may be a nurse, social worker or psychologist and may be supported by a medical assistant or other paraprofessional. The care manager:

- Educates the patient about depression
- Supports antidepressant therapy prescribed by the patient's primary care provider if appropriate
- Coaches patients in behavioral activation and pleasant events scheduling

- Offers a brief (six-eight session) course of counseling, such as Problem-Solving Treatment in Primary Care
- Monitors depression symptoms for treatment response
- Completes a relapse prevention plan with each patient who has improved

3. Designated Psychiatrist

The designated psychiatrist provides consultation for the care manager and primary care physician on the care of patients who do not respond to treatments as expected

4. Outcome measurement

IMPACT care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter. The PHQ-9 (see Sample Screening and Evaluation Instruments section) is highly regarded and widely used, though there are other effective tools as well.

5. Stepped care

- Treatment is adjusted based on clinical outcomes using an evidence-based algorithm
- The goal is a 50 percent reduction in symptoms within 10-12 weeks
- If the patient has not significantly improved at 10-12 weeks from the start of a treatment plan, the plan should be changed. The change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.



Core Components of Evidence-Based Depression Care (IMPACT)

Core Components of Evidence-Based Depression Care

Two Processes	Two New “Team Members” Supporting the Primary Care Providers (PCP)	
	Care Manager	Consulting Psychiatrist
<p>1. Systematic diagnosis and outcomes tracking</p> <p>e.g., PHQ-9 to facilitate diagnosis and track depression outcomes</p>	<ul style="list-style-type: none"> • Patient education / self management support • Close follow-up to make sure patients don’t “fall through the cracks” 	<ul style="list-style-type: none"> • Caseload consultation for care manager and PCP (population-based) • Diagnostic consultation on difficult cases
<p>2. Stepped Care</p> <p>a) Change in treatment according to evidence-based algorithm if patient is not improving</p> <p>b) Relapse prevention once patient is improved</p>	<ul style="list-style-type: none"> • Support of antidepressant medications by PCP • Brief counseling (behavioral activation, PST-PC, CBT, IPT) • Facilitation of treatment change/referral to mental health • Relapse prevention 	<ul style="list-style-type: none"> • Consultation focused on patients not improving as expected • Recommendations for additional treatment / referral according to evidence-based guidelines

Provided by the IMPACT Implementation Center, University of Washington.



Behavioral Health Counselor Roles & Responsibilities in a Primary Care Setting

Useful Traits of Primary Care Behavioral Health Counselors

Behavioral health counselors must be able to function in the fast-paced primary care environment. To be effective, they should:

- Be flexible enough to deal with noise, frequent interruptions, and constant changes in scheduling;
- Be able to offer brief, targeted interventions usually lasting less than 30 minutes;
- Be comfortable with short-term counseling, often lasting less than eight visits;
- Function well in a team-approach, accepting the fact that they are not in charge of the client's care;
- Be behaviorally, rather than personality, focused;
- Be able to perform consultations and give provider feedback “on the fly”; and
- Be able to effectively communicate and interact with primary care providers.

Therapists used to more traditional, long-term, in-depth psychotherapy approaches may experience a “culture shock” in the primary care environment and may need to make significant adjustments in their therapeutic style and way of thinking to be effective in this milieu.

Some Desirable Skill Sets For Behavioral Health Counselors

(Based in part on *Integrated Behavioral Health Care, A Guide to Effective Intervention* by William O'Donohue, 2006):

- Proficiency in the identification and treatment of mental disorders;
- Ability to think in terms of population management, addressing a large clientele in the most efficient ways possible, using approaches like stepped care and group psychotherapy;
- Knowledge of evidence-based behavioral assessments and interventions relevant to medical conditions, e.g., disease management, treatment adherence, and lifestyle change;
- Ability to make quick and accurate clinical assessments;

- Care-management skills and knowledge of local resources for outside referrals;
- Skill in targeted, brief psychotherapy and in running group sessions;
- Knowledge of basic physiology, psychopharmacology, and medical terminology;
- Familiarity with the stepped care model (clients move along different levels of intervention depending on past responses);
- Ability to document services in a way that is useful both to the primary care provider and to management for quality-improvement services; and
- Consultation liaison skills.

Goals of Primary Care Behavioral Health Counselors

(Taken from Open Door Community Health Center's Behavioral Health Program, 2005)
As a whole, the primary behavioral health care model is designed to increase the total proportion of eligible patients that receive appropriate mental and behavioral health services. To do this, the behavioral health counselor may assist primary care providers in:

- Recognition and treatment of mental disorders and psychosocial problems;
- Early detection of "at risk" clients, with the aim of preventing further psychological or physical deterioration;
- Prevention of relapse or morbidity in conditions that tend to recur over time;
- Prevention and management of addiction to pain medicine or tranquilizers;
- Prevention and management of work and/or functional disability;
- Obtaining quality clinical outcomes with high prevalence mental disorders;
- Efficient and effective treatment and management of clients with chronic emotional and/or health problems;
- Management of clients who use medical visits to obtain needed social support;
- Improving the quality of primary care provider interventions without the aid of behavioral health consultation; and
- Efficiently moving clients into appropriate mental health specialty care when indicated.

Common Job Functions of Primary Care Behavioral Health Counselors

The following is, in part, adapted from the sample job description included in "Providing Behavioral Health Services in a Community Center Setting" promulgated by the Washington Association of Migrant and Community Health Centers, 2002 (some of these functions may overlap):

- Assists the primary care provider in recognizing, treating and managing mental health and psychosocial issues and acts as a contributing member to the primary care team;

- Conducts client intakes, focusing on diagnostic and functional evaluations, then makes recommendations to the primary care provider concerning the clients' treatment goals and plan;
- Provides consultation and training to the primary care providers to enhance their skill and effectiveness in treating mental health problems;
- Provides brief, focused intervention for clients who are in need of mental health services;
- Gives primary care providers timely feedback about the client's care, treatment recommendations, and progress via documentation in the client's record and verbal feedback;
- Advises the primary care provider about which clients are better served at the primary care setting and which should be referred to specialty mental health facilities or elsewhere;
- Initiates follow-up to ascertain how clients are doing and to determine if any changes in treatment approaches are indicated;
- Develops, where indicated, relapse prevention plans and helps clients maintain stable functioning;
- Assists in the detection of "at risk" clients and in the development of plans to prevent worsening of their condition;
- Monitors and coordinates the delivery of health services for clients as related to behavioral health care, including linking with other treatment providers not only within the primary care setting but, with the clients' permission, outside it as well;
- Assists, to the extent feasible, in the client's community functioning by helping with public benefits, vocational rehabilitation, social support, housing, etc;
- Documents the client's progress and diagnostic information in the treatment chart;
- Keeps the primary care providers fully informed of the client's needs and progress, and works with providers to formulate treatment plans;
- Works, where indicated, to effect behavioral changes in clients with, or at risk for, physical disorders and helps them make healthier lifestyle choices;
- Provides clients with self-management skills and educational information needed so they can be full participants in their own treatment and recovery;
- Helps the clients, where indicated, to cope with chronic conditions like pain and diabetes;
- Provides consultation to clinic management and other team members about behavioral services and suggested areas of outcome and program evaluation; and
- Assists the clients in complying with any medical treatment initiated by the primary care provider, such as offering strategies to cope with medication side effects.



SAMPLE Job Descriptions

Sample Job Description for Behavioral Health Consultant in a Primary Care Setting

The following was taken from Cherokee Health Systems in Tennessee

Job Title: Behavioral Health Consultant.

Education/License: Licensed Social Worker (Masters) or a licensed Clinical Psychologist (Doctoral).

Position Requirements:

- Has excellent working knowledge of behavioral medicine and evidence based treatments for medical and mental health conditions.
- Has ability to work through brief client contacts as well as to make quick and accurate clinical assessments of mental and behavioral conditions.
- Is comfortable with the pace of primary care, working with an interdisciplinary team, and has strong communication skills.
- Has good knowledge of psycho-pharmacology.
- Has the ability to design and implement clinical pathways and protocols for treatment of selected chronic conditions.

Role:

- Management of psychosocial aspects of chronic and acute diseases.
- Application of behavioral principles to address lifestyle and health risk issues.
- Consultation and co-management in the treatment of mental disorders and psychosocial issues.

Sample Job Description Depression Care Manager

Taken from IMPACT model for treating depression in primary care and furnished by Cherokee Systems in Tennessee.

Job Summary: The depression care manager educates patients about depression and its treatment, provides behavioral activation, monitors depressive symptoms and response to medication and/or psychotherapy using a structured instrument (e.g., the PHQ-9), works closely with the primary care provider and a consulting psychiatrist to revise the treatment plan when patients are not improving, and offers a brief course of counseling for depression (e.g., Problem Solving Treatment in Primary Care).

Duties and Responsibilities

1. Conducts assessment of patient, including completion of the Patient Health Questionnaire (PHQ-9) depression scale
2. Conducts initial visit including detailed depression history and education about the nature of depression and the goals and expectations of treatment
3. Consults with patient and primary care provider about treatment options and preferences; coordinates initiation of treatment plan
4. Monitors patient closely (in-person or by phone) for changes in severity of symptoms and medication side effects; educates patients about medications and medication side effects as needed; encourages treatment adherence
5. Uses behavioral activation techniques with patients as an adjunct to other treatments
6. Provides optional evidence-based, brief structures psychotherapy
7. Participates in regular caseload supervision with psychiatrist, focusing on patients not adequately improved within specified timeframe (e.g., less than 50% reduction in symptoms after 8-12 weeks in treatment)
8. Coordinates and facilitates communication between patient, primary care physician, and consulting psychiatrist; provides recommendations for change in treatment plan according to evidence-based algorithm and expert supervision; supports implementation of new plan
9. Documents all encounters according to organizational policies and procedures; monitors outcome measurements
10. Facilitates treatment referrals, as needed
11. Completes relapse prevention plan with patients who are in remission

Requirements: Degree in nursing, social work, marriage and family therapy or psychology. Effective written and verbal communication skills. Demonstrated ability to establish rapport quickly with a wide range of people. Minimum two years clinical experience in a relevant setting. Knowledge of community resources.

Desired: Experience with depression and depression treatment. Experience working with medically ill and/or older adults. Prior exposure to brief, structured counseling techniques.

Sample Job Description for Consulting Psychiatrist

Job Summary

The consulting psychiatrist is responsible for supporting depression treatment provided by the primary care provider and a depression care manager to patients in the IMPACT program (<http://impact-uw.org>). IMPACT is an evidenced-based model of care that helps primary care physicians and mental health providers collaborate effectively to treat depression. The consulting psychiatrist provides regularly scheduled caseload supervision, suggests changes in treatment, provides telephone or in-person consultation to depression care managers and primary care providers and, when clinically indicated, sees patients who are not responding to initial treatment in primary care in consultation.

Duties and Responsibilities

1. Provide regularly scheduled caseload supervision to one or more depression care managers, primarily focusing on patients who are new to treatment or who are not improving as expected
2. Suggest treatment plan changes for patients who are not improving
3. Provide telephone or in-person consultation to the care manager or prescribing primary care provider, as needed
4. In rare instances, typically about 10% of patients, see patients who present diagnostic or therapeutic challenges in consultation to help develop an effective treatment plan and / or suggest appropriate treatment referrals

Requirements

Licensed psychiatrist. Demonstrated ability to collaborate effectively in a team setting.

Desired

Board-certified in psychiatry. Experience with consultation-liaison psychiatry, geriatric psychiatry, or primary-care-based mental health care. Experience with older adults [if relevant].

Sample Duties of a Primary Care Manager

The following was taken in part from a presentation made by William O'Donohue, CEO of CareIntegra, Inc. (slightly modified here):

- Accurately describes behavioral health services to appropriate clients and encourage their participation
- Demonstrates an understanding of the relationship of medical and psychological systems and how psychological issues may manifest themselves physically.
- Diverts clients with behavioral health issues to the behavioral counselors or specialty mental health, depending severity of condition.
- Refers clients appropriately to classes run by the behavioral health program.
- Clearly states the referral issues to the behavioral counselor.
- Interrupts the behavioral health counselor as needed.
- Conducts effective “curbside” consultations with the behavioral counselors.
- Follows up with the counselors when indicated.
- Engages in co-management of client care with the counselors.
- Charts behavioral referrals and treatment plans.
- Demonstrates knowledge of the behavioral counselors’ role.
- Is comfortable orienting the behavioral counselor to the primary care environment.
- Demonstrates a basic understanding of mental disorders and how to identify them.

Kirk Strosahl, PhD lists the following among the core competencies a primary care provider must have when dealing with behavioral health consultants (in a 2007 presentation at the Collaborative Family Health Care Association Conference):

- Clearly states referral question in the referral to the behavioral counselor.
- Interrupts the behavioral consultant when the need arises.
- Conducts effective “curbside” consultations with the behavioral health consultant.
- Is able to engage in consultative co-management with the behavioral consultant.
- Follows up with the behavioral consultant when indicated.
- Uses intermittent visit strategy (back-and-forth with the behavioral provider) to expand continuity of care.
- Uses the behavioral consultant to “leverage” practice – increase practice capacity, control client flow and prevent back-ups.
- Uses behavioral consultant generated prevention strategies (i.e., relapse prevention plans, behavioral health “vital signs”).
- Uses the behavioral counselor in the triage of patients to specialty mental health and chemical dependency.
- Uses the behavioral consultant as a integral part of chronic condition pathways.
- Sets a timetable for response and uses the behavioral counselor to assist with patients who aren't improving.



Information Sharing Between Mental Health and Primary Care

Because federal and state laws governing confidentiality of medical records for California are both complicated and sometimes contradictory, we will not offer conclusions here, but will make reference to a few informational sources that may shed light on what information can be disclosed and when. Because this area is so complex and, at times, open to debate, our mention of these resources should not be construed as endorsements of their specific content. Rather, they are being furnished simply for informational purposes.

- ***Maintenance and Disclosure of Medical Records in the Primary Care Setting***, an article written by California health care attorney Elizabeth Saviano in 2008 can be accessed via the IBHP website at: www.ibhp.org/uploads/file/MentalHealthRecordMaintenance_article.pdf.
- ***California Health Information Privacy Manual***, published by the California Hospital Association in 2009, is a California-specific resource addressing privacy requirements under the new federal Health Information Technology for Economic and Clinical Health (HITECH) act, the Health Insurance Portability and Accountability Act (HIPAA), the California Confidentiality of Medical Information Act, the California Patient Access to Health Records Act, the Lanterman-Petris-Short Act, and other state laws. The Manual can be purchased via their website at www.calhospital.org
- ***Mental Health Law Manual***, 2005, also published by the California Hospital Association, includes a comprehensive analysis of confidentiality issues. It can be purchased via the CHA website at www.calhospital.org.

Resource for California HIPAA Requirements

The California Department of Health Care Services Office of HIPAA Compliance responsible for implementation by DHCS of all of the final rules of HIPAA under Title II. To access the regulations, go to: www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/default.aspx

Resource for Substance Abuse Confidentiality Requirements

Confidentiality provisions, in many instances are even more rigorous for substance abuse treatment information than for mental health. The prevailing federal regulations governing disclosure of substance abuse information are known as CFR 42, Part 2. A comparison of these regulations and HIPAA requirements can be found on the web at: www.hipaa.samhsa.gov/download2/SAMHSA'sPart2-HIPAAComparisonClearedWordVersion.doc.



How Do You Measure if It's Working?

WORKSHEET FOR ASSESSING COLLABORATIVE CARE

POSSIBLE PROCESS CRITERIA	CONSIDER IT?
• Percentage of clients whose screening indicated a need for mental health services who actually received such services	
• Length of time between referral and provision of services	
• Number of clients provided with mental health services	
• Units of mental health service delivered	
• Ease of access to services for clients	
• Percent of referrals resulting in appropriate behavioral feedback to referral source	
• Number of appropriate referrals for mental or physical health treatment	
• Percent of clients served who meet target criteria	
• Array of mental health services offered within primary care providers	
• Array of physical health services offered or arranged for within mental health providers	
• Usage level and effectiveness of diagnostic screening tools, if any	
• Frequency of cross-discipline training of mental and physical health service providers; number and level of staff attending	
• Number and qualifications of mental health professionals affiliated with primary care program	
• Knowledge level of primary care medical staff in mental health areas, including identification of and approaches to psychiatric problems	
• Knowledge level of mental health staff of physical conditions associated with mental health problems	
• Number of professional staff training sessions geared toward identification and treatment of mental disorders	
• Familiarity of staff with local resources for persons with mental and/or physical disorders	
• Acceptance of staff and administration of mental-physical integration procedures and principles	

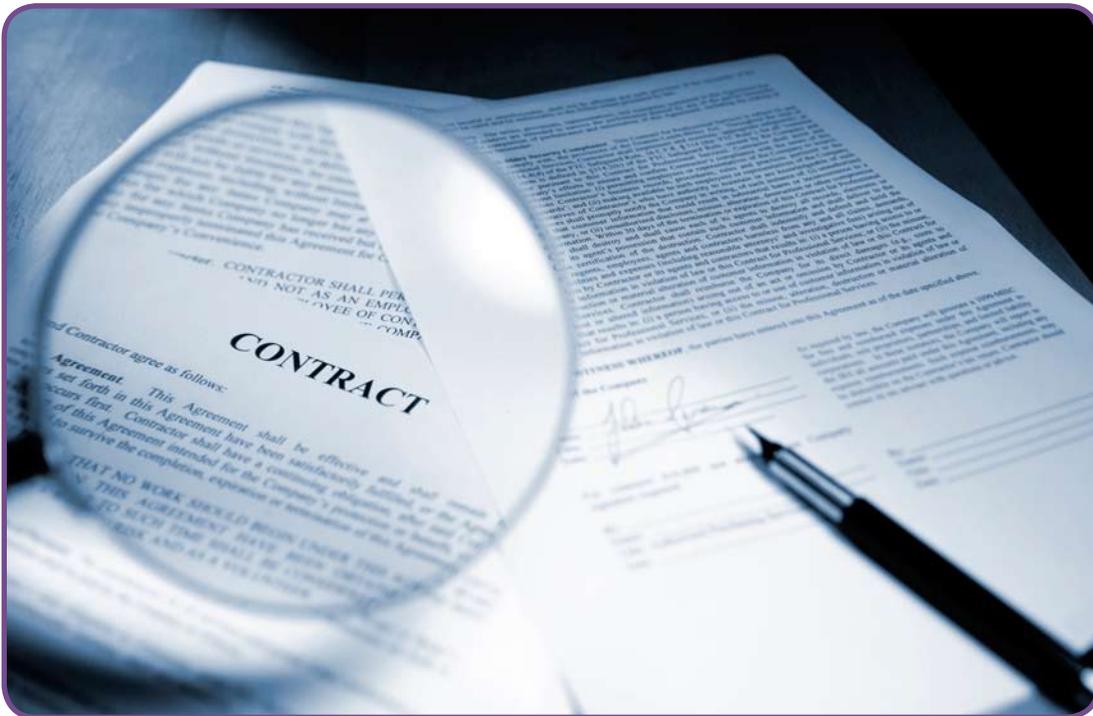
POSSIBLE PROCESS CRITERIA (continued)	CONSIDER IT?
• Strength and effectiveness of linkage between the primary care facility and mental health services in the community	
• Level, appropriateness and effectiveness of staff follow-up	
• Level and adequacy of care management provided	
• Proximity of mental health services to clinic	
• Amount of time devoted to meeting clients' mental health needs	
• Staff awareness of national and local resources for persons with mental health problems	
• Level of behavioral care integration into existing clinical quality assurance improvement programs	
• Accuracy and amount of outcome data collected by the facility	
• Other: _____	
• Other: _____	
• Other: _____	

POSSIBLE OUTCOME CRITERIA ¹	CONSIDER IT?
• Level of client satisfaction with accessibility and effectiveness of mental health services	
• Client self-assessment of functioning and of quality of life	
• Objective testing of disorder level and symptoms (e.g., general mental status exams, depression questionnaires like the PHQ-9, anxiety scales, substance use surveys, etc.)	
• Targeted behavioral changes if specifically addressed by the program (e.g. smoking cessation, improved diet, etc.).	
• Rate of missed and/or kept appointments	
• Cost of integrated services provided	
• Overall impact on total cost of care	
• Frequency of emergency room visits of persons receiving integrated behavioral health care	
• Frequency of hospitalizations of persons receiving integrated behavioral health care	
• Mental health improvement for clients with co-occurring physical disorders	
• Physical health improvement level in clients with co-occurring mental disorders(see below)	

POSSIBLE OUTCOME CRITERIA (continued) ¹	CONSIDER IT?
For clients with co-occurring mental disorders and diabetes:	
<ul style="list-style-type: none"> • Hemoglobin A1C levels 	
<ul style="list-style-type: none"> • Progression of microvascular disease of the eyes 	
<ul style="list-style-type: none"> • Abnormalities of the kidneys 	
<ul style="list-style-type: none"> • Weight 	
<ul style="list-style-type: none"> • Waist girth 	
For clients with co-occurring mental disorders and chronic obstructive pulmonary disease:	
<ul style="list-style-type: none"> • Oxygenation 	
<ul style="list-style-type: none"> • Pulmonary function 	
<ul style="list-style-type: none"> • Exercise capacity 	
For clients with co-occurring mental disorders and heart disease:	
<ul style="list-style-type: none"> • Incidence of death 	
<ul style="list-style-type: none"> • Incidence of heart attacks 	
<ul style="list-style-type: none"> • Incidence of strokes 	
<ul style="list-style-type: none"> • Cholesterol level/ HDL/HDL ratio 	
<ul style="list-style-type: none"> • Blood pressure 	
<ul style="list-style-type: none"> • Heart-sensitive C-reactive protein level 	
<ul style="list-style-type: none"> • Number and severity of relapses 	
<ul style="list-style-type: none"> • Satisfaction of mental health personnel with promptness, level, and effectiveness of services provided by the primary care system 	
<ul style="list-style-type: none"> • Satisfaction of primary care personnel with the promptness, level and effectiveness of services provided by the mental health system 	
<ul style="list-style-type: none"> • Quality of services as assessed by random chart review 	
<ul style="list-style-type: none"> • Level of stigma and/or hesitancy clients experience in accessing mental health care as measured by their self-report 	
<ul style="list-style-type: none"> • Client adherence to treatment plans and medication compliance 	
<ul style="list-style-type: none"> • Other _____ 	
<ul style="list-style-type: none"> • Other _____ 	
<ul style="list-style-type: none"> • Other _____ 	

¹ Note: Some of these measures would require pre and post testing for comparison purposes.

SAMPLE MOUs and Contracts



INTEGRATED MENTAL HEALTH & PRIMARY CARE SERVICES
GRANT AGREEMENT

SHASTA COUNTY, DEPARTMENT OF MENTAL HEALTH
AND
XXXXXX HEALTH CENTER

THIS GRANT AGREEMENT (“Agreement”), is made and entered into effective this 1st day of xxxx, 20xx, by and between the County of Shasta, a political subdivision of the State of California, through its Health and Human Services Agency, Department of Mental Health (“County”), and XXXXXX Clinic, a California nonprofit public benefit corporation (“Health Center”).

RECITALS

A. County provides access to mental health services and desires to provide grant funding to various Federally-qualified health centers (“FQHC’s”) located in Shasta County in order to: (1) provide for new or expanded mental health services; (2) integrate mental health services with the FQHC’s mental health and medical services; and (3) strengthen the relationship between the FQHC’s and the County’s public mental health system.

B. County has a shortage of psychiatrists providing publicly funded mental health services, particularly services to clients who are not covered by public or private insurance, other mental health funds, or other entitlement programs.

C. Health Center is the licensed owner and operator of nonprofit community clinics operating under one license which is located as follows: XXXXXX Clinic, P.O. Box XXX, XXXXXX, CA 960XX.

D. Health Center is an FQHC as defined in 42 U.S.C. §1396d(l)(2)(B)(i) or (ii), and provides physical and mental health services to the “medically underserved population” (as defined in 42 U.S.C. §254b(b)(3)(A)) of County of Shasta.

E. Health Center provides its services on a sliding fee scale basis as required by subdivision (a)(1)(A) of section 1204 of the California Health and Safety Code and section 51c.303 of Title 42 of the Code of Federal Regulations, and is enrolled in the Medicare, Medicaid, and other publicly-funded health care reimbursement programs.

F. Health Center seeks to create an expanded mental health services delivery program (the “Program”) including the addition of **(specify here the exact number, licensure and FTEs of the mental health team being proposed for your integrated primary care/ county mental health pilot project)**, and associated administrative staff, in order to provide a coordinated system of care to its patients in a manner that increases the availability of integrated mental health and medical services, and which enhances the quality of health care services available to the medically underserved population served by Health Center.

G. County and Health Center desire to share the costs of the Program in order to meet the needs of the medically underserved population served by Health Center. Any benefits (financial or otherwise) to Health Center resulting from this Agreement are ancillary to the fundamental purpose of meeting the mental and physical health care needs of the patients served by Health Center, and any payments by County to the Health Center described herein are for the incremental increase in costs to the Health Center of establishing the Program.

NOW, THEREFORE, and in consideration of the mutual covenants hereinafter contained, the parties hereby agree as follows:

TERMS OF AGREEMENT

Section 1. Purpose. The purpose of this Agreement is to provide access to mental health services for Health Center's patients in new or expanded programs, but not to supplant existing funding for services. The purpose of this Agreement is also to integrate County's mental health services with Health Center's mental health and medical services, to strengthen the relationship between County and Health Center to facilitate the provision of mental health services to the people of Shasta County, and to enhance the quality of mental health services provided to the medically underserved population served by Health Center.

Section 2. Target Population. The target population (hereinafter, the "Target Population") which is the focus of this Agreement includes those persons described in section 5600.3 of the California Welfare and Institutions Code, and, by way of illustration and not of limitation, (1) persons who are mentally ill and emotionally disturbed or at-risk thereof within the County of Shasta, and specifically including adults with severe mental illness and children and youth with severe emotional disabilities; (2) persons who require mental health services and/or mental health outreach and support services which are not covered through any other funding source; and (3) the parents and families of the persons described in (1) and (2) of this Section 2.

Section 3. Effective Date. Subject to the termination provisions set forth in Section 16, of this Agreement, the term of this Agreement shall commence as of **xxxx** 1, 20**xx**, (the Effective Date) and shall terminate **xxxx** 30, 20**xx**. This Agreement shall be reevaluated by Health Center at least annually to ensure that this Agreement is expected to continue to contribute meaningfully to Health Center's ability to maintain or increase the availability, or enhance the quality, of services provided to the medically underserved population served by Health Center. If this Agreement fails to meet this standard, this Agreement shall be promptly revised by the Parties or terminated by Health Center in accordance with the provisions of Section 17(b) of this Agreement.

Section 4. Scope of Work. During the term of this Agreement, Health Center shall provide mental and physical health care diagnosis, screening and treatment services to the Target Population. Health Center shall provide the Target Population with integrated culturally and linguistically competent and comprehensive screening for mental health, substance abuse,

domestic violence, and medical needs. Linkages, education, and referral to other services shall be provided by Health Center as needed. In addition, Health Center shall provide the Target Population with a comprehensive and integrated age appropriate mental health assessment. The services to be funded under this Agreement shall include the services more fully prescribed in the scope of work attached hereto as Exhibit A and hereby incorporated into this Agreement (“Scope of Work”).

Section 5. Productivity Standards. The method of documenting productivity applicable to the services provided under this Agreement are as prescribed in Exhibit A-1 (“Productivity Standards”), attached hereto and incorporated into this Agreement. The purpose of the Productivity Standards is to facilitate, on an ongoing basis, the assessment of the impact of this Agreement on increasing the availability, and enhancing the quality, of services provided to the Target Population by Health Center. The Productivity Standards shall be interpreted and applied in a manner that reflects the goal of the parties to value the provision of high quality, effective mental health services that are integrated with medical services over an increase in access to mental health services alone.

Section 6. Reporting Requirements. Timely submission of reports is required. Release of grant funds for the monthly payments to be made to Health Center under this Agreement shall be contingent upon County’s timely receipt and approval of these reports. The reports to be provided to County by Health Center are as follows:

- a). Quarterly Progress Report – A Quarterly Progress Report on the progress made under the Scope of Work reflecting Health Center’s performance and describing any problems or compliance issues shall be submitted to County within 30 days of the end of each quarter of the calendar year.
- b). Budget Expenditure Report – A Budget Expenditure Report shall be submitted to County 30 days after the end of each quarter of each contract year during the term of this Agreement, reflecting expenditures on the budgeted items, as well as any budget problems arising during the reporting period.

Section 7. Annual Budgets. The amount to be paid by County to Health Center under this Agreement is intended to be an amount that is sufficient to permit Health Center to maintain and operate the Program in a manner calculated to ensure the capacity to deliver mental health services of excellent quality that effectively improves patient outcomes. The initial grant amounts to be paid under the terms of this Agreement shall be based on the projected budgets for each year of this Agreement and as prescribed in the Exhibit(s) B (“Initial Budget Detail Worksheet”), attached to and incorporated in this Agreement. Each Exhibit B shall contain four separate line items: (1) Personnel Costs; (2) Operating Expenses; (3) Other Costs; and (4) Overhead Costs. The total amount payable under this agreement shall not exceed \$xxx,xxx, during any County fiscal year (July 1 – June 30).

Section 8. Personnel Costs. Personnel Costs delineated in each Exhibit B shall include staff positions directly involved in delivering mental health services, such as licensed clinical social workers, psychologists, case managers, visit coordinators and dedicated clerical staff. Salaries and wages must be itemized by classification, and shall include the classification and/or job title, the full-time equivalence computation (“FTE”), the full-time annual salary for each classification and/or job title, and the amounts that are to be paid under this Agreement. Fringe benefits shall be budgeted for the classification(s) being funded under this Agreement. Fringe benefits shall not exceed 32 percent of the total salaries and wages. Fringe benefits paid under this Agreement must be consistent with Health Center’s administrative policies regarding fringe benefits. The fringe benefits include, but are not limited to, medical benefits, workers’ compensation, unemployment insurance, and disability insurance.

Section 9. Operating Expenses. Operating Expenses delineated in each Exhibit B shall include, but are not limited to, travel and per diem costs (consistent with the standards set by the California Department of General Services), facility costs (capital expenses associated with expanded facilities directly related to accommodation of professional services provided under this Agreement, rent/lease costs, insurance, utilities, janitorial services, and security services), and other operating expenses such as office supplies, communication costs, printing/duplication costs, audit expenses, staff training, software licensing costs, professional license fees, dues, and registration and membership fees.

Section 10. Other Costs. Other Costs delineated in each Exhibit B shall include expenses for conferences, special projects, subcontracts and other items not include in other expense categories. Subcontract costs may include contracted personnel services, such as an on-call physician, nurse, or the costs of bookkeeping services.

Section 11. Overhead Costs. Overhead Costs delineated in each Exhibit B shall include expenses for administrative/ support services that are not directly attributable to a single program. All costs budgeted under Overhead Costs must be supported by a written cost allocation plan. The cost allocation plan shall document those allowable costs that are attributable to more than one program and provide a reasonable basis for allocating those costs to the Program.

Section 12. Payment of Budgeted Amounts. The amounts to be paid under this Agreement shall be paid prospectively in 12 equal monthly installments per contract year beginning on the first day of the first month following the Effective Date, except that the final monthly payment shall be withheld until receipt of the final cost report for that contract year, and adjusted to performance as described in Attachment A.

Section 13. Payment for Services. Health Center shall have the sole responsibility for billing and collection, in accordance with all applicable laws, from third party payers for the rendering of professional services delivered by Health Center.

Section 14. Right to Audit; Record Retention. County shall have the right to audit the accuracy of reports that Health Center is required to be submitted to County under this Agreement. Such audits shall be conducted in compliance with all applicable laws and regulations regarding the confidentiality of medical and employment records, as well as of trade secrets, and Health Center shall be entitled to receive reasonable assurances from County that such requirements have been met prior to disclosing private or other confidential information to County. Health Center shall maintain books, payroll records, documents, and ledgers in accordance with accounting procedures and practices that reflect all direct and overhead expenses related to this Agreement. The records shall be kept and made available to the County for three years from the date of the final grant payment to Health Center under this Agreement, or longer if an audit finding is under appeal.

Section 15. Insurance. Health Center shall at all times during the term of this Agreement maintain the following minimum levels of insurance:

(a) Comprehensive General Liability Insurance, covering its activities hereunder, in an amount not less than \$1,000,000 per occurrence;

(b) Property Insurance, in an amount not less than 80 percent of the reasonable replacement value of Health Center's property;

(c) Professional Liability Insurance, including deemed coverage under the Federal Tort Claims Act, covering Health Center's activities hereunder, in an amount not less than \$1,000,000 per occurrence/\$3,000,000 aggregate; and

(d) All employment related insurance benefits as are required by law for Health Center's employees (such as workers' compensation, state disability, and unemployment insurance).

Health Center shall provide the above coverage through such reputable carriers or risk retention groups admitted to do business in California as may be selected by Health Center, or by obtaining deemed coverage status under the Federal Tort Claims Act.

The Health Center shall provide a Certificate of Insurance ("COI") to the County immediately upon execution of this Agreement. The COI shall name the County as an Additional Insured to the Comprehensive General Liability policy, and shall contain the following language: 'The County shall be notified not less than thirty (30) days in advance in the event of cancellation or material change in policies. Such policies are primary as to the County.'

Section 16. Indemnification.

In the performance of this Agreement, it is mutually understood and agreed that Health Center is at all times acting and performing as an independent contractor with, and not as an employee or joint venturer of, County. Health Center shall have no claim under this Agreement or otherwise against County for workers' compensation, unemployment compensation, sick

leave, vacation pay, pension or retirement benefits, Social Security benefits or any other employee benefits, all of which shall be the sole responsibility of Health Center. County shall not withhold on behalf of Health Center any sums for income tax, unemployment insurance, Social Security or otherwise pursuant to any law or requirement of any government agency, and all such withholding, if any is required, shall be the sole responsibility of Health Center. Health Center shall jointly and severally indemnify and hold harmless County from any and all loss or liability, if any, arising out of or with respect to any nonpayment of such taxes or withholdings by Health Center.

Each party shall defend, indemnify, and hold the other party, its officials, officers, employees, and agents harmless from and against any and all liability, loss, expense including reasonable attorneys' fees, or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of the indemnifying party, its officials, officers, employees, or agents.

Section 17. Termination. Notwithstanding any other provisions contained herein, this Agreement may be terminated on the basis of any of the following:

(a) Due to Disciplinary Action. In the event Health Center's licensure or certification is suspended or withdrawn or disciplinary action is taken by a state or federal licensing agency, then County may terminate this Agreement immediately upon written notice sent by facsimile transmission.

(b) Due to Changes in Law. In the event legal counsel for either party provides a well-reasoned, written opinion that this Agreement or any practices which could be or are employed in exercising rights under this Agreement may violate any existing law or regulation, the parties in good faith shall undertake to revise this Agreement to comply with such law(s). It is also the intention of the parties that this Agreement shall fully comply with the proposed rule and standards published by the Office of the Inspector General in the July 1, 2005 Federal Register (70 Fed.Reg. 38081-38089), or any superseding rule and standards that may be adopted by the Office of the Inspector General implementing the provisions 42 U.S.C. § 1320a-7b(b)(3)(H) which exempts from criminal penalties (for acts involving Federal health care programs) remuneration between a health center entity and any entity pursuant to an agreement which contributes to the ability of the health center to maintain or increase the availability of services provided to medically underserved populations (the "Safe Harbor Provisions"). In the event of adoption of a final rule and standards, or the issuance of relevant guidance, which would lead the parties to reasonably believe that this Agreement is not in compliance with the Safe Harbor Provisions, the parties shall promptly identify and discuss the substance of modifications to this Agreement that are required in order to ensure compliance with such subsequently adopted rules and standards implementing the Safe Harbor Provisions. In the event the parties are unable to agree upon the revised terms in a timely manner, this Agreement shall terminate immediately upon written notice by one party to the other sent by facsimile transmission.

(c) Without Cause. Either party may terminate this Agreement without cause on 30 days' written notice to the other party.

(d) Lack of Funding. County may terminate this Agreement immediately upon written notice should funding cease or be materially decreased during the term of this Agreement.

(e) Delegation of Right to Terminate. County's right to terminate this Agreement may be exercised by County's Chief Administrative Officer or his/her designee, County's Director of its Health and Human Services Agency or his/her designee, or County's Director of Mental Health or his/her designee.

Section 18. No Requirement to Make Referrals; Obligation to Accept Referrals; Required Notices; and Disclosure to Patients. Nothing in this Agreement is intended to obligate and shall not obligate any party to this Agreement to refer patients to any other party. County shall accept all referrals of patients from Health Center who clinically qualify for the services provided by County, regardless of the patient's payer status or ability to pay. Health Center shall provide notification to patients of their freedom to choose any willing provider or supplier. In addition, Health Center shall disclose the existence and nature of this Agreement to any patient who inquires, and upon the initial referral of any patient by Health Center to County, for the furnishing of separately billable items or services (i.e., an item or service for which the patient or a third-party payer, rather than the Health Center, may be obligated to pay). Such notices and disclosures shall be provided in a timely fashion and in a manner reasonably calculated to be effective and understood by the patient.

Section 19. Compliance with Laws. Each party shall observe and comply with all applicable federal, state, and local laws, ordinances, and codes which relate to the services to be provided pursuant to this Agreement. Health Center shall not discriminate in employment practices or in the delivery of services on the basis of race, color, creed, religion, national origin, sex, age, marital status, sexual orientation, medical condition (including cancer, HIV and AIDS) physical or mental disability or use of family care leave. Health Center represents that it is in compliance with, and agrees that it will continue to comply with, the Americans with Disabilities Act of 1990 (42 U.S.C. section 12101, *et seq.*), the Fair Employment and Housing Act (Government Code sections 12900, *et seq.*), and regulations and guidelines issued pursuant thereto.

Section 20. Licenses and Permits. Health Center shall possess and maintain all necessary licenses, permits, certificates, and credentials required by the laws of the United States, the State of California, County of Shasta, and all other appropriate governmental agencies, including any certification and credentials required by County. Failure to maintain the licenses, permits, certificates, and credentials shall be deemed a breach of this Agreement and constitutes grounds for the termination of this Agreement by County.

Section 21. Relationship of parties. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between the parties other than that of independent parties contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. The parties are not, and shall not be construed to be, in a relationship of joint venturers, partners, or employer-employee.

Section 22. Ethics. In the performance of their respective obligations hereunder, the parties shall at all times conform to the ethical standards and licensure requirements relating to the practice of medicine from time to time prevailing.

Section 23. Notices. Unless otherwise provided in this Agreement, all notices to be given under this Agreement shall be in writing and may be: (1) personally served upon the parties hereto, (2) served by facsimile transmission, (3) served by depositing the same in the United States mail, postage prepaid, return receipt required, or (4) served by national overnight delivery service, as follows:

County: Mark Montgomery, Psy.D., Director
Shasta County Mental Health
2640 Breslauer Way
Redding, CA 96001-4246
Tel: (530) 225-5900
Fax: (530) 225-5977

Health Center: **XXXX XXXXXX**, Executive Director
XXXXXX Clinic
P.O. Box **xxx**
XXXXXX, CA 960**xx**
Tel: (530) **xxx-xxxx**
Fax: (530) **xxx-xxxx**

subject to the right of either party to change said address or addresses by written notice of such new address to the other party.

Section 24. Entire Agreement. The provisions of this Agreement (and all exhibits and schedules hereto) constitute the entire agreement between the parties concerning the subject matter hereof, and this Agreement may be amended, modified or otherwise changed only upon the written consent of the parties hereto. Unless otherwise set forth in this Agreement, this Agreement shall not be construed as conferring upon any third party any right or benefit, and any and all claims which may arise hereunder may be enforced solely by County or by Health Center.

Section 25. Successors. Neither party may assign its rights or obligations hereunder without the written consent of the other party. Subject to the foregoing, this Agreement shall

be binding on and inure to the benefit of the respective successors and assigns of the parties, except to the extent of any contrary provision of this Agreement.

Section 26. Waiver. No waiver of any default shall constitute a waiver of any other breach or default, whether of the same or any other covenant or condition.

Section 27. Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, or if the performance of any such term, provision, covenant or condition is so held to be invalid, void or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

Section 28. Notice of Claim. If any claim for damages is filed with Health Center or if any lawsuit is instituted concerning Health Center's performance under this Agreement and that in any way, directly or indirectly, contingently or otherwise, affects or might reasonably affect County, Health Center shall give prompt and timely notice thereof to County. Notice shall be prompt and timely if given within 30 days following the date of receipt of a claim or 10 days following the date of service of process of a lawsuit.

Section 29. Governing Law. This Agreement shall be governed and construed in accordance with the laws of the State of California.

Section 30. Headings. The headings of the various paragraphs are for convenience and ease of reference only, and do not define, limit, augment, or describe the scope, content, or intent of this Agreement or of any part or parts of this Agreement.

Section 31. Confidentiality. Both parties shall protect the confidentiality of each other's records and information, and shall not disclose confidential information without the prior written consent of the other party.

Section 32. Force Majeure. If either party is unable to perform its duties under this Agreement due to strikes, lock-outs, labor disputes, governmental restricts, fire or other casualty, emergency, or any cause beyond the reasonable control of the party, such non-performing party shall be excused from performance by the other party, and shall not be in breach of this Agreement, for a period equal to any such prevention, delay, or stoppage. Notwithstanding this provision, a party may terminate this Agreement immediately upon written notice if such events continue for 30 days.

Section 33. Assignment. Neither party may assign rights or delegate duties identified in this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld; provided, however, that upon 30 days written notice to the other party, Health Center may assign this Agreement to an "affiliated corporation," as that term is defined in section 150 of the California Corporations Code.

Section 34. Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and

the same instrument.

Section 35. Third-Party Beneficiaries. Unless otherwise expressly provided, this Agreement shall not create any third-party beneficiary rights for any person or entity.

Section 36. Execution. By their signatures below, each of the following represent that they have authority to execute this Agreement and to bind the party on whose behalf their execution is made.

Section 37. HIPAA Addendum. Attached to this Agreement, and incorporated by reference, is an addendum which constitutes a Business Associate Agreement as required by the federal Health Insurance Portability and Accountability Act.

Section 38. Warranty of Authority. The Parties, in signing this Agreement below, are representing that they are acting pursuant to duly delegated authority and warrant that they are authorized to enter into this Agreement

IN WITNESS WHEREOF, the Parties have set their hands on the day or days and year written below.

COUNTY OF SHASTA

Date: _____

MARK CIBULA, CHAIRMAN
Board of Supervisors
County of Shasta
State of California

ATTEST
LAWRENCE G. LEES
Clerk of the Board of Supervisors

By: _____
Deputy

XXXXXX CLINIC
a California nonprofit public benefit corporation.

Date: _____

Xxxx xxxxxx, Executive Director

Approved as to form:

RISK MANAGEMENT APPROVAL

KAREN KEATING JAHR
County Counsel

By: _____

By: John L. Loomis,
Senior Deputy County Counsel

**EXHIBIT A-1
PRODUCTIVITY STANDARDS**

**EXHIBIT B
BUDGET DETAIL WORKSHEET**

GRANTEE:		CLINIC SITE:	
CHECK ONE: <input type="checkbox"/> FY 2007/08 <input type="checkbox"/> FY 2008/09 <input type="checkbox"/> FY 2009/10 <input type="checkbox"/> OR IF SAME BUDGET EACH YEAR			
1. PERSONNEL			
CLASSIFICATION/JOB TITLE	FTE	FULL TIME ANNUAL SALARIES OR WAGES	COSTS PAID BY THIS GRANT
SALARIES AND WAGES			\$
FRINGE BENEFITS			\$
TOTAL (PERSONNEL)			\$
2. OPERATING EXPENSES			
			\$
TOTAL (OPERATING EXPENSES)			\$
3. OVERHEAD COSTS			
			\$
TOTAL (OVERHEAD COSTS)			\$
4. OTHER COSTS			
			\$
TOTAL (OTHER COSTS)			\$
TOTAL BUDGET (SUM OF LINE ITEMS 1 THROUGH 4)			\$

**ADDENDUM TO CONTRACT/AGREEMENT
(HIPAA Business Associate Agreement)
(Revised 3/21/05)**

This Addendum is attached to, and incorporated into the agreement, entitled agreement between County of Shasta and **XXXXXX** Clinic, a California nonprofit public benefit corporation.

Definitions.

All terms and phrases used, but not otherwise defined in this Addendum, shall have the same meaning as those terms are defined in 45 Code of Federal Regulations, subtitle A, subchapter C, parts 160 and 164. All section references in this Addendum are to Title 45 of the Code of Federal Regulations unless otherwise specified.

- (a) **Business Associate.** “Business Associate” shall mean **XXXXXX** Clinic, a California nonprofit public benefit corporation.
- (b) **Underlying Agreement.** “Underlying Agreement” shall mean the agreement or contract between the County of Shasta and the Business Associate, to which this Addendum is attached and incorporated.
- (c) **Covered Entity.** “Covered Entity” shall mean that covered components of the County of Shasta hybrid entity which are subject to the standards for privacy and security of Title 45, Code of Federal Regulations, subchapter C, Parts 160 and 164.

Obligations and Activities of Business Associate.

Business Associate shall:

- (a) Not use or disclose Protected Health Information (PHI), or Electronic Protected Health Information (EPHI), other than as permitted or required by this Addendum or as required by law.
- (b) Use appropriate safeguards to prevent use or disclosure of PHI or EPHI other than as provided for by this Addendum and the Underlying Agreement.
- (c) Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or EPHI by Business Associate in violation of the requirements of this Addendum and the Underlying Agreement.
- (d) Report to Covered Entity any use or disclosure of PHI or EPHI not provided for

by this Addendum and the Underlying Agreement of which it becomes aware.

- (e) Ensure that any agent, including a subcontractor, to whom it provides PHI or EPHI received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Addendum and the Underlying Agreement to Business Associate with respect to such information.
- (f) Provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI and EPHI information in a designated record set, to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under Section 164.524.
- (g) Make any amendment(s) to PHI and EPHI in a designated record set that the Covered Entity directs or agrees to make pursuant to Section 164.526 at the request of Covered Entity or an individual, and in the time and manner designated by Covered Entity.
- (h) Make internal practices, books, and records, including policies and procedures and PHI and EPHI, relating to the use and disclosure of PHI and EPHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary (ie., the Secretary of Health and Human Services [HHS], or to any officer or employee of HHS to the authority involved has been delegated), in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the law.
- (i) Document disclosures of PHI and EPHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures in accordance with Section 164.528.
- (j) Provide to Covered Entity or an individual, in the time and manner designated by Covered Entity, information collected of disclosures of PHI and EPHI, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures in accordance with Section 164.528.
- (k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and EPHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity, as required by law. In addition, Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI or EPHI agrees to implement reasonable and appropriate safeguards to protect it. Business Associate shall also report to Covered Entity any breach of security incident of

which he/she/it becomes aware.

Permitted uses and Disclosures by Business Associate.

Except as otherwise limited in this Addendum and the Underlying Agreement, Business Associate may use or disclose PHI and EPHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the law if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

Obligations of Covered Entity.

- (a) Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with Section 164.520, to the extent that such limitation(s) may affect Business Associate's use or disclosure of PHI and EPHI.
- (b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI and EPHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI and EPHI.
- (c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI and EPHI that Covered Entity has agreed to in accordance with Section 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI and EPHI.

Permissible Requests by Covered Entity.

Covered Entity shall not request Business Associate to use or disclose PHI and EPHI in any manner that would not be permissible under the law if done by Covered Entity.

Term and Termination.

The provisions of this Addendum shall supersede the provisions of the Underlying Agreement insofar as they relate to the term and termination of the Underlying Agreement.

- (a) **Term.** The provisions of this Addendum shall be effective July 1, 2007 and shall terminate when all of the PHI and EPHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity or, if it is infeasible to return or destroy, protections are extended to such information, in accordance with the termination provisions in this Addendum.

- (b) Termination for Cause. Upon County of Shasta or its Covered Entity’s knowledge of a material breach by Business Associate of the provisions of this Addendum, County of Shasta or its Covered Entity may terminate this Addendum and the Underlying Agreement.
- (c) Effect of Termination.
 - (1) Except as provided in paragraph (2) of this provision, upon termination of this Addendum and the Underlying Agreement, for any reason, Business Associate shall return or destroy, in a confidential manner, all PHI and EPHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI and EPHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of said PHI and EPHI.
 - (2) In the event that Business Associate determines that returning or destroying the PHI and EPHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon the agreement of Covered Entity that return or destruction is infeasible, Business Associate shall extend the protections of this Addendum to such PHI and EPHI and limit further uses and disclosures to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI and EPHI.

Miscellaneous

- (a) Amendment. The Parties agree to take such action as is necessary to amend this Addendum and the Underlying Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the regulations enacted pursuant thereto. Any such amendment may be signed on behalf of the County of Shasta by the County Administrative Officer, or his or her designee(s).
- (b) Survival. The respective rights and obligations of Business Associate under the provision of this Addendum entitled “Effect of Termination” shall survive the termination of the Underlying Agreement.
- (c) Interpretation. Any ambiguity in this Addendum and the Underlying Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Memorandum of Agreement
Regarding the CMSP Behavioral Health Pilot Project Grant to Open Door Community Health Centers (ODCHC) for Behavioral Health consultations.
Between ODCHC and Humboldt County Department of Health and Human Services (DHHS)

This agreement is made on **January 22, 2008** between Open Door Community Health Centers (ODCHC), a tax exempt, California private nonprofit corporation, with its principal office located at 670 9th Street, Suite 203, Arcata, California, 95521, and Humboldt County Department of Health and Human Services (DHHS), a government agency, with its principal office located at **507 F STREET, EUREKA, CA 95501.**

ODCHC received a grant from the County Medical Services Program (CMSP) Governing Board, covering three years, from March 1, 2008 through February 28, 2011, for direct services and administrative costs of delivering integrated behavioral health services to the residents of Humboldt and Del Norte Counties.

The term of this Agreement is from March 1, 2008 through February 28, 2011. ODCHC and Humboldt County Department of Health and Human Services, agree as follows:

Humboldt County Department of Health and Human Services, agrees to:

- ◆ Assess ODCHC's most severe cases that fall under our target populations, within available resources and processes.
- ◆ With patient consent, adhering to HIPPA regulations, records shall be shared between stated entities to ensure continuity of care.

ODCHC agrees to:

- ◆ Accept referrals of care to their medical providers for general medical, mental health and medications management of Humboldt County Department of Health and Human Services, Mental Health Branch's stabilized mental health patients.
- ◆ With patient consent, adhering to HIPPA regulations, records shall be shared between stated entities to ensure continuity of care.

Phillip R. Crandall, DHHS Director

Date

Herrmann Spetzler, ODCHC Executive Director

Date

**MEMORANDUM OF AGREEMENT
REGARDING THE CMSP BEHAVIORAL HEALTH PILOT PROJECT GRANT TO
OPEN DOOR COMMUNITY HEALTH CENTERS (ODCHC) FOR BEHAVIORAL
HEALTH CONSULTATIONS BETWEEN ODCHC AND DEL NORTE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
MENTAL HEALTH BRANCH**

This agreement is made on January 25, 2008 between Open Door Community Health Centers (ODCHC) a tax exempt, California private nonprofit corporation, with its principal office located at 670 9th Street, Suite 203, Arcata, California 95521 and Del Norte County Department of Health and Human Services, Mental Health Branch (MHB), a government agency, with its principal office located at 206 Williams Drive, Crescent City, California 95531.

ODCHC received a grant from the County Medical Services Program (CMSP) Governing Board, covering three years, from March 1, 2008 through February 28, 2011, for direct services and administrative costs of delivering integrated behavioral health services to the residents of Humboldt and Del Norte Counties.

The term of this Agreement is from March 1, 2008 through February 28, 2011. ODCHC and MHB agree as follows:

MHB agrees to:

- ◆ Assess Del Norte Community Health Center's most severe cases that fall under our target populations within available resources and processes.
- ◆ With patient consent, adhering to HIPPA regulations, records shall be shared between stated entities to ensure continuity of care.

ODCHC agrees to:

- ◆ Accept referrals of care to their medical providers for general medical, mental health and medication management of MHB's most stable mental health patients.
- ◆ With patient consent, adhering to HIPPA regulations, records shall be shared between stated entities to ensure continuity of care.

Gary Blatnick, Director

Date

Hermann Spetzler, ODCHC Executive Director

Date

1. Scope of Work

Contractor shall manage funding for a Mental Health Services Act (MHSA) Mental Health Specialty Pool for specialty outpatient services through the authorization of requests and payment of resulting invoices for mental health services (including but not limited to outreach, screening for co-occurring disorders, assessment and treatment including medication support services). This funding does not cover emergency mental health services or physical health primary care services. All approvals for service shall be in compliance with MHSA requirements.

- 1.1. **The MHSA Specialty Pool** is intended to pay for medically necessary, diagnostic, therapeutic outpatient services and medication support services for Seriously Mentally Ill (SMI) adults as defined by the MHSA and California Welfare and Institutions Code 5600.3 for whom there is no other funding source (Medi-Cal, County Medical Services, and private insurance). Particular efforts shall be made to outreach un-served and underserved Latino and Asian and Pacific Islander clients.
- 1.2. **The MHSA Mental Health Adult Specialty Pool** funding is intended to provide mental health assessment and short-term treatment integrated with primary care services to Seriously Mentally Ill (SMI) adults age 18 to 59. Services shall include assessment and screening for co-occurring disorders; screening for domestic violence; brief individual and/or group treatment that is strength-based, client- driven, focuses on resiliency and is culturally and linguistically competent. SMI is defined in the Welfare and Institutions Code. Priority consideration shall be given to un-served and underserved Latino and Asian adults in San Diego County.
 - 1.2.1. Community Clinics and Health Center (CCHC) mental health providers shall complete an assessment according to the Adult Mental Health (AMHS) standards that contains all elements as required by the Adult Uniform Medical Record form MHS-912.
 - 1.2.2. CCHC mental health providers shall complete a client driven, strengths based service plan with measurable goals and objectives.
 - 1.2.3. Treatment will be provided by an appropriately trained and supervised psychiatrist, psychologist, marriage and family therapist (MFT), licensed clinical social worker (LCSW), registered MFT intern, registered social work intern, or psychology intern. The reimbursement rate for services will be determined by the Contractor, but initially will be based on Medicare rates.
- 1.3. **IMPACT PROGRAMS.** The **IMPACT (Improving Mood Promoting Access to Collaborative Care Treatment)** program will be implemented at identified clinics.
 - 1.3.1. **IMPACT:** CCC will subcontract with seven sites to implement the IMPACT model for seriously depressed adult patients ages 18 to 59 years. These sites are: XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX. As described in CCHC subcontracts, MHSA funding will cover the cost of 1) part-time depression care managers; 2) depression medication for up to one year; 3) up to four primary care physician visits in which the physician will prescribe and/or monitor prescription medication; 4) consulting psychiatry services; and 5) other consulting and technical assistance.
- 1.4. **The Short Term Medication Pool** is intended to provide clients with short-term access to medications in emergency situations and/or when medication services are deemed medically necessary based upon psychiatric evaluation and when there is no other funding source available. Contractor and its CCHC subcontractors shall assess client eligibility for Pharmacy Assistance Programs (PAP's) or any other known resources for which the consumer may be eligible within 90 days of issuance of the first prescription. Longer terms may be allowed with prior County approval. When a client is referred to a community-based agency for assistance, the clinic is no longer responsible for medications or Pharmacy Assistance Programs.
- 1.5. Adult clients in need of longer term treatment and/or medication management that meet the criteria for SMI, shall be referred to other providers within the County adult system of care through the Access and Crisis Line

within four months. If services are not available in proximity to the patient's home or work, as is the case in much of rural San Diego County, longer terms may be allowed with prior County approval.

- 1.6. **Training:** Contractor shall provide training or access to County training for community clinic primary care and mental health providers by 11/1/07 on:

1.6.1. County Mental Health Services trainings, including information on the Adult systems of care, wraparound principles and approach, domestic violence, and the Comprehensive, Continuous, Integrated System of Care (CCISC).

1.6.1.1. Care Coordination/Consultation with San Diego Mental Health Services (SDMHS): The goal of this training is to facilitate smooth client transfers between primary care mental health providers and the mental health system of care providers. Training shall include information on Title 9 medical necessity criteria for mental health, as well as on jointly developed procedures for joint clients.

1.6.2. Culturally competent service delivery. The goal of this training is to enhance the cultural competence of primary care physicians and mental health providers in the integration of physical and mental health care. Training may involve but not be limited to:

1.6.2.1. Increasing awareness of caregiver attitudes that could be barriers to service, including biases and prejudices,

1.6.2.2. Increasing knowledge of culture-specific way of understanding mental illness, and

1.6.2.3. Skill building to engage and treat persons from diverse cultural backgrounds with a mental illness.

1.6.3. Contractor shall provide training to CCHC subcontractors on common Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) categories treated by primary care physicians.

2. **Background**

The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in November 2004 and became effective January 1, 2005. The MHSA provides funding for expansion of mental health services in California. As required by the law, the County of San Diego, through the Health and Human Services Agency's (HHS), Mental Health Services Division, has completed the MHSA Community Services and Supports (CSS) Program and Expenditure Plan. The MHSA CSS Plan outlines proposed MHSA funded programs and services to be provided locally for Fiscal Year 2005-06 through Fiscal Year 2007-08. San Diego County's initial annual allocation will be used to expand and enhance programs for underserved and un-served county residents who are eligible and in need of public mental health services. The County's MHSA CSS Plan will be updated annually based on funding revisions and other program considerations.

The MHSA provides access to services for identified un-served/underserved clients in new or expanded programs, but may not supplant existing services. The first MHSA expansion will target SED children and youth and SMI adults. This program is intended to integrate mental health services in the primary care clinics and strengthen the relationship of primary care and the public mental health system.

3. **Goals**

The goals of the pooled specialty care services are to provide mechanisms to refer clients and pay for mental health specialty services and short-term medications for adult clients living with serious mental illness. Contractor shall monitor pool funds, authorize requests for services as appropriate, support pool users (community clinics) by offering technical assistance and program training, and pay bills for authorized services rendered.

4. Outcome Objectives

- 4.1. 95% of all service pool requests for authorization shall be approved or denied within 48 hours of receipt on normal business days. This limit shall not apply to incomplete requests. A new 48-hour period will begin upon receipt of the missing information.
- 4.2. 100% of all authorized visits completed will be reimbursed within 30 days of receipt of invoices from CCHC providers.
- 4.3. Contractor shall report the number of unduplicated clients authorized for Mental Health Specialty services and the number of unduplicated clients for which claims were paid for Mental Health Specialty services.
- 4.4. Contractor shall authorize and ensure the provision of mental health services for at least a minimum of 565 adult clients in FY07-08 and annually thereafter.
- 4.5. Contractor shall separately report the number of assessments and brief treatment procedures authorized, claimed, and reimbursed.
- 4.6. Contractor shall separately report the number of prescriptions authorized, claimed, and reimbursed.
- 4.7. Contractor shall report the number of unduplicated clients authorized to receive Short-Term Medications and the number of unduplicated clients for which claims were paid for short-term medications.

5. Target Population

Contractor shall authorize and pay for services to the target population who are adults ages 18-59 with serious mental illness who are eligible for MHSA services in all regions of the county. Contractor shall authorize and pay for services for adults with serious depression who are enrolled in a clinic IMPACT program. Members of the target population are those clients who require mental health specialty services, limited short-term medication services, and/or outreach and support services that are not covered through any other funding source. The uninsured and underserved target population includes clients and families with incomes below 200% of the Federal Poverty Level (FPL).

6. Geographic Service Area

Services shall be available to clients who reside in all regions of San Diego County.

7. Service Locations and Hours of Operation

- 7.1. Contractor shall provide administrative services Monday through Friday, from 8:30 a.m. to 5 p.m. daily, excluding scheduled holidays.
- 7.2. Contractor shall provide County with a list of holidays during which Contractor shall be closed.
- 7.3. Contractor shall not modify the above days and hours without prior written approval by the County.

8. Specific Requirements for Service Delivery

- 8.1. Contractor shall establish and administer accounts to pay for pre-authorized services for the eligible target population (SMI adult [including Transitional Age Youth {TAY},aged 18-59). As the fiscal agent, Contractor shall be responsible for subcontracting with CCHC’s offering mental health services.
- 8.2. Contractor shall ensure that broad, geographically and culturally and linguistically competent service providers are available for clinic clients’ use.

- 8.3. Contractor and its providers shall establish and maintain effective partnerships with other community mental health organizational providers and other community organizations.
- 8.4. Contractor shall provide copies of payment agreements with CCHC subcontractors to the County annually.
- 8.5. Contractor shall provide copies of rosters of participating CCHC subcontractors to the County on request. Rosters shall include at a minimum the name and location of the clinic, telephone number, and list of providers at each clinic site.
- 8.6. Contractor shall develop a mechanism to ensure that all participating clinics are aware of the process to access the pools and eligibility requirements. An instruction sheet outlining how to access services shall be distributed to all participating providers
- 8.7. Contractor shall ensure that all printed materials shall specify that services are funded by the Mental Health Services Act (MHSA) through the County of San Diego, Health and Human Services Agency.
- 8.8. Contractor shall maintain a Policies and Procedures Manual that has been approved by the County. Contractor shall distribute the Policies and Procedures Manuals to all participating clinics by 11/1/07. Contractor shall develop and issue revisions as appropriate and with prior approval of the County.
- 8.9. Contractor shall verify that all required elements of the authorization request form are complete before processing the request.
- 8.10. Contractor shall notify the originator of incomplete forms as soon as reasonably possible, not to exceed the 48 hours of receipt on normal business days compliance turnaround time. The 48-hour turnaround time requirement shall not apply until complete information is received.
- 8.11. Prior to authorization of services, Contractor shall ensure that an assessment is completed according to the Adult Mental Health (AMHS) standards and contains all elements as required by the Adult Uniform Medical Record form MHS-912.
- 8.12. Prior to authorization, Contractor shall ensure that a complete client driven, strengths based Service Plan is developed which contains measurable goals and objectives to determine client success. Service Plan goals and planned interventions shall be consistent with the mental health assessment, client diagnosis and the client's cultural group identification.
- 8.13. Contractor shall authorize up to 12 visits per year for adult clients. Longer terms may be allowed with prior County approval.
- 8.14. Contractor shall provide services that are clinically indicated utilizing a short term evidence based therapy approach such as IMPACT or problem solving therapy.
- 8.15. With County approval, Contractor may limit approval of requests for authorization from clinics/providers, or payment of invoices from participating specialists/providers, that do not comply with all information-reporting requirements.
- 8.16. Contractor shall ensure that procedures are in place to expedite time-sensitive requests.
- 8.17. Contractor shall document the time and date when authorization requests were received and returned to their originators to verify compliance with the 48-hour turn around time requirement.
- 8.18. Contractor shall ensure that no other funding sources are available for the requested services and service providers refer clients to other funding sources if available. If Medi-Cal or other insurance becomes available, contractor shall ensure that clients are served through that funding source and not the MHSA.

- 8.19. Contractor shall develop and maintain an authorization system to ensure that all authorizations for service are related to mental health services and that such authorization meets the program requirements.
- 8.20. Contractor shall track authorized requests for service and process claims as received.
- 8.21. Contractor shall submit monthly claims to the County. Contractor shall monitor pool utilization and submit reports quarterly and as required to the County.
- 8.22. Contractor shall verify that the client has signed an authorization for release of information and the release accompanies the service request.
- 8.23. Contractor shall make available for examination by the County all authorization requests and billing records relative to clients for quality assurance or financial audit purposes. All personally identifiable information shall be maintained in accordance with the laws of the State of California, subject to ethical and legal confidentiality requirements. Except as otherwise specified herein or allowed by law, Contractor shall not be required to disclose medical record information about any client. All other disclosures shall be accompanied by the client's written consent to release such information.
- 8.24. Contractor shall ensure that services provided are entered into the County MIS system for client and service tracking. Data entry shall occur according to the agreed upon timeframe between the County and Contractor.
- 8.25. Contractor shall ensure that its service providers maintain an average time for access to care of less than nine (9) days for adult clients.
- 8.26. Contractor shall ensure that providers adhere to the following Mental Health requirements:
 - 8.26.1. Dual Diagnosis Strategic Plan
 - 8.26.2. Cultural Competence Plan
 - 8.26.3. CA Penal Code and Welfare and Institutions Code.
 - 8.26.4. AMHS Assessment form requirements
 - 8.26.5. AMHS Organizational Provider Operations Handbook
 - 8.26.6. AMHS Organizational Provider Financial Eligibility and Billing Manual

9. Data Collection, Records and Reports

- 9.1. Monthly Client Count Report
 - 9.1.1. Contractor shall submit a monthly report by the 15th of each month that lists the number of unduplicated clients served for the month and YTD by age group and clinic.
- 9.2. Monthly Status Reports (MSR)
 - 9.2.1. Contractor shall submit report by the 15th of each month on progress in achieving process and outcome objectives. The June report shall be an annual summary. County shall provide the format for submission of the MSR data.
- 9.3. Client Data Collection
 - 9.3.1. Contractor shall collect client demographic data including but not limited to age, ethnicity sex,

insurance, income, and other factors, in a format provided by the County and consistent with the demographic requirements outlined by the County, State, and Federal regulations.

- 9.3.2. Contractor shall collect demographic information, including but not limited to:
 - 9.3.2.1. Age
 - 9.3.2.2. Gender
 - 9.3.2.3. Sexual Orientation
 - 9.3.2.4. County region of primary residence
 - 9.3.2.5. Residence
 - 9.3.2.6. Ethnicity
 - 9.3.2.7. Language Preference
 - 9.3.2.8. Language(s) spoken
 - 9.3.2.9. Marital Status
 - 9.3.2.10. Veteran's Status
 - 9.3.2.11. Level of Education
- 9.3.3. Contractor shall collect specific client information at the initial request for service, including but not limited to:
 - 9.3.3.1. Client name
 - 9.3.3.2. Client mailing address and telephone number
 - 9.3.3.3. Social Security Number (if available)
 - 9.3.3.4. Date of birth
 - 9.3.3.5. Place of birth
 - 9.3.3.6. Referring clinic contact information
 - 9.3.3.7. Referred specialist contact information
 - 9.3.3.8. List of requested services, signatures of referring clinic staff verifying that the client meets eligibility requirements.
- 9.3.4. Contractor shall ensure service providers achieve the following outcome objectives for clients:
 - 9.3.4.1. 100% of adult clients shall receive an assessment of their substance use and history of domestic violence upon admission.
- 9.3.5. Contractor shall propose additional outcome measures to evaluate services.

9.4. System-wide County Management Information System (MIS)

9.4.1. Contractor shall use the County Mental Health Services information and data collection system for data collection.

9.4.2. Contractor shall develop written policies and procedures that address security, confidentiality, access, and operations.

9.5. Supporting Documentation

9.5.1. Contractor shall have written documentation available for review by County upon request.

10. Quality Management and Utilization Review

10.1. Quality Management Plan: Contractor shall develop and submit to the County a written Quality Management (QM) Plan by May 31st of each contract year that describes the process for continually assessing the Contractor's effectiveness in achieving the goals and objectives of this agreement.

Contractor shall develop a QM plan that includes the following components:

10.1.1. Internal QM Committee

10.1.2. Written policies and procedures

10.1.3. Process for conducting internal review of client/claim files

10.1.4. Mechanism and timeline for obtaining client feedback

10.1.5. QM Plan implementation

10.1.6. Identification of the structure, process, and outcomes for QM program.

10.2. Quality Management Committee: Contractor shall have an internal QM Committee with the following responsibilities:

10.2.1. Develop, review, and revise the QM plan on an annual basis.

10.2.2. Assess program outcomes and make recommendations for improvement of program services

10.2.3. Develop plans for corrective action for identified program deficiencies, review and action of results of process and outcome data, and review and action from client/provider feedback.

10.2.4. Contractor shall maintain written minutes of all meetings of the QM Committee.

10.3. QM Policies and Procedures:

10.3.1. Contractor shall have written policies and procedures for development and implementation of the QM Plan.

10.3.2. Contractor shall review and revise written policies and procedures annually, with approval and signature by the Executive Director or designee.

11. Special Terms and Conditions

11.1. Complaint Process:

Contractor shall have written policies and procedures for a complaint process. The policy shall identify staff responsible, an appeal process, tracking system, follow-up procedures, and a timeline. Contractor shall use relevant Federal, State, and County regulations for investigating and resolving complaints. A copy of the complaint policy shall be provided to participating service providers. Complaints and investigation results shall be forwarded to County within 24 hours of both the receipt and resolution of the complaint.

11.2. Confidentiality Training:

Contractor shall develop a written policy on confidentiality. Contractor shall train all service providers and volunteers working under this agreement. All service providers and volunteers shall sign a confidentiality agreement, which will be kept by Contractor.

11.3. Treatment of Individuals with Confirmed Mental Health Diagnosis:

Services provided under the terms of this Agreement shall only be provided to eligible individuals, that are adults with a confirmed diagnosis of Serious Mental Illness (SMI) or adults with serious depression as identified in this Statement of Work. Verification shall be provided to County upon request.

11.4. Fees:

Contractor shall ensure that service providers financially screen according to their customary sliding fee scale to assess fees for services reimbursed under the terms of this Agreement. No client shall be denied services due to lack of ability to make payment.

11.5. Bilingual Access:

Contractor shall ensure that service provider staff can provide bilingual/bicultural services to individuals who need or prefer to communicate in their own language. If there are no staff that can perform this function, contractor shall develop alternate methods to ensure that language appropriate services are available.

6.6 MHSA Funding Adjustments

To assure expenditure of all MHSA funds within the contract period, contracts with projected savings are subject to reduction by the County and contracts with projected over expenditures may be subject to an increase. The County is authorized to issue a unilateral contract amendment for a total change in the contract price by 10%, not to exceed fifty thousand dollars (\$50,000). Contractor shall accept any reduction or increase in funding.

1. Scope of Work

Contractor shall manage funding for a Mental Health Services Act (MHSA) Mental Health Specialty Pool for specialty older adult outpatient services through the authorization of requests and payment of resulting invoices for mental health services (including but not limited to outreach, screening for co-occurring disorders, assessment, and treatment including medication support services). This funding does not cover emergency mental health services or primary care services. All approvals for service shall be in compliance with MHSA guidelines.

- 1.1. **The MHSA Flex Fund** is intended to pay for medically necessary, diagnostic, therapeutic outpatient services, and medication support services for Seriously Mentally Ill (SMI) Older Adults as defined by the MHSA and California Welfare and Institutions Code 5600.3 for whom there is no other funding source (Medi-Cal, County Medical Services, and private insurance). Particular efforts shall be made to outreach un-served and underserved Latino and Asian and Pacific Islander clients aged 60 and over.
- 1.2. **The MHSA Mental Health Older Adult Specialty Pool** funding is intended to pay for integrated mental health services such as outreach, education and engagement, peer/family counseling and support, social services referrals, advocacy, transportation, screening, assessment, referral, linkages, consultative services, and brief therapeutic outpatient services with priority to un-served and underserved Latino and Asian older adults in San Diego County.
- 1.3. Services shall be age and culturally/linguistically appropriate, based on evidence based approaches and designed to meet the various developmental needs of the clients. The services to be provided shall include but not be limited to:
 - 1.3.1. Outreach, Education and Engagement, Individual and/or Group Peer Support and Transportation Services: Contractor shall subcontract with to conduct outreach, education, and engagement activities to assist older adults and their families in accessing mental health and primary care services and staying in treatment. The majority of paid staff they recruit, hire, and train shall be older adult mental health consumers or family members. The clinics will not be able to ask about or document age during the hiring process, however, clinics will hire individuals, who based on appearance, would be classified as older adults. The balance shall be experienced family care givers of older adult individuals with mental illness. This provision will not apply to staff hired prior to November, 1, 2007. Senior peer promotoras and outreach workers shall be trained to provide cultural/linguistic and ethnic/gender specific outreach, education, engagement, peer counseling and support, social service referrals, advocacy, and transportation referrals or resources for isolated and hard to reach older adults. Services shall include client and family/caregiver information, education and advocacy on how to navigate the mental health system, and peer support to help them through difficult times.
 - 1.3.1.1. Senior Peer Promotora Programs: Contractor shall subcontract with five (5) to develop and implement senior peer promotora programs: XXXX, which will implement the Adultos Activos Y Unidos Latino Senior Peer Promotora Program; XXXX (4-5 promotoras); XXXX (10 promotoras); XXXX (4-5 promotoras) and XXXX (10 promotoras). XXXX subcontractors shall assure that Senior Peer Promotora program staff include consumers and/or their family members, and shall engage clients, their family members and/or their caregivers as appropriate. Supervision shall be provided to the Senior Promotores outreach workers as well as incentives to promote retention.
 - 1.3.1.2. Senior Transportation Services: Transportation services shall be available during regular business hours to ensure clients' and family/caregivers' timely access to services, whether through a transportation voucher system, contracted van service, or other means.

- 1.3.1.2.1. Transportation services shall be made available to serve individuals confined to a wheelchair.
 - 1.3.1.2.2. Contractor shall participate in an interagency collaborative that will seek to develop countywide Consolidated Transportation Services.
- 1.4. **Screening and Assessment:** XXXX mental health providers will provide the client with an age appropriate, culturally and linguistically competent, comprehensive and integrated screening and bio-psychosocial assessment for mental health, substance abuse, domestic violence, and medical needs. Linkages, education, and referral to other services will be provided as needed for clients identified as needing a full range of services and supports.
 - 1.4.1. XXXX mental health providers shall complete an assessment consistent with the Adult/Older Adult Mental Health Standards (AOAMHS), and that contains all elements of the Adult Uniform Medical Record form MHS-912.
- 1.5. **Linkages, Information and Referral:** XXXX physical and mental health providers will provide the client with appropriate linkages, information, and referral to mental health services, health care services, social services, housing, employment services, advocacy, and other needed services.
 - 1.5.1. XXXX subcontractors will maintain an up-to-date listing of community resources adequate to meet the needs of the target population.
 - 1.5.2. When appropriate, XXXX staff will determine the client’s eligibility for health coverage programs, pharmacy assistance programs, or other health-related programs as needed.
- 1.6. **Brief Treatment:** The MHSA specialty pool shall pay for short-term medically necessary, diagnostic, therapeutic outpatient services and medication support services for Seriously Mentally Ill (SMI) Older Adults for whom there is no other funding source (Medi-Cal, County Medical Services, and private insurance), as well as older adults with serious depression and other mental illness. Brief treatment to include interventions such as IMPACT or other therapeutic approaches as clinically indicated. Treatment will be provided by an appropriately trained and supervised psychiatrist, psychologist, marriage and family therapist (MFT), licensed clinical social worker (LCSW), registered MFT intern, registered social work intern, or psychology intern. The reimbursement rate for services will be based on Medicare rates.
- 1.7. **IMPACT PROGRAMS.** The IMPACT (Improving Mood Promoting Access to Collaborative Care Treatment) program will be implemented at identified clinics.
 - 1.7.1. IMPACT: CCC will subcontract with seven sites to implement the IMPACT model for seriously depressed adult patients ages 60 and over. These sites are: XXXX, XXXX, XXXX, XXXX, XXXX, XXXX, and XXXX. As described in XXXX subcontracts, MHSA funding will cover the cost of 1) part-time depression care managers; 2) depression medication for up to one year; 3) up to four primary care physician visits in which the physician will prescribe and/or monitor prescription medication; 4) consulting psychiatry services; and 5) other consulting and technical assistance.
 - 1.7.2. IMPACT Model & Senior Peer Program Co-location: To insure effective implementation of both of these programs, the IMPACT model and the Senior Peer Promotora Program staff will be co-located at the same site. The following are the locations where programs will be co-located: Escondido (XXXX), San Marcos (XXXX), City Heights (XXXX), San Ysidro (XXXX), and Central San Diego (XXXX).

- 1.8. **The Short Term Medication Pool** is intended to provide clients with short-term access to medications in emergency situations and/or when medication services are deemed medically necessary based upon psychiatric evaluation and when there is no other funding source available. Contractor and its XXXX subcontractors shall assess client eligibility for Pharmacy Assistance Programs (PAP's) or any other known resources for which the consumer may be eligible within 90 days of issuance of the first prescription. Longer terms may be allowed with prior County approval. When a client is referred to a community-based agency for assistance, the clinic is no longer responsible for medications or Pharmacy Assistance Programs.

- 1.9. **Training:** In partnership with local academic institutions, Contractor shall develop and implement a Primary Care /Mental Health Provider Training Curricula.
 - 1.9.1. Contractor shall train XXXX subcontractors' health and mental health providers. Providers shall receive training and education that supports increased coordination and integration of mental health in primary care and other health services by 11/1/07.
 - 1.9.1.1. Training for health care and mental health providers in primary care settings shall include but not be limited to: 1) Older Adult Mental Health and Aging process, 2) Clinical Practice Guidelines; 3) Screening /Assessment Protocols (to include protocols for alcohol, substance abuse and domestic violence); 4) Title 9 medical necessity criteria for mental health and referral and liaison with San Diego County Mental Health Services (SDCMHS), 5). Chronic disease management; 6) Cultural Competence.
 - 1.9.1.2. This training shall also include specialized training in Geriatric Mental Health, Evidence-based practices in older adults, and on Integration and Coordination of Mental Health services in Primary Care settings.
 - 1.9.1.3. One time funding for the provision of this training curricula, materials and other related expenses has been included with this procurement.
 - 1.9.2. Training for Senior Peer Promotores/ Educators: In coordination with the MHS Older Adult Mental Health Coordinator, Contractor shall coordinate a 40-80 hour training program for up to sixty (60) seniors and/or to family/caregivers interested in providing outreach, education, and emotional support to other seniors and their families, and to licensed professionals interested in providing training, clinical supervision, and support to cultural /ethnic and linguistic specific senior peer promotores/health educator programs.
 - 1.9.2.1. This training curricula shall include but not be limited to the following topics: 1) Senior Peer Promotora/Community Health Educators: Definition, characteristic, role, work environment, and cultural issues, 2) Culturally competent outreach, engagement, education, community resources, linkages, information, and referral with older adults , 3) Senior Peer Counseling Skills and Confidentiality, 4) The aging process , 5) Older Adult Mental Health, 6) Medications Use and Misuse, 7) Substance Abuse, 8) Wellness, habilitation, recovery and self-sufficiency, 9) Care Management and record keeping, 10) Family/ caregiver support.
 - 1.9.2.2. One time funds for training curricula, materials, and other related expenses to the provision of this training is included with this procurement.

- 1.10. Contractor shall ensure that all subcontracted staff is appropriately trained:
 - 1.10.1. All subcontracted staff shall have received initial program orientation and training within 30 days from date of hire

1.10.2. All subcontracted staff shall have completed training for Primary Care Providers by 11/1/07 or within ninety (90) days of employment if employed after the initial training occurred.

1.10.3. All Senior Peer/Family Promotor (a) Program staff shall complete training by 12/15/07.

2. **Background**

The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in November 2004 and became effective January 1, 2005. The MHSA provides funding for expansion of mental health services in California. As required by the law, the County of San Diego, through the Health and Human Services Agency's (HHSA), Mental Health Services Division, has completed the MHSA Community Services and Supports (CSS) Program and Expenditure Plan. The MHSA CSS Plan outlines proposed MHSA funded programs and services to be provided locally for Fiscal Year 2005-06 through Fiscal Year 2007-08. San Diego County's initial annual allocation will be used to expand and enhance programs for underserved and un-served county residents who are eligible and in need of public mental health services. The County's MHSA CSS Plan will be updated annually based on funding revisions and other program considerations.

The MHSA provides access to services for identified un-served/underserved clients in new or expanded programs, but may not supplant existing services. The first MHSA expansion will target Seriously Emotionally Disturbed (SED) children and youth and Seriously Mentally Ill (SMI) adults. This program is intended to integrate mental health services in the primary care clinics and strengthen the relationship of primary care and the public mental health system.

3. **Goals**

The goals of the pooled specialty care services are to provide mechanisms to refer clients and pay for mental health specialty services and short-term medications for older adult clients living with serious mental illness. Contractor shall monitor pool funds, authorize requests for services as appropriate, support pool users (community clinics) by offering technical assistance and program training, and pay bills for authorized services rendered.

4. **Outcome Objectives**

- 4.1. 95% of all service pool requests for authorization shall be approved or denied within 48 hours of receipt on normal business days. This limit shall not apply to incomplete requests. A new 48-hour period will begin upon receipt of the missing information.
- 4.2. 100% of all authorized visits completed will be reimbursed within 30 days of receipt of invoices from XXXX providers.
- 4.3. Contractor shall report the number of unduplicated clients authorized for Mental Health Specialty services and the number of unduplicated clients for which claims were paid for Mental Health Specialty services.
- 4.4. Contractor shall authorize and ensure the provision of mental health services for at least 244 SMI older adult clients in FY07-08 and annually thereafter.
- 4.5. Contractor shall separately report the number of outreach, screenings, assessments, and brief treatment procedures authorized, claimed, and reimbursed.
- 4.6. Contractor shall separately report the number of prescriptions authorized, claimed, and reimbursed.
- 4.7. Contractor shall report the number of unduplicated clients authorized to receive Short-Term Medications and the number of unduplicated clients for which claims were paid for short-term medications.

5. **Target Population**

Contractor shall authorize and pay for services to the target population who are older adults with serious mental illness aged 60 and over who are eligible for MHSA services in all regions of the county. Contractor shall authorize

and pay for services for older adults with serious depression who are enrolled in a clinic IMPACT program. Members of the target population are those clients who require mental health specialty services, limited short-term medication services, and/or outreach and support services that are not covered through any other funding source. The uninsured and underserved target population includes clients and families with incomes below 200% of the Federal Poverty Level (FPL).

6. Geographic Service Area

Services shall be available to clients who reside in all regions of San Diego County.

7. Service Locations and Hours of Operation

- 7.1. Contractor shall provide administrative services Monday through Friday, from 8:30 a.m. to 5 p.m. daily, excluding scheduled holidays.
- 7.2. Contractor shall provide County with a list of holidays during which Contractor shall be closed.
- 7.3. Contractor shall not modify the above days and hours without prior written approval by the County.

8. Specific Requirements for Service Delivery

- 8.1. Contractor shall establish and administer accounts to pay for pre-authorized services for the eligible target populations (SMI older adults aged 60 and over). As the fiscal agent, Contractor shall be responsible for subcontracting with XXX's offering mental health services.
- 8.2. Contractor shall ensure that broad, geographically and culturally and linguistically competent service providers are available for clinic clients' use.
- 8.3. Contractor and its providers shall establish and maintain effective partnerships with other community mental health organizational providers, substance abuse and social service agencies, and other Aging Network community organizations.
- 8.4. Contractor shall develop a consultant agreement with a professional individual who is Board certified geriatric psychiatrist for a minimum of 3 hours per week. As the most experienced mental health provider, the geriatric psychiatrist will have the following responsibilities:
 - 8.4.1. Consultant shall be available during business hours, via beeper/phone,
 - 8.4.1.1. To consult / discuss specific cases.
 - 8.4.1.2. To provide weekly clinical consultation and supervision with all subcontracted program staff to include the IMPACT Project staff.
 - 8.4.1.3. Direct patient consultation in treatment resistant cases and as needed and to perform face-to-face evaluations.
 - 8.4.1.4. Active participation in all client utilization and outcome evaluation activities.
 - 8.4.1.5. Technical assistance for the design and implementation of the Primary Care Provider Training and on-going training as needed.
- 8.5. Contractor shall provide copies of payment agreements with XXXX subcontractors to the County annually.
- 8.6. Contractor shall provide copies of rosters of participating XXXX subcontractors available to the County on request. Rosters shall include at a minimum the name and location of the clinic, telephone number, and list of providers at each clinic site.

- 8.7. Contractor shall develop a mechanism to ensure that all participating clinics are aware of the process to access the pools and eligibility requirements. An instruction sheet outlining how to access services shall be distributed to all participating providers.
- 8.8. Contractor shall ensure that all printed materials shall specify that services are funded by the Mental Health Services Act (MHSA) through the County of San Diego, Health and Human Services Agency.
- 8.9. Contractor shall maintain a Policies and Procedures Manual that has been approved by the County. Contractor shall distribute the Policies and Procedures Manuals to all participating clinics by 11/1/07. Contractor shall develop and issue revisions as appropriate and with prior approval of the County.
- 8.10. Contractor shall verify that all required elements of the authorization request form are complete before processing the request.
- 8.11. Contractor shall notify the originator of incomplete forms as soon as reasonably possible, not to exceed the 48 hours of receipt on normal business days compliance turnaround time. The 48-hour turnaround time requirement shall not apply until complete information is received.
- 8.12. Prior to authorization of services, Contractor shall ensure that an assessment is completed according to the Adult /Older Adult Mental Health (AMHS) standards and contains all elements as required by the Adult Uniform Medical Record form MHS-912.
- 8.13. Contractor shall authorize up to 12 visits per year per client. Longer terms may be allowed with prior County approval.
- 8.14. Contractor shall provide services that are clinically indicated utilizing a short term evidence based therapy approach such as IMPACT or problem solving therapy.
- 8.15. With County approval, Contractor may limit approval of requests for authorization from clinics/providers, or payment of invoices from participating specialists/providers, that do not comply with all information-reporting requirements.
- 8.16. Contractor shall ensure that procedures are in place to expedite time-sensitive requests.
- 8.17. Contractor shall document the time and date when authorization requests were received and returned to their originators to verify compliance with the 48-hour turn around time requirement.
- 8.18. Contractor shall ensure that no other funding sources are available for the requested services and service providers refer clients to other funding sources if available. If Medi-Cal or other insurance becomes available, contractor shall ensure that clients are served through that funding source and not the MHSA.
- 8.19. Contractor shall develop and maintain an authorization system to ensure that all authorizations for service are related to mental health services and that such authorization meets the program requirements.
- 8.20. Contractor shall track authorized requests for service and process claims as received.
- 8.21. Contractor shall submit monthly claims to the County. Contractor shall monitor pool utilization and submit reports quarterly and as required to the County.
- 8.22. Contractor shall verify that the client or the adult legally responsible for the client has signed an authorization for release of information and the release accompanies the service request.
- 8.23. Contractor shall make available for examination by the County all authorization requests and billing records relative to clients for quality assurance or financial audit purposes. All personally identifiable information shall be maintained in accordance with the laws of the State of California, subject to ethical and legal confidentiality requirements. Except as otherwise specified herein or allowed by law, Contractor

shall not be required to disclose medical record information about any client. All other disclosures shall be accompanied by the client’s written consent to release such information.

- 8.24. Contractor shall ensure that services provided are entered into the County MIS system for client and service tracking. Data entry shall occur according to the agreed upon timeframe between the County and Contractor.
- 8.25. Contractor shall ensure that its service providers maintain an average time for access to care of less than 10 days for adult clients.
- 8.26. Contractor shall ensure that providers adhere to the following Mental Health requirements:
 - 8.26.1. Older Adult Strategic Plan
 - 8.26.2. Dual Diagnosis Strategic Plan
 - 8.26.3. Cultural Competence Plan
 - 8.26.4. CA Penal Code and Welfare and Institutions Code.
 - 8.26.5. AMHS Assessment form requirements
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9. Data Collection, Records and Reports

- 9.1. Monthly Status Reports (MSR)
 - 9.1.1. Contractor shall submit report by the 15th of each month on progress in achieving process and outcome objectives. The June report shall be an annual summary. County shall provide the format for submission of the MSR data.
 - 9.1.2. Contractor shall collect client demographic data including but not limited to age, ethnicity, sex, insurance, income, and other factors, in a format provided by the County and consistent with the demographic requirements outlined by the County, State, and Federal regulations.
 - 9.1.3. Contractor shall collect specific client information at the initial request for service, including but not limited to:
 - 9.1.3.1. Client name
 - 9.1.3.2. Client mailing address and telephone number
 - 9.1.3.3. Social Security Number (if available)
 - 9.1.3.4. Date of birth
 - 9.1.3.5. Place of birth
 - 9.1.3.6. Referring clinic contact information
 - 9.1.3.7. Referred specialist contact information
 - 9.1.3.8. List of requested services, signatures of referring clinic staff verifying that the client meets eligibility requirements.
 - 9.1.4. Contractor shall collect demographic information, including but not limited to:

- 9.1.4.1. Age
- 9.1.4.2. Gender
- 9.1.4.3. Sexual Orientation
- 9.1.4.4. County region of primary residence
- 9.1.4.5. Residence
- 9.1.4.6. Ethnicity
- 9.1.4.7. Language Preference
- 9.1.4.8. Language(s) spoken
- 9.1.4.9. Marital Status
- 9.1.4.10. Veteran's Status
- 9.1.4.11. Level of Education
- 9.1.5. Contractor shall collect and report the number of unduplicated clients served by age group and data reflecting attainment of goals and objectives as stated under this agreement.
- 9.1.6. Contractor shall ensure that subcontracted service providers achieve the following outcome objectives for clients:
 - 9.1.6.1. 50% of all clients receiving services will report increased ability to participate in meaningful community activities such as: structured social, educational, and /or vocational opportunities
 - 9.1.6.2. 75% of clients receiving services will report not having been admitted or re-admitted to hospital due to mental health reasons while under the care of a XXXX subcontractor.
 - 9.1.6.3. 80% of all clients/family receiving services and peer support expressed satisfaction with services during and post services.
 - 9.1.6.4. 85% of all participants in the Primary Care Provider and Senior Peer Promotora training course evaluations shall demonstrate increased knowledge of the subject matter covered by the training.
 - 9.1.6.5. Contractor shall report outcomes related to the senior peer promotoras including a roster of promotoras for each clinic with the promotora's name, ethnicity, age, and languages spoken; a report of sites visited; the number of contacts made; the types of services provided; the number of referrals to clinics for mental health services; and other measures to be agreed upon between the contractor and the county.
 - 9.1.6.6. The senior peer outreach worker(s) will report sites visited; the number of contacts made; the types of services provided; the number of referrals to clinics for mental health services; and other measures to be agreed upon between the contractor and the county.
 - 9.1.6.7. Contractor shall report specific outcomes related to the IMPACT project including the number of unduplicated clients, the number of visits, the number of primary care visits needed by the patient for medication management by the primary care physician, and the number of psychiatric consults.

9.1.7. Process Outcomes

- 9.1.7.1. 100% of clients shall receive comprehensive and integrated mental health/ substance abuse screening.
- 9.1.7.2. 100% of clients shall receive a Domestic Violence assessment.
- 9.1.7.3. 100% of all clients shall receive a comprehensive geriatric assessment.
- 9.1.7.4. 75% of clients shall complete a client satisfaction survey and 85% or better shall expressed satisfaction with services.

9.1.8. The program site shall be welcoming to the various cultural populations in the community and to individuals with co-occurring disorders (COD) by providing materials, brochures, posters, and other information regarding cultural competence and COD.

9.2. System-wide County Management Information System (MIS)

- 9.2.1. Contractor shall use the County Mental Health Services information and data collection system for data collection.
- 9.2.2. Contractor shall develop written policies and procedures that address security, confidentiality, access, and operations.

9.3. Supporting Documentation

Contractor shall have written documentation available for review by County upon request.

10. Quality Management and Utilization Review

10.1. Quality Management Plan: Contractor shall develop and submit to the County a written Quality Management (QM) Plan by May 31st of each contract year that describes the process for continually assessing the Contractor’s effectiveness in achieving the goals and objectives of this agreement.

Contractor shall develop a QM plan that includes the following components:

- 10.1.1. Internal QM Committee
- 10.1.2. Written policies and procedures
- 10.1.3. Process for conducting internal review of client/claim files
- 10.1.4. Mechanism and timeline for obtaining client feedback
- 10.1.5. QM Plan implementation
- 10.1.6. Identification of the structure, process, and outcomes for QM program.

10.2. Quality Management Committee: Contractor shall have an internal QM Committee with the following responsibilities:

- 10.2.1. Develop, review, and revise the QM plan on an annual basis.
- 10.2.2. Assess program outcomes and make recommendations for improvement of program services
- 10.2.3. Develop plans for corrective action for identified program deficiencies, review and action of results of process and outcome data, and review and action from client/provider feedback.

10.2.4. Contractor shall maintain written minutes of all meetings of the QM Committee.

10.3. QM Policies and Procedures:

10.3.1. Contractor shall have written policies and procedures for development and implementation of the QM Plan.

10.3.2. Contractor shall review and revise written policies and procedures annually, with approval and signature by the Executive Director or designee.

11. Special Terms and Conditions

11.1. Complaint Process:

Contractor shall have written policies and procedures for a complaint process. The policy shall identify staff responsible, an appeal process, tracking system, follow-up procedures and a timeline. Contractor shall use relevant Federal, State, and County regulations for investigating and resolving complaints. A copy of the complaint policy shall be provided to participating service providers. Complaints and investigation results shall be forwarded to County within 24 hours of both the receipt and resolution of the complaint.

11.2. Confidentiality Training:

Contractor shall develop a written policy on confidentiality. Contractor shall train all service providers and volunteers working under this agreement. All service providers and volunteers shall sign a confidentiality agreement, which will be kept by Contractor.

11.3. Treatment of Individuals with Confirmed Mental Health Diagnosis:

Services provided under the terms of this Agreement shall only be provided to eligible individuals, that are older adults with a confirmed diagnosis of Serious Mental Illness (SMI) or adults with serious depression as identified in this Statement of Work. Verification shall be provided to County upon request.

11.4. Fees:

Contractor shall ensure that service providers financially screen according to their customary sliding fee scale to assess fees for services reimbursed under the terms of this Agreement. No client shall be denied services due to lack of ability to make payment.

11.5. Bilingual Access:

Contractor shall ensure that service provider staff can provide bilingual/bicultural services to individuals who need or prefer to communicate in their own language. If there are no staff that can perform this function, contractor shall develop alternate methods to ensure that language appropriate services are available.

6.6 MHSA Funding Adjustments

To assure expenditure of all MHSA funds within the contract period, contracts with projected savings are subject to reduction by the County and contracts with projected over expenditures may be subject to an increase. The County is authorized to issue a unilateral contract amendment for a total change in the contract price by 10%, not to exceed fifty thousand dollars (\$50,000). Contractor shall accept any reduction or increase in funding.

1. Scope of Work

Contractor shall manage funding for a Mental Health Services Act (MHSA) Mental Health Specialty Pool for specialty outpatient services through the authorization of requests and payment of resulting invoices for mental health services (including but not limited to outreach, screening for co-occurring disorders, assessment and treatment including medication support services). This funding does not cover emergency mental health services or physical health primary care services. All approvals for service shall be in compliance with MHSA requirements.

- 1.1. The MHSA Specialty Pool is intended to pay for medically necessary, diagnostic, therapeutic outpatient services and medication support services for Seriously Emotionally Disturbed (SED) children and youth as defined by the MHSA and California Welfare and Institutions Code 5600.3 for whom there is no other funding source (Medi-Cal, County Medical Services, and private insurance). Particular efforts shall be made to outreach un-served and underserved Latino and Asian and Pacific Islander clients.
- 1.2. The MHSA Mental Health Children's Specialty Pool funding is intended to provide mental health assessment and treatment integrated with primary care services to Seriously Emotionally Disturbed (SED) children and youth ages 0-17. Services shall include assessment and screening for co-occurring disorders; screening for domestic violence; individual, group and/or family therapy; and skill building activities that are strength-based, client and family driven, focus on resiliency and are culturally and linguistically competent.
 - 1.2.1. Community Clinics and Health Center (CCHC) mental health providers shall complete an assessment according to the Children's Mental Health (CMHS) standards that contains all elements as required by the CMHS Uniform Medical Record assessment form MHS-650.
 - 1.2.2. CCHC mental health providers shall complete a client driven, strengths based service plan with measurable goals and objectives.
 - 1.2.3. Treatment will be provided by an appropriately trained and supervised psychiatrist, psychologist, marriage and family therapist (MFT), licensed clinical social worker (LCSW), registered MFT intern, registered social work intern, or psychology intern. The reimbursement rate for services will be determined by the Contractor, but initially will be based on Medicare rates.
- 1.3. The Short Term Medication Pool is intended to provide clients with short-term access to medications in emergency situations and/or when medication services are deemed medically necessary based upon psychiatric evaluation and when there is no other funding source available. Contractor and its CCHC subcontractors shall assess client eligibility for Pharmacy Assistance Programs (PAP's) or any other known resources for which the consumer may be eligible within 90 days of issuance of the first prescription. Longer terms may be allowed with prior County approval. When a client is referred to a community-based agency for assistance, the clinic is no longer responsible for medications or Pharmacy Assistance Programs.
- 1.4. Children and youth may continue receiving services in the clinic setting for a full year, but shall not exceed 24 visits per year without prior county approval.
- 1.5. Training: Contractor shall provide training or access to County training for community clinic primary care and mental health providers by 11/1/07 on:
 - 1.5.1. County Mental Health Services trainings, including information on the Children's systems of care, wraparound principles and approach, domestic violence, and the Comprehensive, Continuous, Integrated System of Care (CCISC).
 - 1.5.1.1. Care Coordination/Consultation with San Diego Mental Health Services (SDMHS): The goal of this training is to facilitate smooth client transfers between primary care mental health providers and the mental health system of care providers. Training shall

include information on Title 9 medical necessity criteria for mental health, as well as on jointly developed procedures for joint clients.

1.5.2. Culturally competent service delivery. The goal of this training is to enhance the cultural competence of primary care physicians and mental health providers in the integration of physical and mental health care. Training may involve but not be limited to:

1.5.2.1. Increasing awareness of caregiver attitude that could be barriers to service, including biases and prejudices

1.5.2.2. Increasing knowledge of culture-specific way of understanding mental illness, and

1.5.2.3. Skill building to engage and treat persons from diverse cultural backgrounds with a mental illness

1.5.3. Contractor shall provide training to CCHC subcontractors on common Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) categories treated by primary care physicians.

2. Background

The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in November 2004 and became effective January 1, 2005. The MHSA provides funding for expansion of mental health services in California. As required by the law, the County of San Diego, through the Health and Human Services Agency's (HHSA), Mental Health Services Division, has completed the MHSA Community Services and Supports (CSS) Program and Expenditure Plan. The MHSA CSS Plan outlines proposed MHSA funded programs and services to be provided locally for Fiscal Year 2005-06 through Fiscal Year 2007-08. San Diego County's initial annual allocation will be used to expand and enhance programs for underserved and un-served county residents who are eligible and in need of public mental health services. The County's MHSA CSS Plan will be updated annually based on funding revisions and other program considerations.

The MHSA provides access to services for identified un-served/underserved clients in new or expanded programs, but may not supplant existing services. The first MHSA expansion will target SED children and youth and SMI adults. This program is intended to integrate mental health services in the primary care clinics and strengthen the relationship of primary care and the public mental health system.

3. Goals

The goals of the pooled specialty care services are to provide mechanisms to refer clients and pay for mental health specialty services and short-term medications for children and youth with serious emotional disturbance. Contractor shall monitor pool funds, authorize requests for services as appropriate, support pool users (community clinics) by offering technical assistance and program training, and pay bills for authorized services rendered.

4. Outcome Objectives

- 4.1. Contractor shall report the number of unduplicated clients seen for Mental Health Specialty services.
- 4.2. Contractor shall authorize and ensure the provision of mental health services for at least a minimum of 247 children in FY07-08 and annually thereafter
- 4.3. Contractor shall separately report the number of prescriptions reimbursed.
- 4.4. Contractor shall report the number of unduplicated clients authorized to receive Short-Term Medications.

- 4.5. Contractor shall authorize and pay for laboratory work requests made by psychiatrists at the participating clinics. The laboratory work will be paid out of the medication fund. Contractor shall report the number of laboratory work requests reimbursed.
- 4.6. Contractor shall submit a monthly report by the 15th of each month that lists the number of unduplicated clients served for the month and YTD by age group and clinic.

5. Target Population

Contractor shall authorize and pay for services to the target population who are children and youth ages 0 – 17 with serious emotional disturbance who are eligible for MHSA services in all regions of the county. Members of the target population are those clients who require mental health specialty services, limited short-term medication services, and/or outreach and support services that are not covered through any other funding source. The uninsured and underserved target population includes clients and families with incomes below 200% of the Federal Poverty Level (FPL).

6. Geographic Service Area

Services shall be available to clients who reside in all regions of San Diego County.

7. Service Locations and Hours of Operation

- 7.1. Contractor shall provide administrative services Monday through Friday, from 8:30 a.m. to 5 p.m. daily, excluding scheduled holidays.
- 7.2. Contractor shall provide County with a list of holidays during which Contractor shall be closed.
- 7.3. Contractor shall not modify the above days and hours without prior written approval by the County.

8. Specific Requirements for Service Delivery

- 8.1. Contractor shall establish and administer accounts to pay for pre-authorized services for each of the eligible target populations (children [including Transitional Age Youth {TAY}]). As the fiscal agent, Contractor shall be responsible for subcontracting with CCHC's offering mental health services.
- 8.2. Contractor shall ensure that broad, geographically and culturally and linguistically competent service providers are available for clinic clients' use.
- 8.3. Contractor and its providers shall establish and maintain effective partnerships with other community mental health organizational providers and other community organizations.
- 8.4. Contractor shall provide copies of payment agreements with CCHC subcontractors to the County annually.
- 8.5. Contractor shall provide copies of rosters of participating CCHC subcontractors to the County on request. Rosters shall include at a minimum the name and location of the clinic, telephone number, and list of providers at each clinic site.
- 8.6. Contractor shall develop a mechanism to ensure that all participating clinics are aware of the process to access the pools and eligibility requirements. An instruction sheet outlining how to access services shall be distributed to all participating providers.
- 8.7. Contractor shall ensure that all printed materials shall specify that services are funded by the Mental Health Services Act (MHSA) through the County of San Diego, Health and Human Services Agency.

- 8.8. Contractor shall maintain a Policies and Procedures Manual that has been approved by the County. Contractor shall distribute the Policies and Procedures Manuals to all participating clinics by 11/1/07. Contractor shall develop and issue revisions as appropriate and with prior approval of the County.
- 8.9. Contractor shall verify that all required elements of the authorization request form are complete before processing the request.
- 8.10. Contractor shall notify the originator of incomplete forms as soon as reasonably possible, not to exceed the 48 hours of receipt on normal business days compliance turnaround time. The 48-hour turnaround time requirement shall not apply until complete information is received.
- 8.11. Prior to authorization of services, Contractor shall ensure that an assessment is completed according to the Children's Mental Health (CMHS) standards and contains all elements as required by the CMHS Uniform Medical Record assessment form MHS-650.
- 8.12. Prior to authorization, Contractor shall ensure that a complete client driven, strengths based Service Plan is developed which contains measurable goals and objectives to determine client success. Service Plan goals and planned interventions shall be consistent with the mental health assessment, client diagnosis and the client's cultural group identification.
- 8.13. Contractor shall authorize up to 24 visits per year per client for children and youth. Longer terms may be allowed with prior County approval.
- 8.14. Contractor shall provide services that are clinically indicated utilizing a short term therapy approach.
- 8.15. With County approval, Contractor may limit approval of requests for authorization from clinics/providers, or payment of invoices from participating specialists/providers, that do not comply with all information-reporting requirements.
- 8.16. Contractor shall ensure that procedures are in place to expedite time-sensitive requests.
- 8.17. Contractor shall document the time and date when authorization requests were received and returned to their originators to verify compliance with the 48-hour turn around time requirement.
- 8.18. Contractor shall ensure that no other funding sources are available for the requested services and service providers refer clients to other funding sources if available. If Medi-Cal or other insurance becomes available, contractor shall ensure that clients are served through that funding source and not the MHSA.
- 8.19. Contractor shall develop and maintain an authorization system to ensure that all authorizations for service are related to mental health services and that such authorization meets the program requirements.
- 8.20. Contractor shall track authorized requests for service and process claims as received.
- 8.21. Contractor shall submit monthly claims to the County. Contractor shall monitor pool utilization and submit reports quarterly and as required to the County.
- 8.22. Contractor shall verify that the client or the adult legally responsible for the minor child has signed an authorization for release of information and the release accompanies the service request.
- 8.23. Contractor shall make available for examination by the County all authorization requests and billing records relative to clients for quality assurance or financial audit purposes. All personally identifiable information shall be maintained in accordance with the laws of the State of California, subject to ethical and legal confidentiality requirements. Except as otherwise specified herein or allowed by law, Contractor shall not be

required to disclose medical record information about any client. All other disclosures shall be accompanied by the client's written consent to release such information.

8.24. Contractor shall ensure that services provided are entered into the County MIS system for client and service tracking. Data entry shall occur according to the agreed upon timeframe between the County and Contractor.

8.25. Contractor shall ensure that its service providers maintain an average time for access to care of less than five (5) days for initial appointments for children and youth. Contractor shall report the average number of days for an initial appointment

8.26. Contractor shall ensure that providers adhere to the following Mental Health requirements:

- 8.26.1. Youth Transition Plan
- 8.26.2. Dual Diagnosis Strategic Plan
- 8.26.3. Cultural Competence Plan
- 8.26.4. CA Penal Code and Welfare and Institutions Code.
- 8.26.5. CMHS Assessment form requirements
- 8.26.6. CMHS Organizational Provider Operations Handbook
- 8.26.7. CMHS Organizational Provider Financial Eligibility and Billing Manual

9. Data Collection, Records and Reports

1.1 Monthly Client Count Report

1.1.1 Contractor shall submit a monthly report by the 15th of each month that lists the number of unduplicated clients served for the month and YTD by age group and clinic.

1.2 Monthly Status Reports (MSR)

1.2.1 Contractor shall submit report by the 15th of each month on progress in achieving process and outcome objectives. The June report shall be an annual summary. County shall provide the format for submission of the MSR data

1.3 Client Data Collections

1.3.1 Contractor shall collect client demographic data including but not limited to age, ethnicity sex, insurance, income, and other factors, in a format provided by the County and consistent with the demographic requirements outlined by the County, State, and Federal regulations.

1.3.2 Contractor shall collect demographic information, including but not limited to:

- 1.3.2.1 Age
- 1.3.2.2 Gender
- 1.3.2.3 Sexual Orientation

1.3.2.4 County region of primary residence

1.3.2.5 Residence

1.3.2.6 Ethnicity

1.3.2.7 Language Preference

1.3.2.8 Language(s) spoken

1.3.2.9 Level of Education

1.3.3 Contractor shall collect specific client information at the initial request for service, including but not limited to:

1.3.3.1 Client name

1.3.3.2 Client mail address and telephone number

1.3.3.3 Social Security Number (if available)

1.3.3.4 Date of birth

1.3.3.5 Place of birth

1.3.3.6 Referring clinic contact information

1.3.3.7 Referred specialist contact information

1.3.3.8 List of requested services, signatures of referring clinic staff verifying that the client meets eligibility requirements.

9.3.6 Contractor shall ensure service providers achieve the following outcome objectives for clients:

9.3.7 100% of children and youth clients shall receive an assessment of their substance use and history of domestic violence upon admission.

9.3.8 Contractor shall propose additional outcome measures to evaluate services.

9.4 System-wide County Management Information System (MIS)

9.4.1 Contractor shall use the County Mental Health Services information and data collection system for data collection.

9.4.2 Contractor shall develop written policies and procedures that address security, confidentiality, access, and operations.

9.5 Supporting Documentation

9.5.1 Contractor shall have written documentation available for review by County upon request.

10. Quality Management and Utilization Review

10.1 Quality Management Plan: Contractor shall develop and submit to the County a written Quality Management (QM) Plan by May 31st of each contract year that describes the process for continually assessing the Contractor’s effectiveness in achieving the goals and objectives of this agreement.

Contractor shall develop a QM plan that includes the following components:

- 10.1.1 Internal QM Committee
- 10.1.2 Written policies and procedures
- 10.1.3 Process for conducting internal review of client/claim files
- 10.1.4 Mechanism and timeline for obtaining client feedback
- 10.1.5 QM Plan implementation
- 10.1.6 Identification of the structure, process, and outcomes for QM program.

10.2 Quality Management Committee: Contractor shall have an internal QM Committee with the following responsibilities:

- 10.2.1 Develop, review, and revise the QM plan on an annual basis.
- 10.2.2 Assess program outcomes and make recommendations for improvement of program services
- 10.2.3 Develop plans for corrective action for identified program deficiencies, review and action of results of process and outcome data, and review and action from client/provider feedback.
- 10.2.4 Contractor shall maintain written minutes of all meetings of the QM Committee.

10.3 QM Policies and Procedures:

- 10.3.1 Contractor shall have written policies and procedures for development and implementation of the QM Plan.
- 10.3.2 Contractor shall review and revise written policies and procedures annually, with approval and signature by the Executive Director or designee.

11. Special Terms and Conditions

11.1 Complaint Process:

Contractor shall have written policies and procedures for a complaint process. The policy shall identify staff responsible, an appeal process, tracking system, follow-up procedures, and a timeline. Contractor shall use relevant Federal, State, and County regulations for investigating and resolving complaints. A copy of the complaint policy shall be provided to participating service providers. Complaints and investigation results shall be forwarded to County within 24 hours of both the receipt and resolution of the complaint.

11.2 Confidentiality Training:

Contractor shall develop a written policy on confidentiality. Contractor shall train all service providers and volunteers working under this agreement. All service providers and volunteers shall sign a confidentiality agreement, which will be kept by Contractor.

11.3 Treatment of Individuals with Confirmed Mental Health Diagnosis:

Services provided under the terms of this Agreement shall only be provided to eligible individuals, that are children and youth with a diagnosis of Serious Emotional Disturbance (SED) as identified in this Statement of Work. Verification shall be provided to County upon request.

11.4 Fees:

Contractor shall ensure that service providers financially screen according to their customary sliding fee scale to assess fees for services reimbursed under the terms of this Agreement. No client shall be denied services due to lack of ability to make payment.

11.5 Bilingual Access:

Contractor shall ensure that service provider staff can provide bilingual/bicultural services to individuals who need or prefer to communicate in their own language. If there are no staff that can perform this function, contractor shall develop alternate methods to ensure that language appropriate services are available.

6.6 MHSa Funding Adjustments

To assure expenditure of all MHSa funds within the contract period, contracts with projected savings are subject to reduction by the County and contracts with projected over expenditures may be subject to an increase. The County is authorized to issue a unilateral contract amendment for a total change in the contract price by 10%, not to exceed fifty thousand dollars (\$50,000). Contractor shall accept any reduction or increase in funding.



City and County of San Francisco

Office of the Controller CITY SERVICES AUDITOR

REQUEST FOR PROPOSALS FOR Behavioral Health and Primary Care Integration Services RFP#CON2009-3

CONTACT: Mary Lui, Mary.Lui@sfgov.org

Background

San Francisco is the fourth largest city in California and serves as a center for business, commerce and culture for the West Coast. The City and County of San Francisco (the "City") established by Charter in 1850, is a legal subdivision of the State of California with the governmental powers of both a city and a county under California law. The City's powers are exercised through a Board of Supervisors serving as the legislative authority, and a Mayor and other independent elected officials serving as the executive authority.

The Controller's Office of the City and County of San Francisco ("Controller's Office") has partnered with the San Francisco Department of Public Health ("DPH") to seek proposals from experienced healthcare contractors to provide expert analysis and technical assistance to build upon current efforts to integrate behavioral health and primary care services provided through DPH and contracted nonprofit providers such as the San Francisco Community Clinics Consortium ("SFMCC"). Please see Section 2 of the RFP for more details.

Intent of this RFP

It is the intent of the Controller's Office to select the most responsive and qualified Proposer to negotiate a contract for services under this RFP. Proposers are not guaranteed a contract.

Anticipated Contract Period

July 2009 through July 2011, with the option, at the City's sole and absolute discretion, to renew for up to two (2) additional years. However, actual contract periods may vary, depending upon service and program needs. Proposer selected must be available to commence work on or before July 1, 2009.

Subcontracting Requirement

There is a five (5)% Human Rights Commission Local Business Enterprise ("LBE") subcontracting requirement under this RFP and resulting contracts.

Please be sure to review the City's LBE Good Faith Outreach requirements referenced in RFP Attachment II. They are time-sensitive.

Schedule*

*Subject to change. Check website for latest schedule.

RFP issued	04-17-09
Deadline for advance RFP questions	04-27-09 (12 pm PT)
Pre-Proposal Conference	05-01-09 (2 pm PT)
Answers to RFP questions posted online	05-13-09
Updated Deadline for proposals	06-17-09 (12 pm PT)
Updated Contract award intent notification	06-26-09
Updated Contract begins	08-01-09

RFP Questions and Communications

Pre-proposal conference attendance is recommended for firms interested in submitting proposals for partnering opportunities and clarification purposes. See RFP Section 3 for more information.

If you would like to ensure your questions about this RFP are addressed at the pre-proposal conference, e-mail your advance questions to Mary.Lui@sfgov.org **before 12 pm PT on Monday, April 27, 2009**. No questions will be accepted after conclusion of the pre-proposal conference with the exception of City vendor compliance or Human Rights Commission sub consulting requirement questions.

A summary of the questions and answers pertaining to this RFP will be posted on the City Controller's Office website at <http://www.sfgov.org/controller> under "Contract Opportunities."

Controller's Office • City Hall, Room 316 • 1 Dr. Carlton B. Goodlett Place • San Francisco, CA 94102 • 415.554.7500
<http://www.sfgov.org/controller>

1. Introduction

General terms used in this RFP. The “Proposer” refers to any entity submitting a proposal to this Request for Proposals (“RFP”). The “Contractor” refers to the Proposer awarded a contract for services under this RFP.

1.1 Background and Overview of Project

Project Objective: The City and County of San Francisco Controller's Office (“Controller's Office”) in partnership with the San Francisco Department of Public Health (“DPH”) seeks proposals from experienced healthcare contractors to provide expert analysis and technical assistance to build upon current efforts to integrate behavioral health and primary care services provided through DPH and contracted nonprofit providers such as the San Francisco Community Clinics Consortium (“SFCCC”). DPH plans to integrate aspects of behavioral health and primary care services through coordinated service delivery to achieve increased efficiency and better health outcomes. Such efforts are consistent with priorities at the national and state level and efforts in local delivery systems (National Association of State Mental Health Program Directors, 2005).

Since early 2009, DPH has been working with nonprofit and DPH providers to integrate services. DPH is currently piloting integration at three clinics: Silver Avenue, Tom Waddell and, the Castro-Mission Health Center. Also, DPH has placed primary care providers in behavioral health clinics and is utilizing roving behavioral health teams to provide services in primary care sites. For this project, DPH seeks healthcare contractor(s) with clinical background and experience in primary care and behavioral health integration to support DPH's current and future integration efforts. Please see Section 5.2 of the RFP for more details.

The DPH Community Programs Division (“Community Programs”) includes:

- Community-Oriented Primary Care
- Housing and Urban Health
- Maternal Child Health
- Health Promotion and Prevention
- Community Behavioral Health Services
- HIV Health Services
- HIV Prevention

Community Programs has a \$479 million budget for FY09, comprising approximately one quarter of the DPH annual budget. Contractual services represent over two-thirds of Community Programs' budget. Due to citywide budget shortfalls, DPH has made significant budget reductions in FY09. Additional cuts are likely to occur in FY10.

The Primary Care Health Services System is comprised of 24 clinics including DPH and San Francisco Community Clinic Consortium (“SFCCC”) clinics.

(For more information about DPH and Community Programs, please see the DPH website: www.sfdph.org)

1.2 Role of Controller's Office / City Services Auditor

Proposition C, passed in November 2003, amended City Charter Section 3.105 to instruct the City's Controller to serve as City Services Auditor. This role makes the Controller's Office responsible for providing objective, rigorous measurement of City service levels and effectiveness and authorizes it to contract with outside, independent experts for a variety of consultant services. For more information regarding City Services Auditor roles and responsibilities, visit <http://www.sfgov.org/controller>.

2. Scope of Work

This scope of work is a general guide to the work the City expects to be performed, and is not a complete listing of all services that may be required or desired.

To minimize duplication of effort and to allow the City to coordinate data requests and data available for the services requested within this RFP, as well as for previous and future projects, the selected Contractors' findings and data may be shared by the City with other City contractors, as deemed appropriate by the City.

Each Proposer should demonstrate its capabilities by providing summaries of representative projects as part of RFP Attachment V. The City will negotiate the specific scope of services, budget, deliverables, and timeline with the highest-scoring Proposer selected for contract negotiations. There is no guarantee of a minimum amount of work or compensation for any Proposer(s) selected for contract negotiations.

Selected Contractor will work closely with the Controller's Office, DPH, and relevant Community Based Organizations.

The Contractor shall provide expert analysis to further DPH's efforts to integrate behavioral health and primary care services provided through DPH, San Francisco Community Clinic Consortium ("SFCCC") clinics, and other contracted nonprofit health providers.

PHASE 1: PROJECT ASSESSMENT AND PLAN

The Contractor shall conduct a preliminary assessment of the needs and models of behavioral health and primary care integration of DPH-funded health services in San Francisco. The Contractor's assessment shall inform the project plan and determine the scale of this project and the level of effort required to complete it. Implementation of Phases 3 and 4 will be contingent upon the City's review and acceptance of the deliverables in Phase 1 and budget considerations. As part of the assessment, the Contractor shall:

- Review the clinical, management and infrastructure elements at 24 DPH and SFCCC clinics.
- Review coordinated case management system within the Behavior Health System and the Community Oriented Primary Care system.
- Review psychiatric services in both behavioral health and primary care.
- Consult with key DPH staff, SFCCC, nonprofit providers and other stakeholders, as needed.
- Incorporate existing research and analysis already completed by DPH, such as work resulting from the 2009 Community Programs Consultative Planning Process. Develop a detailed methodology to accomplish Phases 2 and 3 of the project (outlined below).

Deliverables:

Upon completion of Phase 1, the Contractor shall present draft and final versions of a written summary report to the DPH Director of Community Programs ("Director") and other senior staff, as designated by the Director for approval, including:

- Method of review, including stakeholders and documents consulted.
- Results of assessment of needs and models.
- Project plan and timeline with start and finish dates, description of data to be analyzed and gaps, project tasks, deliverables, staff resources and hours, as well as costs to accomplish Phases 2 and 3 of the project.
- Any other recommendations for how the Contractor may assist the City in achieving desired project outcomes.

PHASE 2: TRAINING

The City may request that Phases 1 and 2 of the project occur simultaneously.

A. Training Assessment

The Contractor shall identify training needs in Behavioral Health and Primary Care Systems with pilot integration programs. The Contractor shall make specific recommendations such as target staff, training topics (e.g., chronic care management), training approaches, training frequency, efficient and effective training delivery mechanisms, and outcome measures.

Deliverables:

The Contractor shall present written findings from the training assessment to the DPH Director of Community Programs, and other designated staff, and incorporate feedback. This task and deliverable may be scheduled to occur simultaneously with Phase 1 (Project Plan) tasks and deliverables described above.

B. Training Implementation

Based on the findings of the training assessment, the Contractor shall develop training curricula and materials, and provide training to increase clinical expertise of behavioral health and primary care staff to better deliver integrated services.

Deliverables:

- The Contractor shall present the training curriculum and materials to the Director of Community Programs and other senior staff, as designated by the Director, and incorporate feedback.
- The Contractor shall conduct the specified number of trainings to DPH clinical staff.

PHASE 3: INTEGRATION ANALYSIS AND RECOMMENDATIONS

A. Integration Analysis

The Contractor shall conduct an integration analysis in order to provide DPH with recommendations for the integration of its primary care and behavioral health delivery system. Integration recommendations may include suggested approaches or models and should be applicable to a variety of clinical settings. The Contractor shall:

1. Identify models and best practices approaches in the integration of primary care and behavioral health services that will be useful and relevant to DPH, including a review of the recent experience of local counties, such as Contra Costa.
2. Analyze DPH behavioral health and primary care systems and make integration recommendations to DPH, including the following elements:
 - Models of best practices
 - Social work and case management Change management and training
 - Updating/ expanding/ adapting integrated quality assurance programs.
 - Information technology needs and solutions.
 - Cultural and linguistic competency
 - Structure and location of facilities
 - Reimbursement and payment for services
 - Care coordination

In order to conduct this analysis, the Contractor should consider conducting program visits from the perspective of the client receiving services, conducting staff surveys and/interviewing staff, etc.

3. Work closely with the Director of Community Programs and designated senior staff to develop integration recommendations that are feasible for implementation.
4. Develop a written implementation work plan for DPH to assist Community Programs in adopting and implementing strategies to improve and expand integrated primary care and behavioral health services. The Contractor shall ensure that the work plan is a "living" document that can be reviewed and updated by staff. It shall include an evaluation component to assist Community Programs in monitoring and evaluating implementation of implementation strategies.

Deliverables:

Upon completion of Phase 3 Tasks, the Contractor shall present draft and final versions of a written summary report to the DPH Director of Community Programs and designated senior staff for approval. This report shall describe the overall approach to integrating primary care and behavioral health systems of care, detailed recommendations, data, critical pathways and an implementation work plan, as described above.

PHASE 4: IMPLEMENTATION ASSISTANCE

Subject to the City's approval, upon completion of Phases 1 through 3, the contract(s) awarded under this RFP may be amended to include additional implementation assistance from the selected Contractor(s). Phase 4 services and related costs will be negotiated for a fixed, not-to-exceed price at the hourly rates submitted as part of the selected Proposal. This assistance may include:

- Providing technical assistance and training to DPH and clinical staff to implement strategies to improve and expand integrated primary care and behavioral health services.
- Providing other implementation and evaluation support to DPH staff, as needed.
- Support DPH in developing quality metrics for on-going monitoring and to measure performance outcomes on a quarterly basis.

Deliverables:

To be determined.

3. City-Proposer Communications

Proposers are specifically directed NOT to contact any employees or officials of the City other than those specifically designated in this RFP and its Attachments. Unauthorized contact may be cause for rejection of proposals at the City's sole and absolute discretion.

3.1 Pre-Proposal Conference

Pre-proposal conference attendance is recommended for firms interested in proposing as prime contractors to this RFP. Firms who attend this conference will receive 15 points towards the minimum 80 points that must be achieved in order to be responsive to the City's Human Rights Commission ("HRC") Local Business Enterprise ("LBE") Good Faith Outreach requirements. See "Form 2B-HRC Good Faith Outreach Requirements Form" referenced in RFP Attachment II.

At the pre-proposal conference, the City will provide an overview of submission requirements, answer advance questions received about the RFP, take additional questions, and provide networking opportunities for interested parties to explore potential partnerships, including those formed per the LBE subcontracting requirement.

The pre-proposal conference will be at 2 pm PT on Friday, May 1, 2009 at City Hall, 1 Dr. Carlton B. Goodlett Place (Polk Street) in Room 400 (4th Floor), San Francisco, CA 94102. The main entrances to City Hall are at Polk Street and Van Ness Avenue between Grove and McAllister Streets. The closest

main thoroughfares are Market Street and Van Ness Avenue. This location is accessible by BART (Civic Center Station) and a number of MUNI routes.

Upon conclusion of the pre-proposal conference, **no questions or requests for interpretation will be accepted** with the exception of City vendor compliance or Human Rights Commission subconsulting requirement questions.

3.2 Advance Questions

If you would like to ensure your questions about this RFP are addressed at the pre-proposal conference, e-mail your questions to Mary.Lui@sfgov.org **before 12 pm PT on Monday, April 27, 2009**.

A summary of the substantive information, advance and pre-proposal questions and answers pertaining to this RFP will be posted on the Controller's Office website at http://www.sfgov.org/site/controller_index.asp under "Contract Opportunities".

4. Proposal Requirements

4.1 Time and Place for Submission of Proposals

Proposals and all related materials must be received **before 12 pm PT on Wednesday, June 17, 2009 (updated)**. Proposals may be delivered to the Controller's Reception Desk (Room 316) at City Hall, or to:

*Mary Lui
Office of the Controller
City Hall, Room 388
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102*

Postmarks will not be considered in judging the timeliness of submissions. Proposals submitted by e-mail or fax will not be accepted. Late submissions will not be considered, including those submitted late due to mail or delivery service failure. Note that Proposers hand-delivering proposals to City Hall may be required to open and make packages accessible for examination by security staff.

4.2 Proposal Package

The following items must be included in your proposal and packaged in a box or envelope clearly marked **RFP# CON2009-3 DPH Integration Services**.

Complete, but concise proposals, are recommended for ease of review by the Evaluation Team. Proposals should provide a straightforward, concise description of the Proposer's capabilities to satisfy the requirements of the RFP. Marketing and sales type information should be excluded. All parts, pages, figures, and tables should be numbered and clearly labeled.

A. Original printed proposal (with original signatures) labeled as "Original"

<i>RFP Attachment I</i>	Acknowledgement of RFP Terms and Conditions (Word)
<i>RFP Attachment II</i> links) - 2 copies	Human Rights Commission Local Business Enterprise Forms (Word with
<i>RFP Attachment III</i>	City's Administrative Requirements (Word with links)
<i>RFP Attachment IV</i>	City's Agreement Terms and Conditions (Word)

- B. **One (1) CD-ROM containing entire contents of proposal, including all Attachments.** The CD-ROM and electronic files on the CD-ROM must be labeled with the Proposer's name. All files should be submitted in unprotected PDF or Word format.
- C. **Five (5) complete printed copies of Attachment V.** Proposers are advised to review Attachments I through IV before beginning work on the proposal template in Attachment V to ensure they can meet the City's requirements.

5. Evaluation Criteria

This section describes the guidelines used for analyzing and evaluating the proposals. It is the City's intent to select a Proposer for contract negotiations that will provide the best overall service package to the City inclusive of fee considerations. Proposers selected for contract negotiations are not guaranteed a contract. This RFP does not in any way limit the City's right to solicit contracts for similar or identical services if, in the City's sole and absolute discretion, it determines the proposals are inadequate to satisfy its needs.

5.1 Evaluation Team

City representatives will serve as the Evaluation Team responsible for evaluating Proposers. Specifically, the team will be responsible for the evaluation and rating of the proposals, for conducting reference checks, and for interviews, if desired by the City.

5.2 Minimum Qualifications

Any proposal that does not demonstrate that the Proposer meets these minimum qualifications by the proposal deadline may be considered non-responsive and may not be evaluated or eligible for award of any subsequent contract(s).

The Proposer certifies that it:

- A. **RFP ATTACHMENTS:** Has completed the requirements and submitted the forms described in RFP Attachments I, II, III, IV, and V as part of Proposal.
- B. **QUALIFICATIONS:** Has submitted Prior Project Descriptions in accordance with RFP Attachment V, Section B clearly demonstrating successful completion of a minimum of one (1) and a maximum of three (3) behavioral health and primary care system integration project(s) within the last ten (10) years of the date of this RFP (successful completion means project outcomes have been assessed by client). The lead staff proposed to be assigned to the City's project(s) must individually have had a similar role in at least one of these or comparable projects within the last ten (10) years of the date of this RFP.
- C. **HIPAA COMPLIANCE:** Is compliant with the Business Associates provision of the Health Insurance Portability and Accountability Act (HIPAA).

5.3 Proposal Evaluation Criteria (100 points)

Proposals will be evaluated in accordance with the information provided by the Proposer in RFP Attachment V (including Sample Reports), and the criteria below. The City reserves the right to evaluate additional criteria it deems appropriate, whether or not such factors have been stated in this section.

5.3.1 Qualifications of Proposer – 30 points

- a) Firm history and structure, including Proposer's depth and breadth of experience providing consulting services to public health systems in California (includes client list).

- b) Demonstrated experience with and understanding of behavioral health and primary care integration.
- c) Specific clinical background and experience in primary care and behavioral health case management.
- d) Experience in organizational and systems redesign.
- e) Experience facilitating and training diverse populations in the successful implementation of integrated behavioral health and primary care services.
- f) Experience in developing evaluation tools and building staff capacity in evaluation and program monitoring.
- g) Experience with a project of similar scope in the City and County of San Francisco.

5.3.2 Qualifications of Proposed Staff – 30 points

- a) Total staff size and composition.
- b) Capacity and office staff size and resources proposed for services under this RFP, including staffing structure (Proposed Staff Organization Chart) and proposed staff roles and responsibilities.
- c) Commitment of the Proposer to provide continuity of qualified staff through completion of services.
- d) Staff qualifications.

5.3.3 Appropriateness and Feasibility of Approach and Cost – 30 points

- a) Work plan/approach broken down by Phase, including coordination and timeline of tasks, deliverables, and assignments where a partnership (including subcontractor) is proposed.
- b) Ability to complete all services as soon as possible.
- c) Client involvement or level of effort.
- d) Competitive differences and lessons learned.
- e) Reasonableness and clarity of Cost Proposal broken down by Phase.

5.3.4 Completeness and Applicability of Proposal Submission – 10 points

- a) Conformance with and applicability of information to RFP requirements.
- b) Clarity of organization and exposition.
- c) Overall quality of presentation including completeness and accuracy of information.

5.4 Contractor Selection Processes

Selection Interviews

Following the Proposal Evaluation process, up to three of the highest scoring Proposers may be invited to interviews with the Evaluation Team. Interviews, if pursued by the City, will consist of standard questions asked of selected Proposers, and specific questions regarding individual proposals. Interviews will be worth 100 points. Points awarded for interviews will be separate from the points awarded during the Proposal Evaluation process. The lead staff members that will be assigned to the project should be present for the interview, as well as the lead staff of subcontractor partner(s), including Local Business Enterprise firms.

The City has sole and absolute discretion over whether interviews will be conducted or not to select Proposers for contract negotiations.

Other Terms and Conditions

The selection of any Proposer for contract negotiations shall not imply acceptance by the City of all terms of the proposal, which may be subject to further negotiation and approvals before the City may be legally bound thereby.

The Controller's Office will select the most qualified and responsive Proposer with whom the Controller's Office staff will commence contract negotiations. If a satisfactory contract cannot be negotiated in a reasonable time with the selected Proposer, then the Controller's Office, in its sole discretion, may terminate negotiations and begin contract negotiations with the next highest scoring Proposers it deems qualified. The Controller's Office, in its sole discretion, has the right to approve or disapprove any staff person assigned to its projects before and throughout the contract term. The Controller's Office reserves the right at any time to approve, disapprove, or modify proposed project plans, timelines and deliverables.

6. Protest Procedures

6.1 Protest of Non-Responsiveness Determination

Within five (5) working days of the City's issuance of a notice of non-responsiveness, any Proposer that has submitted a proposal and believes that the City has incorrectly determined that its proposal is non-responsive may submit a written notice of protest by mail or e-mail (fax is not acceptable). Such notice of protest must be received by the City on or before the fifth (5th) working day following the City's issuance of the notice of non-responsiveness. The notice of protest must include a written statement specifying in detail each and every one of the grounds asserted for the protest. The protest must be signed by an individual authorized to represent the Proposer, and must cite the law, rule, local ordinance, procedure or RFP provision on which the protest is based. In addition, the protestor must specify facts and evidence sufficient for the City to determine the validity of the protest.

6.2 Protest of Contract Award

Within five (5) working days of the City's issuance of a notice of intent to award a contract under this RFP, any Proposer that has submitted a responsive proposal and believes that the City has incorrectly selected another Proposer for award may submit a written notice of protest by mail or e-mail (fax is not acceptable). Such notice of protest must be received by the City on or before the fifth (5th) working day after the City's issuance of the notice of intent to award a contract.

The notice of protest must include a written statement specifying in detail each and every one of the grounds asserted for the protest. The protest must be signed by an individual authorized to represent the Proposer, and must cite the law, rule, local ordinance, procedure or RFP provision on which the protest is based. In addition, the protestor must specify facts and evidence sufficient for the City to determine the validity of the protest.

6.3 Delivery of Protests

All protests must be received by the due date. If a protest is mailed, the protestor bears the risk of non-delivery within the deadlines specified herein. Protests should be transmitted by a means that will objectively establish the date the City received the protest. Protests or notice of protests made orally (e.g., by telephone) or by fax will not be considered. Protests must be delivered to:

Esther Reyes
Office of the Controller
City Hall, Room 388
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Or by e-mail to: Esther.Reyes@sfgov.org

SANTA CRUZ COUNTY AGREEMENT SCCHO/SANTA CRUZ COUNTY MENTAL HEALTH LINKAGE

Vision/Values

Patients should experience a continuum of quality, culturally competent and comprehensive care which is, as much as possible, focused, coordinated, and managed in the primary care setting.

The chief role of the mental health system is to support the primary care practitioner in providing appropriate psychological/psychiatric services. Additionally, the mental health professional is available to provide specialty mental health services when indicated.

Principles

1. The majority of patients initially present their distress in primary care settings.
2. Their problems are not either biological or psychological—they are both, presenting in an undifferentiated form.
3. For problems that are clearly psychological or psychiatric, (e.g. depression and anxiety) primary medical settings are the predominant locus of treatment.
4. There is a greater likelihood of adherence to treatment regimes and better outcomes when treatment is provided in the primary care setting.
5. When specific patient needs are identified which exceed the scope and practice of primary care, the mental health system is available to provide specialty mental health services.
6. It is critically important that relevant clinical information is readily accessible to both the primary care and mental health providers consistent with the standards of medical record confidentiality and the protection of patient privacy.
7. Children and adolescents may have special needs and require different approaches to the provision and coordination of services.

Tiered Approach to Specialty Mental Health Services

Santa Cruz County Mental Health (SCCMH) has a structured approach to meeting the mental health needs of SCCHO members. There are four “levels of care” and specific criteria for each “level” to guide access and utilization of specialty mental health. The four levels are:

1. telephone psychiatric consultation
2. face-to-face psychiatric consultation (time limited)
3. *on-going* psychiatric treatment/management
4. non-physician mental health services

Referrals and requests for mental health services other than telephone consultation with a psychiatrist will be addressed to the SCCMH ACCESS team. This team will review the referrals and arrange for appropriate follow-up. By careful evaluation of the patients’ and practitioners’ needs, and appropriate/efficient utilization of specialty mental health services, SCCMH can provide optimal access and quality care within the constraints of limited resources.

The **phone number** for the Santa Cruz County Mental Health **ACCESS Team** is **XXXXXXXXXX**

In addition to providing consultation and treatment to individuals, SCCMH will provide on-going continuing education for SCCHO’s primary care providers. This training will be based upon an assessment of the training needs and interests of the primary care practitioners and should help to provide them the information and skill needed to enhance their ability to provide effective psychological/psychiatric services in the context of primary care.

Below is a brief description of each level of care and the criteria associated with its use

I. Psychiatry PRN (*P*HYSICIAN *R*ESPONSE *N*OW)

In an effort to provide primary care providers the consultation and support they may require on a case-by-case basis, Santa Cruz County Mental Health will provide “on demand” telephone consultation. These are intended to be brief “curbside” consultations typically regarding questions about psychopharmacological treatment e.g., selection of a therapeutic agent, dosage, side effects, treatment monitoring, etc.

The **phone number** to access this consultation is **XXXXXXXXXX**. Every attempt will be made to have the consulting psychiatrist answer each call. There may be occasions when it will be necessary to leave a message or page at this number.

The objective is to provide the consultation and support while the patient is in the primary care office and to enhance the value and benefit of the primary care visit for the patient and the provider. There will be no written follow-up from the consulting psychiatrist.

SCCMH will strive towards providing timely and prompt response to calls minimizing the need for call-backs, return visits, etc. One possible outcome may be a recommendation for face-to-face consultation with a psychiatrist.

II. Psychiatric Consultation—Time Limited

At times there is no substitute for face-to-face evaluation of the patient by a psychiatric consultant. The objective of such consultations is to provide the primary care practitioner with additional clinical information advice and direction so that the ongoing care of the patient can be continued in the primary care setting.

Typically such consultations are time limited and may require only one meeting of the patient with the psychiatrist. These services may be provided by the staff psychiatrists at SCCMH or may be provided by a managed care network provider. At times some periodic follow-up and re-evaluation may be appropriate.

Consultations are generally most effective when the referring provider can clearly express their questions and concerns and their informational needs. For example, typical requests for consultation may address issues such as

- uncertain diagnosis
- non-response to treatment
- medication side-effects
- strategies for on-going management
- possible need for additional specialty mental health services

In making the request for consultation, the primary care provider should make available to the psychiatric consultant any relevant medical data including but not limited to laboratory and other diagnostic studies, medical diagnoses, medications and other prescribed treatments, physical impairments, etc.

The consultant's finding should be reported back to the primary care provider in a timely manner with a specific plan and recommendations for further care. Follow-up will always be in writing although the primary care physician may also request a telephone review of the consultant's findings and recommendations.

SPECIAL CONSIDERATIONS FOR CHILDREN

1. Most emotional or behavioral problems in children can be capably handled by a pediatrician or a family practitioner with special interest and experience.

Examples: discipline issues, school avoidance, attention deficit/hyperactivity, fear and grief reactions, school failure, encopresis/enuresis, adolescent defiance, substance experimentation and abuse.

2. In contrast to emotional problems among adults, many of whom are socially isolated, children virtually always have several adult support figures, of varying commitment and skill.
3. The supportive role and therapeutic efficacy of the primary care practitioner is accentuated, compared to adult care, because of the more frequent contacts for "physical" illnesses and the "license" to discuss behavioral problems of dependent children.
4. Mental Health professional involvement with children is usually of short duration, for clarification and confirmation of diagnosis and development of treatment plan, including

drug treatment. The primary care practitioner customarily stays actively involved and assumes primary responsibility when situations have stabilized.

Examples: Tourette's syndrome, phobias, obsessive-compulsive behavior, abuse/trauma reactions, depression, suicidal ideation, eating disorders.

5. Disabling psychiatric problems, while uncommon, may require extended direct mental health involvement, often with use of "higher echelon" drug treatment, specialized schooling, or institutional care "over the head" of nearly all FP and pediatric practitioners. The mental health professional usually makes this determination after a series of encounters.

Examples: psychosis, complicated multi-agency treatment with risk of out of home placement

6. While acute psychotic episodes and acute suicide threats obviously require emergent involvement, the great majority of children's behavioral challenges can be managed in a planned, orderly way. For these cases, a consistent approach to communication between primary care and mental health professionals will work best.

The **telephone number** to reach the Mental Health ACCESS to team for **urgent crisis needs** or to initiate a **routine referral** for consultation and services for children is the same as for adults. That number is **XXXXXXXXXX**.

The telephone number for "**on-demand**" **consultation for children** is also the same as for adults. The number is **XXXXXXXX**

7. No clinical bridge between mental and physical health can realistically anticipate all children's behavioral problems. SCCHO PCP's are invited to contact the SCCHO medical director (XXXXXXXXXX) for case management assistance in unusual situations.

III. On-Going Psychiatric Management

There are cases when the patient requires on-going psychiatric and psychopharmacologic care which is too complex for the primary care provider to manage.

This may occur when

- the patient requires treatment with multiple psychoactive medications (i.e. combined therapy)
- the patient requires treatment with an antipsychotic medication or other medication with which the primary care provider is unfamiliar
- the patient has not achieved adequate therapeutic benefit despite multiple treatment attempts and initial psychiatric consultation

- the patient is chronically unstable and has treatment needs which exceed the skill/resources of the primary care provider

During the course of such treatment, the psychiatrist should inform the primary care physician of the patient's medication regime and any significant changes. Likewise, the primary care physician should advise the treating psychiatrist of any changes in the patient's general health status and treatment.

Patients receiving only pharmacotherapy who do not in addition require non-physician mental health services may be referred back to the primary care practitioner if and when they meet the following criteria:

- stable medication regime for a minimum of 6 months
- able to access community resources
- able to self manage mental health treatment needs without requiring on-going multidisciplinary/team-based mental health services

There may be occasions when the primary care physician and psychiatrist cannot agree on an acceptable and reasonable plan for a patient's care. In these circumstances, the SCCHO medical director should be contacted so that in conjunction with the mental health plan medical director, problems and differences can be resolved and an appropriate plan of care can be implemented.

The primary care provider accepting a referral from the treating psychiatrist to assume/resume ongoing treatment in the primary care setting should receive a treatment summary and transition plan to include at minimum:

- diagnosis
- medication(s) and dosage
- recommended laboratory monitoring and frequency
- plans/recommendations for follow-up consultation
 - typically at least once in the next 6-12 months for patients in on-going treatment
 - should be determined on a case-by-case basis

IV. Non-Physician Mental Health Services

Patients may at times require non-physician mental health services ranging from family/group/individual psychotherapy to more complex multidisciplinary team-based treatment (intensive case management).

Adult patients and the families of children may obtain these services either by referral from the primary care physician or by self-referral directly to the mental

health plan. The ACCESS team for both children and adults can be reached at XXXXXXXXXXXX. This number is for both physician and patient self referral.

In response to a physician referral or a patient initiated request for services the patient will be evaluated by licensed clinician member of the SCCMH ACCESS team. This will include some initial telephone screening, triage and referral as well as face-to-face evaluation as indicated. Following assessment by the ACCESS team, a treatment plan will be developed. Recommendations for specialty mental health services will be made based upon established medical necessity criteria.

Following a contact with the ACCESS team, the primary care provider should receive a report summarizing the assessment and recommendations of the ACCESS team.

The patient's plan may include referral to specialty mental health services. These services will be provided by managed care network clinics and therapists in the Santa Cruz community. The large majority of patients will require only time limited, focused, brief out-patient therapy/counseling.

In some cases, the ACCESS team may provide referral to community based services and resources. Examples include the Mental Health Resource Center, 12 step programs, self help and support groups, etc.

At other times, when medical necessity criteria for therapy/counseling are *not* met, the patient may be referred back to the primary care provider with recommendations for continued treatment/management in that setting.

Some patients may present with severe, disabling and persistent mental disorders. These individuals will require referral to the SCCMH adult system of care for case management and other team-based services including pharmacotherapy.

Children and youth under the age of 21 who are seriously emotionally disturbed, and at risk of out-of-home placement through Social Services, Juvenile Justice or Special Education, may require referral through ACCESS team to the Children's Mental Health System of Care. A full range of therapy, day treatment, intensive case management, and pharmacotherapy may be accessed for persistent and severe emotion/behavioral disorders affecting eligible youth.

Non-physician mental health services are, in general, indicated when the patient is experiencing significant distress and some degree of impairment in an important aspect of their daily life and responsibilities. Non-physician mental health services are further indicated when these difficulties are likely to respond to psychotherapy and other psychosocial interventions. Typically one of the following criteria will be met:

- the patient is at risk of harm to self or others
- there is a need for consultation to support on-going medical counseling and or behavior management in the primary care setting
- the patient is experiencing significant acute physical and/or emotional distress as a result of life events (e.g. death, divorce, etc.) and the patient's usual coping skills and resources are overwhelmed
- psychotherapy is requested by the physician and/or the patient to address specific emotional/behavioral problems and needs
 - as much as possible, *a referral for psychotherapy should specifically identify the patient's needs along with the desired/intended goals and outcomes of psychotherapy*
 - *Examples*
 - develop coping skills to better manage parent child conflict
 - relieve persistent feelings of poor self esteem which contribute to social withdrawal and recurrent problems of depression
 - decrease episodes of self-destructive behavior
 - specific requests for individual group and/or family therapy should be identified when indicated

The overall goal of specialty mental health services is to help maintain the individual's highest level of independent function. To this end, services and interventions will, for the most part, be targeted and time limited. The intent is to return the patient to on-going treatment in the primary care setting as quickly as possible.

**Bonita House Inc., HOST Program
Contract for Professional Services**

**Bonita House Inc. and (BHI)
LifeLong Medical Care (LMC)**

This contract is made and entered into this 1st day of July 2008 in the State of California, by and between Lifelong Medical Care (hereafter called “LMC”) at 2344 Sixth Street, Berkeley, CA 94710 and Bonita House Inc. HOST Program (hereafter called “BHI”) at 1422 Harrison Street, Oakland, CA 94612. For the purpose of the Contract, LMC, its employees or agents shall be considered as an independent contractor and not an employee(s) of BHI.

I. SCOPE OF WORK

By accepting this agreement LMC will:

1. Provide a 36 hour per week mid-level practitioner to serve on the HOST team. Supervision for this position will be provided by the LMC Downtown Oakland Clinic Associate Medical Director for all medical issues and by the HOST Director for all non-medical issues related to HOST. LMC will provide BHI with copies of licenses for the mid-level practitioner.
2. Provide to HOST partners preventive and primary care services including physical exams, diagnostic services, management of chronic disease, referrals for specialty care, health advocacy, and health education. Services will be provided at the HOST Office, the Downtown Oakland Clinic, through home visits, and at community sites according to the needs of the HOST consumer and the ACT Team.
3. Submit an invoice to BHI each month for services provided.

By accepting this agreement BHI will:

1. Provide reimbursement to LMC for the Team’s part-time mid-level practitioner.
2. Provide project-related, non-medical supervision to the Team’s mid-level practitioner.

II. RATE OF REIMBURSEMENT: For the mid-level practitioner, BHI will reimburse LMC for an average of ____ hours per month at the rate of \$ ____ per hour for a maximum annual total not to exceed \$_____.

III. PERIOD OF CONTRACT: Shall commence on July 1, 2008 and continue until June 30, 2009 unless amended by mutual agreement of the parties or upon termination of agreement by either of the two parties.

IV. TERMINATION: This contract will be in effect until terminated. This contract may be terminated by either party with a 30 day written notification being sent by registered mail to the above addresses. If any provisions of this agreement are held to be contrary to law,

such provisions will be deemed invalid and subsisting only to the extent permitted by law, but all other provision will continue in effect.

V. INSURANCE: Professional and general liability insurance shall be maintained by LMC for the services rendered. As the mid level practitioner is not a BHI employee, workers' compensation insurance shall be the responsibility of LMC.

VI. INDEMNIFICATION: BHI and LMC shall indemnify, defend, and hold each other harmless from any actions, claims, losses, demands, or expenses (including attorney's fees and costs) brought against BHI and LMC as a result: (a) of the failure of BHI and LMC or its agents, subcontractors, employees, representatives, affiliates, or any other related or unrelated persons to perform their obligations under this Agreement; (b) any bodily injury, property damage, or economic loss occurring as a result of this Agreement; or (c) any neglect or reckless conduct by BHI and LMC or its agents, subcontractors, employees, representatives, affiliates, or any other related or unrelated persons. BHI and LMC shall not provide indemnity against claims or losses caused by BHI and LMC or its agents to perform their obligations under this agreement, negligence, or willful misconduct. This provision survives termination of this contract.

VI. SIGNATURES:

Brenda Shipp, Chief Operating Officer, LMC

Date

Rick Crispino, Executive Director, BHI

Date

**MEMO OF UNDERSTANDING
BETWEEN
PRIMARY CARE CLINIC
AND
THE WASHTENAW COMMUNITY HEALTH ORGANIZATION**

The WCHO and _____ intend by this agreement to set forth the mutual goals, objectives, and scope of the integrated health project. The parties agree as follows:

I. DEFINITIONS

Washtenaw Community Health Organization: The Community Mental Health Services Provider for the County of Washtenaw, a program operated under Chapter Two of the Michigan Mental Health Code, under contract with the Michigan Department of Community Health.

Serious and Persistently Mentally Ill (SPMI): State term for Medicaid and indigent recipients who meet established criteria that entitles them to public mental health services.

II. MUTUAL GOALS AND OBJECTIVES

1. Identify public mental health consumers who are PRIMARY CARE CLINIC patients and who might be appropriate to use PRIMARY CARE CLINIC as their “medical home”.
2. Improve the overall health of consumers involved in the project.
3. Enhance PRIMARY CARE CLINIC service capacity by having on-site substance abuse and mental health screening and regular ongoing therapy services located at the primary clinic.
4. Enhance PRIMARY CARE CLINIC service capacity via ready access to adult psychiatric consultation for the public SPMI patient.

III. IDENTIFIED PARTNERS

Identified partners in this project include the following:

- WCHO, providing funding and project oversight;
- Washtenaw Community Support and Treatment Services (CSTS), an outpatient mental health service provider serving SPMI consumers in Washtenaw County under contract with the WCHO;
- Primary Care Clinic, a primary healthcare provider for vulnerable citizens of Washtenaw County.

IV. TARGET POPULATION

The target population will be public mental health consumers who are already patients at PRIMARY CARE CLINIC, as well as other vulnerable patients with mental health or substance abuse issues served by PRIMARY CARE CLINIC who are not currently consumers of public mental health services.

The number of public mental health consumers served at PRIMARY CARE CLINIC is unknown at this time, but is expected to be at least fifty (50).

V. EXPECTED OUTCOMES, MEASURES, AND BENEFITS

1. Demonstration of an effective public-private partnership in Washtenaw County Communities of

Interest as evidenced by:

- Improved health care for the mutual consumer/patient as a result of one integrated team communicating regularly about patient care, and a medical home for the consumer/patient;
- Enhanced services for vulnerable populations at PRIMARY CARE CLINIC;
- Expansion of PRIMARY CARE CLINIC on-site services for vulnerable populations.

2. A blueprint for integrated treatment in Washtenaw County, Michigan.

3. Specific clinical outcomes to be determined, but may include:

- Increased ability by primary care staff to manage mental health and substance abuse disorders in a primary health care setting;
- Prevention of medical and psychiatric deterioration via early identification and direct, on-site treatment of at-risk consumers and families;
- Improved health by increasing medication adherence via psychosocial interventions;
- Reduction in poverty-related destabilizing events, such as eviction prevention.

4. Agreement indicator

- The identification of common consumers/patients and the inclusion of those individuals in the project to determine if PRIMARY CARE CLINIC could become their medical home. This presumes that the staffing provided by WCHO would remain in place.

Review: A regular review by all stakeholders shall occur regarding the progress of the project.

VI. FINANCING PLAN

Funding: WCHO shall provide funds for mental health staffing as agreed between the parties with the goal that the project will be sustainable over time.

Staffing: Mental health staff located at PRIMARY CARE CLINIC shall be CSTS employees except in those instances where the University of Michigan Department of Psychiatry provides psychiatric services.

Billing: CSTS will bill and collect for mental health services provided by the CSTS employees located at PRIMARY CARE CLINIC. Billable services and capitation offsets will apply towards WCHO costs.

Annual Report: WCHO will prepare an annual report, which will be shared with PRIMARY CARE CLINIC. It is the hope and expectation that results will support a continuing partnership.

VII. POLICIES AND PROCEDURES

PRIMARY CARE CLINIC agrees to follow those policies, procedures, and administrative directives or other documents as specified by the WCHO. During the term of this Agreement, WCHO shall advise PRIMARY CARE CLINIC of any applicable modifications to the Mental Health Code or any changes in the WCHO Policies and Procedures or the MDCH Administrative Rules promulgated according to the Michigan Administrative Procedures Act of 1969, PA 306 of 1969, as amended, which have a bearing on this Agreement or PRIMARY CARE CLINIC. PRIMARY CARE CLINIC shall expressly acknowledge receipt of any such changes.

VIII. HIPAA COMPLIANCE AND CONFIDENTIALITY

HIPAA Compliance: PRIMARY CARE CLINIC shall be in compliance with all applicable aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Administrative Simplification Section, Title II, Subtitle F, regarding standards for privacy and security of PHI (protected health information) as outlined in the Act.

PRIMARY CARE CLINIC Requirements. PRIMARY CARE CLINIC, as a business associate of WCHO, must agree to appropriately safeguard any protected health information received from, or created or received by the PRIMARY CARE CLINIC on behalf of WCHO in accordance with WCHO policies and applicable state and federal laws.

- A. Appropriate Uses and Disclosures of PHI. PRIMARY CARE CLINIC may use or disclosure such information:
- for the proper management and administration of its business;
 - for purposes of treatment, payment (if allowed by law), or healthcare operations;
 - for the purpose of providing data aggregation services relating to the health care operations of WCHO (“data aggregation” means combining protected health information created or received by the provider to permit data analyses that relate to the health care operations of a covered entity); or
 - for purposes set forth in WCHO policies or required by law.

PRIMARY CARE CLINIC will not use or further disclose the information other than as permitted or required by this Agreement, or as required by law. Any other use or disclosure of protected health information must be made pursuant to a properly executed Release of Information.

B. Subcontractors. PRIMARY CARE CLINIC will ensure that any agents, including any subcontractors, to whom it provides protected health information received from, or created or received by PRIMARY CARE CLINIC on behalf of WCHO agrees to the same restrictions and conditions that apply to PRIMARY CARE CLINIC with respect to such information.

C. Consumer Requests to Review Record. Since WCHO is the holder of the mental health record for public mental health consumers, WCHO will respond to any consumer request to review such records. PRIMARY CARE CLINIC should notify WCHO immediately of the receipt of any such request.

D. Cooperation with the Secretary of Health and Human Services. PRIMARY CARE CLINIC will make its internal practices, books, and records relating to the use and disclosures of protected health information received from, or created or received by PRIMARY CARE CLINIC on behalf of WCHO available to the Secretary of Health and Human Services, or its designee, for the purpose of determining WCHO’s compliance with the Health Insurance Portability and Accountability Act of 1996.

E. Agreement Termination. At termination of this Agreement, PRIMARY CARE CLINIC will return all protected health information received from, or created or received by PRIMARY CARE CLINIC on behalf of WCHO that PRIMARY CARE CLINIC still maintains in any form, and will retain no copies of such information. If such return is not feasible, PRIMARY CARE CLINIC must extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

F. Breaches of Confidentiality. If PRIMARY CARE CLINIC becomes aware of a material breach or any violation of its obligation to protect the confidentiality and security of consumers' protected health information, PRIMARY CARE CLINIC must immediately take reasonable steps to cure the breach or end the violation, and must report the breach or violation to the WCHO Privacy Officer. The alleged breach or violation will be investigated and an appropriate sanction issued. WCHO reserves the right to terminate this Agreement if it determines that the PRIMARY CARE CLINIC has violated a material term of the Agreement.

G. Additional Confidentiality Requirements: PRIMARY CARE CLINIC acknowledges that consumers of public mental health services are entitled to additional confidentiality protections awarded under the Michigan Mental Health Code, which may supersede the confidentiality protections provided by HIPAA. Furthermore, consumers of substance abuse treatment services are entitled to additional confidentiality protections awarded under 42 CFR, Part 2, which may supersede the confidentiality protections provided by HIPAA. When serving public mental health consumers or when providing substance abuse treatment services at its site, PRIMARY CARE CLINIC will comply with the confidentiality requirements of these and any other applicable state or federal laws, rules, or regulations.

IX. STAFF SUPERVISION

PRIMARY CARE CLINIC will participate in the oversight and supervision of CSTS staff working on site at PRIMARY CARE CLINIC.

X. NOTICE

Any notice substantially affecting the terms or conditions of this Agreement shall be directed to:

WCHO: Kathleen Reynolds, Executive Director
555 Towner Boulevard
Ypsilanti, MI 48197

PRIMARY CARE CLINIC: NAME
 ADDRESS
 ADDRESS

XI. INDEMNIFICATION

The parties shall protect, defend, and indemnify one another, one another's Board members, officers, agents, volunteers, and employees from any and all liabilities, claims, liens, demands, costs, and judgments, including court costs, costs of administrative proceedings, and attorney's fees, which arise out of the occupancy, use, service, operations, performance or nonperformance of work, or failure to comply with federal, state, or local laws, ordinances, codes, rules and regulations, or court or administrative decisions, negligent acts, intentional wrongdoing, or omissions by either party, its officers, employees, agents, representatives, or subcontractors in connection with this Agreement. Nothing herein shall be construed as a waiver of any public or governmental immunity granted to CMHSP and/or any representative of CMHSP as provided in statute or court decisions.

XII. TERMINATION

Termination Without Cause. Either party may terminate this agreement by giving thirty (30) days written notice to the other party.

Termination Effective Immediately Upon Delivery of Notice. The above notwithstanding, either party may immediately terminate this agreement if upon reasonable investigation it concludes:

- 1. That the other party’s Board of Directors, Director/CEO, or other officer or employee has engaged in malfeasance;
- 2. That the other party lost its state licensing (if applicable);
- 3. That the other party lost its eligibility to receive federal funds;
- 4. That the other party cannot maintain fiscal solvency.

XIII. AUTHORITY TO SIGN

The persons signing below certify by their signatures that they are authorized to sign this Agreement on behalf of the party they represent, and that this Agreement has been authorized by said party.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year written below.

Washtenaw Community Health Organization

PRIMARY CARE CLINIC

Kathleen Reynolds
Executive Director

Date

*

Title:

Date

SAMPLE FORMS



Practice: _____
 Address: _____
 Phone: _____ Fax: _____

Napa County Mental Health Referral

Patient Name: _____		DOB: ____/____/____
Parent/Guardian Name: _____	Contact information	
Patient Phone: _____	Language/communication needs: _____	
Referral Date: _____	Provider: _____	
Secure email: _____		

FAX TO NAPA COUNTY MENTAL HEALTH at (707) 251-1070

Reason for PCP Referral:

Crisis Evaluation / Management of Acute Mental Health Disturbance

Routine Intake for Psychiatric Evaluation and Management/Medicine Clinic Priority

I have evaluated this patient and do not have the expertise to treat. Need expert consultation to assist with treatment plan.

Suspected diagnosis/problem and Services Needed

Adult		Pediatric	
Bipolar disorder Schizophrenia Psychosis NOS Depression/Anxiety (failed multiple meds) Post Traumatic Stress (failed multiple meds) Substance abuse Other	Medication O/P Psychotherapy Case Management Substance Abuse Link to other service: (name): _____ _____	Episodic mood disorder Mood disorder Anxiety Disorder Obsessive-compulsive disorders Intermittent Explosive disorder Eating disorder Acute reaction to stress ADD/ADHD Conduct disturbance Substance Abuse Psychotic disorder	Medication O/P

Symptoms:

--

Current Medication

Allergies:

--

Previous psych history (brief, see reverse for details)

Mental Health Provider Communication to PCP:

Current Medication	Past Medication
Allergies:	

Name of Provider _____

Email _____

Diagnosis _____

Brief Treatment Plan or Recommendations

Discharged from hospital, D/C summary att'd

Hospitalize

Evaluate

Medication management

PCP to continue or initiate medication(s)

Note medication change

Referred for services and supports: Case management O/P Therapy Access team

Medication issues: _____

Phone consult with _____ on (date) _____

-See Reverse-

Additional Comments/Notes:

Printed name & signature of person completing form: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient consent to exchange information (to be completed by patient):

I, _____ authorize _____

(Print patient name)

Provider(s) or Facility

behavioral health provider(s), and _____ Primary Care Provider, to exchange information regarding my mental health/ substance abuse treatment and medical health care for coordination of care purposes. This authorization is effective immediately and shall remain in effect for one year from the date of signature. I may revoke/stop this authorization at any time by delivering a written request to the above named parties. A photocopy or facsimile of this signed authorization shall have the same effect as the original.

PHYSICAL HEALTH INFORMATION

I authorize release of the following information:

Diagnosis Medication Treatment Plan

MENTAL HEALTH INFORMATION

I authorize release of the following information:

Diagnosis Medication Treatment Plan

SUBSTANCE ABUSE INFORMATION

I authorize release of the following information:

Diagnosis Medication Treatment Plan

I UNDERSTAND THAT MENTAL HEALTH RECORDS ARE PROTECTED UNDER STATE AND FEDERAL CONFIDENTIALITY REGULATIONS (including, but not limited to California Welfare & Institutions Code 5328) AND SUBSTANCE ABUSE RECORDS ARE PROTECTED BY FEDERAL CONFIDENTIALITY RULES (including, but not limited to 42 CFR, part 2), AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR IN STATE AND FEDERAL REGULATIONS.

Date: _____ Signature: _____

If signed by other than patient, indicate relationship _____

Sample Form: Napa County
Mental Health Referral

Patient Name: _____ Client DOB: _____ Date: _____

Session Number: _____ Contact: Phone In Person Diagnosis: _____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>Circle number to indicate answer.</i>	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the Newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Prior PHQ-9 score _____

Add columns: _____ + _____ + _____

TOTAL: _____

PHQ 9 Key – Depression Severity

0-4 None, 5-9 Mild Depression, 10-14 Moderate Depression, 15-19 Moderately Severe Depression, 20-27 Severe Depression

Does not have/Does have: S/I, Plan, or Intent: _____

Assessment/Observations/Interventions: _____

TREATMENT PLAN:

Behavioral Activation: _____

PST: _____

Medication: Name: _____ Dose: _____ (mg) for _____ days
 _____ Dose: _____ (mg) for _____ days

Side Effects: _____

Other: _____

DCM Signature _____

PCP Signature _____

Date of IMPACT Follow Up apt: _____

Patient Name: _____ Client DOB: _____ Date: _____

Session Number: _____ Contact: Phone In Person Diagnosis: _____

PHQ-9

Over the last 2 weeks, how often have you been bothered By any of the following problems? <i>Circle number to indicate answer</i>	Nunca	Varios Dias	Mas de la mitad de los dias	Casi todos los dias
1. Tener poco interes o placer en hacer las cosas	0	1	2	3
2. Sentirse desanimado/a, deprimido/a, o sin esperanza	0	1	2	3
3. Con problemas en dormirse o en mantenerse dormido/a o en dormir demasiado	0	1	2	3
4. Sentirse cansado/a or tener poca energia	0	1	2	3
5. Tener poco apetito o comer en exceso	0	1	2	3
6. Sentir falta de amor propio o que sea un fracaso o que decepcionara a si mismo o a su familia	0	1	2	3
7. Tener dificultad para concentrarse en cosas tales como leer el periodico o mirar la television	0	1	2	3
8. Se mueve o habla tan lentamente que otra gente se podria dar cuenta o de lo contrario esta tan agitado/a inquieto/a que se mueve mucho mas de lo acostumbrado	0	1	2	3
9. Se la han ocurrido pensamientos de que seria mejor estar muerto/a O de que haria daño de alguna manera a si mismo	0	1	2	3

Prior PHQ-9 score _____ Add
columns: _____ + _____ + -----
TOTAL: _____

PHQ 9 Key – Depression Severity

0-4 None, 5-9 Mild Depression, 10-14 Moderate Depression, 15-19 Moderately Severe Depression, 20-27 Severe Depression

Does not have/Does have: S/I, Plan, or Intent: _____

Assessment/Observations/Interventions: _____

TREATMENT PLAN:

Behavioral Activation: _____

PST: _____

Medication: Name: _____ Dose: _____ (mg) for _____ days
Dose: _____ (mg) for _____ days

Side Effects: _____

Other: _____

DCM Signature _____ PCP Signature _____

Date of IMPACT Follow Up apt: _____





Mental Health and Primary Care Integration Project Suicide Protocol

Assess for thoughts, plan, intent and means.

1. If client has thoughts of suicide but is not at imminent risk and will contract for safety

- a. Provide San Diego Access and crises hotline # (800) 479-3339.
- b. If it is the therapist's on going patient, therapist will create a safety plan and have patient sign a no-harm contract in which the client will agree to contact the therapist and/or county crises if he/she becomes actively suicidal.
- c. Schedule a follow up in person or phone contact within one week.

2. If patient is not an ongoing patient but has thoughts of suicide but is not at imminent risk:

- a. Provide San Diego Access and crises hotline # (800) 479-3339.
- b. Provide referrals to local mental health agencies.
- c. Have patient sign a no harm contract and schedule an in-person or phone session. Include in contract that if client becomes actively suicidal, that he/she will contact therapist and/or county crises immediately.
- d. Contact patient to confirm that he/she has scheduled an appointment with another therapist/ agency. Document information in progress note.

3. If patient has thoughts of suicide and is at imminent risk

- a. Inform Dr and/or Physician Assistant of patient's suicidality.
- b. Find someone to monitor patient while therapist or other provider contact 911 and request PERT.
- c. Contact therapist's licensed supervisor if no other provider is on site.

4. ** If police do not transport client but client appears at risk**

- a. Contact patients identified emergency contact and include him/her in no-harm safety contract. Have emergency contact contract that he/she will transport patient to hospital or walk-in crisis center.
- b. Therapist will provide crises hotline # as well as well create written safety contract including follow up session date/time.
- c. Therapist will obtain name and contact information of patient's therapist, if applicable, to inform him/her of suicidal ideations.
- d. Therapist will document information in a progress note, including times and contact person's names.



Mental Health and Primary Care Integration Project IMPACT - Relapse Prevention Plan

Client Name: _____ Date: _____

Contact/Appointment Information

Primary Care Physician: _____ Telephone _____

Next Appointment: _____ Recommended timeframe for appointments: _____

Depression Care Manager: _____ Telephone _____

Next Appointment: _____ Recommended timeframe for appointments: _____

Comments: _____

Medications

1) _____; _____ tablets of _____ mg, Take until _____

2) _____; _____ tablets of _____ mg, Take until _____

3) _____; _____ tablets of _____ mg, Take until _____

** It is important that you call your DCM or primary care physician before stopping any medications.*

Healthy Behaviors to Continue

1) _____

2) _____

3) _____

4) _____

5) _____

Personal Warning Signs

1) _____

2) _____

3) _____

4) _____

5) _____

Sample Form: IMPACT Relapse Prevention Plan (CCC, San Diego)



Mental Health and Primary Care Integration Project

Medication and Lab Test Formulary

* Please note all prescriptions are to be filled with generic medications unless the medication is available only by brand name. The 5 brand name medications are starred and listed in italics.

Anti-Depressants	Antipsychotics
Amitriptyline (generic for Elavil)	* <i>Ability</i>
Bupropion (generic for Wellbutrin)	* <i>Geodon</i>
Bupropion XL (generic for Wellbutrin XL)	Haloperidol (generic for Haldol)
Bupropion SR (generic for Wellbutrin SR)	* <i>Risperdal</i>
Citalopram (generic for Celexa)	Sleep Aids
Fluoxetine (generic for Prozac)	Triazolam (generic for Halcion)
Mirtazapine (generic for Remeron)	Zolpidem (generic for Ambien)
Paroxetine (generic for Paxil)	Temazepam (generic for Restoril)
Sertraline (generic for Zoloft)	Flurazepam (generic for Dalmane)
Trazodone (generic for Desyrel)	Trazodone (generic for Desyrel)
* <i>Effexor XR</i>	Hydroxyzine (generic for Vistaril)
Mood Stabilizers	Other Misc Medications
Carbamazepine (generic for Tegretol)	Benzotropine (generic for Cogentin)
Divalproax (generic for Depakote)	Diphenhydramine (generic for Benadryl)
Lithium (generic for Lithobid)	Trihexyphenidyl (generic for Artane)
Anxiolytics	Covered Lab Tests
Alprazolam (generic for Xanax)	Carbamazepine Level (3 times max)
Bupirone (generic for Buspar)	CBC (2 times max)
Clonazepam (generic for Klonopin)	Comprehensive Metabolic Panel (2 times)
Lorazepam (generic for Ativan)	Lipid Panel (2 times max)
Stimulants	Lithium Level (3 times max)
* <i>Adderall XR</i>	Liver Enzymes (3 times max)
d&l- Amphetamine (generic for Adderall)	TSH (2 times max)
Methylphenidate (generic for Ritalin)	Valproic Acid Level (3 max)

Rev. 2/5/09

Chart Audit Tool

Mental Health and Primary Care Integration Project

CCC ID # _____ Name _____ County Case # _____

1. Chart Structure					
a.	Is the mental health record <input type="checkbox"/> separate or <input type="checkbox"/> combined with the medical record?	Date: _____	Date: _____	Date: _____	Date: _____
b.	If the records are combined is there a clearly identified mental health section? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date: _____	Date: _____	Date: _____	Date: _____
2. Per CCC records how many visits has the client had with the therapist/DCM _____ and PCP/Psychiatrist _____					
For remaining questions answer YES or NO in the columns to the right for the six most recent visits.					
3. Chart Contents – Psychotropic Medication; does the chart contain the following items?					
a.	Prescriptions for psychotropic medications	Date: _____	Date: _____	Date: _____	Date: _____
b.	Medication Pre-Authorization/Reimbursement Request form	Date: _____	Date: _____	Date: _____	Date: _____
c.	If so was form received by CCC per CCC records	Date: _____	Date: _____	Date: _____	Date: _____
d.	Billing Sheet for medication management visit	Date: _____	Date: _____	Date: _____	Date: _____
e.	If so was form received by CCC per CCC records	Date: _____	Date: _____	Date: _____	Date: _____
For remaining questions answer YES or NO in the column below.					
4. Chart Contents – Mental Health Treatment; does the chart contain the following items?					
f.	Mental Health Assessment (County approved forms)	YES	NO	Medications Prescribed	Dates Prescribed
g.	Treatment Plan				
h.	Progress Notes				
i.	Other County Forms (Demographic form, Diagnosis form, etc.)				
j.	Completed "Authorization to Use and Disclose Protected Health Information" (HIPAA) forms.				
k.	Documentation of reimbursement for medication or medication management visit by other sources? If so, note whom?				
5. Note other problems or concerns:					

SAMPLE Screening and Evaluation Instruments

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use “√” to indicate your answer)

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

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

FORM A: FOR SELF-ADMINISTRATION BY THE RESPONDENT (revised 4-2000)
DUKE HEALTH PROFILE (The DUKE)

Copyright © 1989-2005 by the Department of Community and Family Medicine,
 Duke University Medical Center, Durham, N.C., U.S.A.

Date Today: _____ Name: _____ ID Number: _____

Date of Birth: _____ Female _____ Male _____

INSTRUCTIONS: Here are some questions about your health and feelings. Please read each question carefully and check (✓) your best answer. You should answer the questions in your own way. There are no right or wrong answers. (Please ignore the small scoring numbers next to each blank.)

Sample Screening & Evaluation Instruments: Duke Health Profile

	Yes, describes me exactly	Somewhat describes me	No, doesn't describe me at all
1. I like who I am	_____ 12	_____ 11	_____ 10
2. I am not an easy person to get along with	_____ 20	_____ 21	_____ 22
3. I am basically a healthy person	_____ 32	_____ 31	_____ 30
4. I give up too easily	_____ 40	_____ 41	_____ 42
5. I have difficulty concentrating	_____ 50	_____ 51	_____ 52
6. I am happy with my family relationships	_____ 62	_____ 61	_____ 60
7. I am comfortable being around people	_____ 72	_____ 71	_____ 70

TODAY would you have any physical trouble or difficulty:

	None	Some	A Lot
8. Walking up a flight of stairs	_____ 82	_____ 81	_____ 80
9. Running the length of a football field	_____ 92	_____ 91	_____ 90

DURING THE PAST WEEK: How much trouble have you had with:

	None	Some	A Lot
10. Sleeping	_____ 102	_____ 101	_____ 100
11. Hurting or aching in any part of your body	_____ 112	_____ 111	_____ 110
12. Getting tired easily	_____ 122	_____ 121	_____ 120
13. Feeling depressed or sad	_____ 132	_____ 131	_____ 130
14. Nervousness	_____ 142	_____ 141	_____ 140

DURING THE PAST WEEK: How often did you:

	None	Some	A Lot
15. Socialize with other people (talk or visit with friends or relatives)	_____ 150	_____ 151	_____ 152
16. Take part in social, religious, or recreation activities (meetings, church, movies, sports, parties)	_____ 160	_____ 161	_____ 162

DURING THE PAST WEEK: How often did you:

	None	1-4 Days	5-7 Days
17. Stay in your home, a nursing home, or hospital because of sickness, injury, or other health problem	_____ 172	_____ 171	_____ 170

MANUAL SCORING FOR THE DUKE HEALTH PROFILE

Copyright ©1994-2005 by the Department of Community and Family Medicine
Duke University Medical Center, Durham, N.C., U.S.A.

Item	Raw Score*	
8 =	_____	<u>PHYSICAL HEALTH SCORE</u>
9 =	_____	
10 =	_____	
11 =	_____	
12 =	_____	
Sum =	_____ x 10 =	<input type="text"/>

Item	Raw Score*	
1 =	_____	<u>MENTAL HEALTH SCORE</u>
4 =	_____	
5 =	_____	
13 =	_____	
14 =	_____	
Sum =	_____ x 10 =	<input type="text"/>

Item	Raw Score*	
2 =	_____	<u>SOCIAL HEALTH SCORE</u>
6 =	_____	
7 =	_____	
15 =	_____	
16 =	_____	
Sum =	_____ x 10 =	<input type="text"/>

<u>GENERAL HEALTH SCORE</u>		
Physical Health score =	_____	<input type="text"/>
Mental Health score =	_____	
Social Health score =	_____	
Sum =	_____ ÷ 3 =	

<u>PERCEIVED HEALTH SCORE</u>		
Item	Raw Score*	
3 =	_____ x 50 =	<input type="text"/>

Item	Raw Score*	
1 =	_____	<u>SELF-ESTEEM SCORE</u>
2 =	_____	
4 =	_____	
6 =	_____	
7 =	_____	
Sum =	_____ x 10 =	<input type="text"/>

To calculate the scores in this column the raw scores must be revised as follows:
If 0, change to 2; if 2, change to 0; if 1, no change.

Item	Raw Score*	Revised	
2 =	_____	_____	<u>ANXIETY SCORE</u>
5 =	_____	_____	
7 =	_____	_____	
10 =	_____	_____	
12 =	_____	_____	
14 =	_____	_____	
Sum =	_____	_____ x 8.333 =	<input type="text"/>

Item	Raw Score*	Revised	
4 =	_____	_____	<u>DEPRESSION SCORE</u>
5 =	_____	_____	
10 =	_____	_____	
12 =	_____	_____	
13 =	_____	_____	
Sum =	_____	_____ x 10 =	<input type="text"/>

Item	Raw Score*	Revised	
4 =	_____	_____	<u>ANXIETY-DEPRESSION (DUKE-AD) SCORE</u>
5 =	_____	_____	
7 =	_____	_____	
10 =	_____	_____	
12 =	_____	_____	
13 =	_____	_____	
14 =	_____	_____	
Sum =	_____	_____ x 7.143 =	<input type="text"/>

<u>PAIN SCORE</u>		
Item	Raw Score*	
11 =	_____ Revised _____	x 50 = <input type="text"/>

Item	Raw Score*	Revised	
17 =	_____	_____	x 50 = <input type="text"/>

* Raw Score = last digit of the numeral adjacent to the blank checked by the respondent for each item. For example, if the second blank is checked for item 10 (blank numeral = 101), then the raw score is "1", because 1 is the last digit of 101.

Final Score is calculated from the raw scores as shown and entered into the box for each scale. For physical health, mental health, social health, general health, self-esteem, and perceived health, 100 indicates the best health status, and 0 indicates the worst health status. For anxiety, depression, anxiety-depression, pain, and disability, 100 indicates the worst health status and 0 indicates the best health status.

Missing Values: If one or more responses is missing within one of the eleven scales, a score cannot be calculated for that particular scale.

Sample Screening & Evaluation Instruments: Duke Health Profile

MINI Patient Health Survey

(furnished by Sierra Family Medical Clinic, Nevada City)

Patient Name: _____ Date: _____

SECTION I Male ___ Female ___ Your age _____ Phone: _____

YES	NO	
		1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?
		2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?

If your answer to both questions above is “no”, please go to Section II without answering question 3 below.

YES	NO	
		3. Over the past two weeks, when you felt depressed or uninterested:
		a. Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e. by plus or minus 5% body weight or plus or minus 8 lbs or plus or minus 3.5 kg for a 160 lb/70 kg person in a month)? (If yes to either, please check “YES”.)
		b. Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?
		c. Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?
		d. Did you feel tired or without energy almost every day?
		e. Did you feel worthless or guilty almost every day?
		f. Did you have difficulty concentrating or making decisions almost every day?
		g. Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?

SECTION II

YES	NO	
		1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?

If your answer to this question is “no”, you have completed Section II – please do not answer the questions below. Please go to Section III.

YES	NO	
		2. In the past 12 months:
		a. Did you need to drink more in order to get the same effect as when you first started drinking?
		b. When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms? (If yes to either please check “YES”.)

YES	NO	
		c. During the times when you drank alcohol, did you end up drinking more than you planned when you started?
		d. Have you tried to reduce or stop drinking alcohol but failed?
		e. On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?
		f. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?
		g. Have you continued to drink even though you knew that it caused you problems?

SECTION III

YES	NO	
		1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either please check “YES”.)
		2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?

If your answer to both questions above is “NO”, please proceed to Section IV without answering any other questions below in Section III.

		3. Have you even had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack?
		4. During the worst spell that you can remember:
		a. Did you have skipping, racing or pounding of your heart?
		b. Did you have sweaty or clammy hands?
		c. Were you trembling or shaking?
		d. Did you have shortness of breath or difficulty breathing?
		e. Did you have a choking sensation or lump in your throat?
		f. Did you have chest pain, pressure, or discomfort?
		g. Did you have nausea, stomach problems, or sudden diarrhea?
		h. H. Did you feel dizzy, unsteady, lightheaded, or faint?
		i. Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?
		j. Did you fear that you were losing control or going crazy?
		k. Did you fear that you were dying?
		l. Did you have tingling or numbness in parts of your body?
		m. Did you have hot flashes or chills?
		5. In the past month, did you have such attacks repeatedly (two or more) followed by persistent fear of having another attack?

SECTION IV

YES	NO	
		1. In the past month, were you fearful of or embarrassed by being watched or being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public alone or with others, writing while someone watches, or being in social situations?
		2. Is this fear excessive or unreasonable?
		3. Do you fear these situations so much that you avoid them or suffer through them?
		4. Does this fear disrupt your normal work or social functioning or cause you significant distress?

SECTION V

YES	NO	
		1. Have you had excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities (such as work or school performance)?
		2. Did you find it difficult to control the worry?

If you answered “no” to question 1 or 2 in this section, you are finished with this form. If you answered “yes” please answer these last two questions. Thank you!

		3. During that six months, which of the following symptoms were present for more days than not?
		a. restlessness or feeling keyed up or on edge
		b. being easily fatigued
		c. difficulty concentrating or mind going blank
		d. irritability
		e. muscle tension
		f. sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
		4. Do the anxiety, worry, or physical symptoms disrupt your normal work or functioning, or cause you significant distress?

PROVIDERS PLEASE COMPLETE THIS SECTION

DX: OK D AD PD SAD GAD

Other _____

RX by Provider only? Yes No

Provider Initials: _____

RAND HEALTH 36-Item Health Survey 1.0 Questionnaire

Another self-administered quality-of-life measure “widely used for routine monitoring and assessment of care in adult patients”, the 36-item Health Survey developed by the Rand Corporation, is available for use contingent on meeting Rand’s stipulations.

1. In general, would you say your health is:	
Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago , how would you rate your health in general now ?	
Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

(Circle One Number on Each Line)

	Yes, Limited a Lot	Yes, Limited a Little	No, Not limited at All
3. Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	[1]	[2]	[3]
4. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	[1]	[2]	[3]
5. Lifting or carrying groceries	[1]	[2]	[3]

6. Climbing several flights of stairs	[1]	[2]	[3]
7. Climbing one flight of stairs	[1]	[2]	[3]
8. Bending, kneeling, or stooping	[1]	[2]	[3]
9. Walking more than a mile	[1]	[2]	[3]
10. Walking several blocks	[1]	[2]	[3]
11. Walking one block	[1]	[2]	[3]
12. Bathing or dressing yourself	[1]	[2]	[3]

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

(Circle One Number on Each Line)

	Yes	No
13. Cut down the amount of time you spent on work or other activities	1	2
14. Accomplished less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

(Circle One Number on Each Line)

	Yes	No
17. Cut down the amount of time you spent on work or other activities	1	2
18. Accomplished less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(Circle One Number)

Not at all 1 Slightly 2 Moderately 3 Quite a bit 4 Extremely 5

21. How much **bodily** pain have you had during the **past 4 weeks**?

(Circle One Number)

None 1 Very mild 2 Mild 3 Moderate 4 Severe 5 Very severe 6

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

(Circle One Number)

Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely 5

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks** . . .

(Circle One Number on Each Line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6

25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

(Circle One Number)

All of the time 1 Most of the time 2 Some of the time 3 A little of the time 4
None of the time 5

How TRUE or FALSE is each of the following statements for you.

(Circle One Number on Each Line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

LOCUS ASSESSMENT

(Version 2000)

Consumer Name: _____ Facility Chart Number: _____

Rater Name: _____ Date of Rating: _____

1. Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

I. Risk Of Harm

- 1 Minimal Risk of Harm
 - 2 Low Risk of Harm
 - 3 Moderate Risk of Harm
 - 4 Serious Risk of Harm
 - 5 Extreme Risk of Harm
- Score _____

IV-B. Recovery Environment – Support

- 1 Highly Supportive Environment
 - 2 Supportive Environment
 - 3 Limited Support in Environment
 - 4 Minimal Support in Environment
 - 5 No Support in Environment
- Score _____

II. Functional Status

- 1 Minimal Impairment
 - 2 Mild Impairment
 - 3 Moderate Impairment
 - 4 Serious Impairment
 - 5 Severe Impairment
- Score _____

V. Treatment and Recovery History

- 1 Full Response to Treatment/Recovery Mgmt.
 - 2 Significant Response to Treatment/Recovery Mgmt
 - 3 Moderate or Equivocal Resp to Treatment/Recovery Mgmt
 - 4 Poor Response to Treatment and Recovery Mgmt.
 - 5 Negligible Response to Treatment/Recovery Mgmt.
- Score _____

III. Co-Morbidity

- 1 No Co-Morbidity
 - 2 Minor Co-Morbidity
 - 3 Significant Co-Morbidity
 - 4 Major Co-Morbidity
 - 5 Severe Co-Morbidity
- Score _____

VI. Engagement

- 1 Optimal Engagement
 - 2 Positive Engagement
 - 3 Limited Engagement
 - 4 Minimal Engagement
 - 5 Unengaged
- Score _____

IV-A. Recovery Environment - Level of Stress

- 1 Low Stress Environment
 - 2 Mildly Stressful Environment
 - 3 Moderately Stressful Environment
 - 4 Highly Stressful Environment
 - 5 Extremely Stressful Environment
- Score _____

Total Composite Score (Total I –VI, above): _____

- Care Level I = Recovery/Health Maintenance = 10 – 13**
- Level II = Low Intensity Community Based Services = 14 – 16**
- Level III = High Intensity Community Based Services = 17 – 19**
- Level IV = Medically Monitored Non-Residential Services = 20 – 22**
- Level V = Medically Monitored Residential Services = 23 – 27**
- Level VI = Medically Managed Residential Services = 28 or more**

Note: Due to independent criteria, some scores require automatic admissions to a higher level of care regardless of combined score. A score of 4 on dimensions I, II or III results in placement at level five and a score of 5 on dimensions I, II or III results in placement at level six. These automatic higher level placements may be waived if “2” equals the sum of the IVA and IVB scores.

2. LOCUS Derived Level of Care Recommendation (consult grid): _____

3. Actual (Disposition) Level of Care: _____

Reason for Deviation from LOCUS Level of Care Recommendation (at #2 above) if applicable:

CAGE questionnaire — screen for alcohol misuse

Alcohol dependence is likely if the patient gives two or more positive answers to the following questions:

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticising your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

The combination of CAGE questionnaire, MCV and GGT activity will detect about 75% of people with an alcohol problem.

RESOURCES





COUNTY Mental Health Contacts

Alameda

Alameda County Behavioral Health Care
Services
2000 Embarcadero Cove
Oakland, CA 94606
Ph: 610 567-8100

Alpine

Alpine County Behavioral Health Services
75 C Diamond Valley Rd
Markleeville, CA 96120
Ph: 530-694-1816

Amador

Amador County Mental Health
10877 Conductor Blvd
Sutter Creek, CA 95685
Ph: 209 223-6412

Berkeley City

Berkeley City Mental Health Administration
1947 Center Street
Berkeley, CA 94704
Ph: 510 981-5270

Butte

Butte County Department of Behavioral
Health
107 Parmac Rd, Suite 4
Chico, CA 95926
Ph: 530 891-2850

Calaveras

Calaveras County Behavioral Health Services
891 Mountain Ranch Rd.
San Andreas, CA 95249
Ph: 209 754-6525

Colusa

Colusa County Department of Behavioral
Health

162 E. Carson St., Suite A
Colusa, CA 95932
Ph: 530 458-0520

Contra Costa

Contra Costa County Mental Health
1340 Arnold Drive
Martinez, CA 94553
Ph: 925 957-5111

Del Norte

Del Norte County Mental Health
880 Northcrest Drive
Crescent City, CA 95531
Ph: 707 463-3191

El Dorado

Health Services Department, Mental Health Division
670 Placerville Drive, Suite 1B
Placerville, CA 95667
Ph: 530 621-6200

Fresno

Department of Behavioral Health
5108 E. Clinton Way, Ste 108
Fresno, CA 93727
Ph: 559 452-3463

Glenn

Glen County Behavioral Health
242 N. Villa Ave.
Willows, CA 95988
Ph: 530934-6582

Humboldt

Humboldt County Department of Health and Human
Services
720 Wood St.
Eureka, CA 95501
Ph: 707 268-2990

Imperial

Imperial County Behavioral Health Services
202 No. 8th St
El Centro, CA 92243
Ph: 760 482-4068

Inyo

Inyo County Mental Health
162 J Grove St.
Bishop, CA 95314
Ph: 760 873-6533

Kern

Kern County Mental Health Services
P.O. Box 1000
Bakersfield, CA 93302
Ph: 661 868-6600

Kings

Kings County Behavioral Health Administration
1400 W. Lacey Blvd.
Hanford, CA 93230
Ph: 559 582-3211

Lake

Lake County Mental Health Department
991 Paralle Drive
Lakeport, CA 95453
Ph: 707 263-4338

Lassen County

Lassen County Health and Social Services
1445 Paul Bunyan Rd.
Susanville, CA 96130
Ph: 530 251-8128

Los Angeles

Los Angeles County Mental Health 550 So. Vermont
Los Angeles, CA 90020
Ph: 213 738-4601

Madera County

Madera County Behavioral Health Services
P.O. Box 1288
Madera, CA 93639
Ph: 559 675-7926

Marin

Marin County Community Mental Health
Services
20 N. San Pedro
San Rafael, CA 94903
Ph: 415 499-6769

Mariposa

Mariposa County Mental Health
P.O. Box 99
Mariposa, CA 95338
Ph: 209 966-2000

Mendocino

Mendocino County Mental Health
860 N. Bush St.
Ukiah, CA 95482
Ph: 707 463-4303

Merced

Merced County Mental Health
3090 M Street
Merced, Ca 95348
Ph: 209 381-6813

Modoc

Modoc County Mental Health Services
441 N. Main St.
Alturas, CA 96101
Ph: 530 233-6312

Mono

Mono County Mental Health Services
P.O.x Box 2619
Mammoth Lakes, CA 93546
Ph: 760 924-1740

Monterey

Monterey County Mental Health
1270 Natividad Rd
Salinas, CA 93906
Ph: 831 755-4510

Napa

Napa County Health & Human Services
2261 Elm Street
Napa, CA 94559
Ph: 707 253-4279

Nevada

Nevada County Behavioral Health
500 Crown Pont Circle
Grass Valley, CA 95945
Ph: 530 265-1437

Orange

Orange County Behavioral Health Services
405 West 5th Street
Santa Ana, CA 92701
Ph: 714 834-6023

Placer

Placer County Adult Systems of Care
11512 B Avenue, DeWitt Center
Auburn, CA 95603
Ph: 530 889-7240

Plumas

Plumas County Mental Health Services
270 County Hospital Road
Quincy, CA 95971
Ph: 530 283-6307

Riverside

Riverside County Mental Health
P.O. Box 7549
Riverside, CA 92503
Ph: 951 358-4500

Sacramento

Department of Health & Human Services
7001-A East Parkway
Sacramento, CA 95823
Ph: 916 875-6091

San Benito

San Benito County Behavioral Health
1131 San Felipe Road
Hollister, CA 95023
Ph: 831 636-4020

San Bernardino

San Bernardino County Behavioral Health
268 West Hospitality Lane
San Bernardino, Ca 92415
Ph: 909 382-3133

San Diego

San Diego County Behavioral Health Division
3255 Camino Del Rio South
San Diego, CA 92108
Ph: 619 563-2700

San Francisco

San Francisco Community Behavioral Health
Services
1380 Howard Street
San Francisco, CA 94103
Ph: 415 255-3400

San Joaquin County

San Joaquin County Behavioral Health Services
1212 North California Street
Stockton, CA 95202
Ph: 209 468-8700

San Luis Obispo

San Luis Obispo County Behavioral Health
Department
2178 Johnson Avenue
San Luis Obispo, CA 93401
Ph: 805 781-4719

San Mateo

San Mateo County Behavioral Health and Recovery
Services
225 37th Avenue
San Mateo, CA 94403
Ph: 650 573-2541

Santa Barbara

Santa Barbara County Alcohol, Drug & Mental
Health Services
300 No. San Antonio Road
Santa Barbara, CA 93110
805 681-5220

Santa Clara

Santa Clara County Valley Health and Hospital
System – Mental Health Department
828 South Bascom Avenue
San Jose, CA 95128
Ph: 408 885-5770

Santa Cruz

Santa Cruz County Mental Health and Substance Abuse Services
1400 Emeline Avenue, Bldg. K
Santa Cruz, CA 95060
Ph: 831 454-4170

Shasta

Shasta County Mental Health, Alcohol & Drug Department
Mental Health Department
P.O. Box 496048
Redding, CA 96049
Ph: 530 225-5200

Sierra

Sierra County Mental Health
704 Mill Street/P.O. Box 265
Loyalton, CA 96118
Ph: 530 993-6748

Siskiyou

County of Siskiyou Behavioral Health Services
2060 Campus Drive
Yreka, CA 96097
Ph: 530 841-4100

Solano

Solano County Health and Social Services
275 Beck Avenue
Fairfield, CA 94533
Ph: 707 784-8320

Sonoma

Sonoma County Mental Health
3322 Chanate Road
Santa Rosa, CA 95404
Ph: 707 565-4850

Stanislaus

Stanislaus County Behavioral Health and Recovery Services
800 Scenic Drive
Modesto, CA 95350
Ph: 209 525-6225

Sutter/Yuba

1965 Live Oak Blvd.
P.O. Box 1520

Yuba City, CA 95991
Ph: 530 822-7200

Tehama

Tehama County Health Services Agency,
Mental Health Division
P.O. Box 400
Red Bluff, CA 96080
Ph: 530 527-5631

Tri-City

Tri-City Mental Health Center
2008 N. Garey Avenue
Pomona, CA 91767
Ph: 900 623-6131

Trinity

Trinity County Behavioral Health Services
1450 Main Street/P.O. Box 1640
Weaverville, CA 96093
Ph: 530 623-1362

Tulare

Tulare County Health and Human Services Agency, Department of Mental Health
5957 South Mooney Blvd.
Visalia, CA 93277

Tuolumne

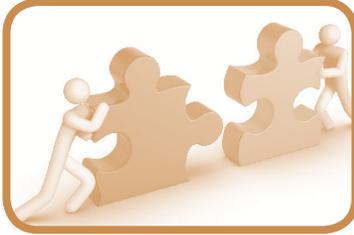
Tuolumne County Behavioral Health Department
2 South Green Street
Sonora, CA 95370
Ph: 209 533-6245

Ventura

Ventura County Behavioral Health Department
1911 Williams Drive
Oxnard, CA 93036
Ph: 805 981-6830

Yolo

Yolo County Department of Alcohol, Drug & Mental Health
137 North Cottonwood Stretts
Woodland, CA 95695
Ph: 530 666-8516



CALIFORNIA Primary Care Organizations

Statewide

California Primary Care Association	Carmela Castellano – Garcia, President /CEO	1215 K Street, Suite 700 Sacramento, CA 95814	(916) 440-8170	www.cPCA.org
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Regional

Alameda Health Consortium	Ralph Silber, Executive Director	1320 Harbor Bay Parkway, Suite 250 Alameda, CA 94502	(510) 769-2232	www.chcn-eb.org
Alliance for Rural Community Health (Lake and Mendocino Counties)	Cathy Frey, Executive Director	367 North State Street, Suite 201, Ukiah, CA 95482	(707) 462-1477	www.ruralcommunityhealth.org
Capitol Community Health Network (Sacramento region)	Marty Keale, Executive Director	1401 21st Street, Suite 320, Sacramento CA 95811	(916) 447-7222	www.capitolhealthnetwork.org
Central Valley Health Network (including Fresno, Bakersfield, Stockton, Merced, and other Central Valley sites)	David Quackenbush, CEO	2000 O Street, Suite 100, Sacramento CA 95811	(916) 552-2846	www.cvhnclinics.org
Coalition of Orange County Community Clinics	Isabel Becerra, CEO	17701 Cowan Avenue, Suite 220, Irvine CA 92614-6057	(949) 486-0458	http://www.coccc.org

Community Clinic Association of Los Angeles County	Gloria Rodriguez, CEO	1055 Wilshire Boulevard, Suite 100, Los Angeles, CA 90017	(213) 201-6513	www.ccalac.org
Community Clinic Consortium (Contra Costa and Solano County)	Tanir Ami, Executive Director	3720 Barrett Avenue Richmond, CA 94805-2253	(510) 233-6230	www.clinicconsortium.org
Community Health Partnership (Santa Clara County area)	Victoria Emmons, CEO	100 North Winchester Boulevard, Suite 250 Santa Clara CA 95050-6250	(408) 556-6605	www.chpscc.org
Council of Community Clinics	Steve O’Kane, CEO	Post Office Box 880969 San Diego CA 92168	(619) 542-4300	www.ccc-sd.org
North Coast Clinics Network (Humboldt and nearby area)	Tim Rine Interim Executive Director	P.O. Box 966 Eureka, CA 95502	(707) 444-6226	www.northcoastclinics.org
Northern Sierra Rural Health Network	Doreen Bradshaw	1900 Churn Creek Rd. Suite 208 Redding, CA 96002	(530) 722-1156	www.nsrhn.org
Redwood Community Health Coalition (Marin, Napa, Yolo and Sonoma)	Nancy Oswald, Executive Director	1180 4th Street Suite B Santa Rosa CA 95404-4010	(707) 542-7242	www.rchc.net
San Francisco Community Clinic Consortium	John Gressman, President/ CEO	1550 Bryant Street, Ste 450 San Francisco, CA 94103	(415) 355-2233	www.sfccc.org
Shasta Consortium of Community Health Centers	Doreen Bradshaw. Executive Director	2280 Benton Drive, Building. C, Suite C Redding CA 96003	(530) 247-1560	www.shastaconsortium.org



Other Key California Organizations

California Department of Alcohol & Drug Programs

1700 K ST.
Sacramento, CA 95811
(916) 327-4178
Resource Center: (916) 327-3728
Email (Resource Center): askadp@adp.ca.gov

California Department of Health Care Services

Primary and Rural Health Division
P.O. Box 997413, MS 8501
Sacramento, CA 95899-7413
916-445-4171; general: 916-449-5770

California Department of Mental Health Stephen Mayberg Ph.D, Director

1600 9th Street, Rm. 151
Sacramento, CA 95814
(800) 896-4042
email: dmh.dmh@dmh.ca.gov

California Institute for Mental Health (CiMH)

Sandra Naylor Goodwin, Ph.D
Executive Director
2125 19th Street, 2nd Floor
Sacramento, CA 95818
Office: (916) 556-3480
Fax: (916) 446-4519
E-mail: bfield@cimh.org

California Mental Health Directors Association (CMHDA)

Patricia Ryan, Executive Director
2125 19th Street, 2nd Floor
Sacramento, CA 95818
Office: (916) 556-3477
Fax: (916) 446-4519

California Mental Health Planning Council

[Ann Arneill-Py](#), Executive Officer
1600 9th Street, Room 350
Sacramento, CA 95814
Office: (916) 654-3585
Fax: (916) 654-2739

California Network of Mental Health Clients

Larry Belcher, Executive Director
2012 19th Street, Suite 100
Sacramento, CA 95818
800 626-7447
email: Main@californiaclients.org

California Telehealth and Telemedicine Center

1215 K St, Ste 800
Sacramento, CA 95814
(916) 552-7579

County Medical Services Program (CMSP)

1451 River Park Drive, Suite 222
Sacramento, CA 95815
(916) 649-2631
info@cmspcounties.org

Mental Health Association in California

[Rusty Selix](#), Executive Director
1127 11th Street, Suite 925
Sacramento, CA 95814
Office: (916) 557-1167

National Alliance for the Mentally Ill (NAMI) California

Grace McAndrews, Executive Director
1111 Howe Avenue, Suite 475
Sacramento, CA 95825
Office: (916) 567-0163
Fax: (916) 567-1757
E-mail: nami@namicalifornia.org



WEBSITES for Collaborative Care Information

We at IBHP have created a virtual library as a resource for those contemplating, planning and operating treatment programs that integrate behavioral and medical services. The IBHP website contains collaborative models, procedures, operational manuals, forms, tools, research findings, screening instruments, papers, policy and more that we think might be valuable to others starting down the road to collaborative care.

GO TO: www.ibhp.org

There are several other websites that contain valuable information and tools to assist in the development of integrated programs, among them:

Bureau of Primary Care (HRSA)

<http://bphc.hrsa.gov>

California Department of Health Care Services
Office of HIPAA Compliance www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/default.aspx

CaIMEND

<http://www.calmend.org>

Collaborative Family Healthcare Association

www.cfha.net

Hogg Foundation for Mental Health (Texas)

www.utexas.edu/programs_ihc.html

ICARE Partnership (North Carolina)

www.icarenc.org

IMPACT Model for Treating Depression in Primary Care www.impact-uw.org

Integrated Primary Care

www.integratedprimarycare.org

MacArthur Initiative on Depression in Primary Care

www.depression-primarycare.org

Mountainview Consulting Group

www.behavioral-health-integration.com

National Guideline Clearinghouse

www.guideline.gov

National Council for Community Behavioral Healthcare

www.thenationalcouncil.org

Rand Partners in Care Initiative

www.rand.org/health/projects/pic

Robert Wood Johnson Foundation
Depression in Primary Care Initiative

www.wpic.edu/dppc

The Reach Institute

Guidelines for Adolescent Depression in Primary Care

www.thereachinstitute.org/guidelines-for-adolescent-depression-in-primary-care-glad-pc.html

Washtenaw County Health Organization
(Michigan)

www.ewashtenaw.org/government/departments/wcho/ch

[behealthcarepresentation.pdf](#) (Powerpoint of their integrated program)



SAMPLE Collaborative Initiatives Across the Nation

The following table of collaborative initiatives from across the nation are taken from a 2007 report prepared for the Robert Wood Johnson Foundation by Health Management Associates, entitled *Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives*.

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Center for Adolescent Health – Adolescent Treatment Initiative Eastern Grafton County, New Hampshire	The Center for Adolescent Health, a specialty adolescent health program affiliated with Dartmouth-Hitchcock Medical Center	Adolescents	Collaborating partners staff an interdisciplinary clinic that provides biopsychosocial, diagnostic, treatment planning and intervention services, as well as general medical services. Support provided to area PCPs so they can screen, assess and provide brief interventions. Grounded in Dr. Engel’s biopsychosocial model.	Grants, county funds and 3 rd party reimbursement	Provide a seamless continuum of high-quality, evidenced based adolescent substance abuse screening, assessment and treatment.	In the process of conducting a two-year evaluation. Will assess community readiness to address adolescent substance abuse; measure access and retention; and assess client needs and outcomes.
Cleveland Coalition for Pediatric Mental Health Cuyahoga County, Ohio	A coalition of local pediatricians, child psychiatrists, child psychologists, county mental health board administrators and other community leaders	Pediatricians, and their adolescent patients and families	Piloting use of the Child Health and Development Interaction System (CHADIS), a web-based diagnostic, management and tracking tool. Also developed a web-based mental health resource guide to maximize available mental health resources and help pediatricians link adolescent patients to appropriate resources.	Grants and 3 rd party reimbursement (providers who use CHADIS can bill Medicaid for developmental testing)	1) Educate/support pediatricians; 2) Engage/support parents; 3) Build/strengthen networks between pediatricians and behavioral health providers; 4) Advocate on mental health issues.	Surveys of resource guide and CHADIS users is pending.

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Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
<p>Colorado Access Integration Model</p> <p>Denver, Colorado and surrounding areas</p>	<p>Colorado Access, a managed care organization formed by Denver area safety-net providers to serve publicly insured populations</p>	<p>Adult Medicaid enrollees, focusing on the most costly 2-3%</p>	<p>A RWJ Depression in Primary Care pilot. Screened high risk health plan members for depression using the PHQ-9, provided evidence-based treatment of depression and bipolar disorder in primary care and created care management teams. A centralized care management model based in part on the Assertive Community Treatment and Wagner chronic care models.</p>	<p>Grants and Medicaid managed care capitation payments</p>	<p>1) Provide better primary care for SPMI patients, including pharmacy management; 2) Improve access to mental health care for those who primarily seek care in the primary care setting.</p>	<p>Significant reduction in physical health care costs for high risk plan members, making it an economically sustainable model of integration</p>
<p>Community Care of North Carolina Mental Health Integration</p> <p>North Carolina</p>	<p>Community Care of North Carolina, the state's PCCM program</p>	<p>Adolescents and adults in the Medicaid PCCM program</p>	<p>Behavioral health providers are located in primary care facilities and universal screening tools are used. Provides support to improve communication between PCPs and behavioral health care providers. There is a mental health focus. Based on the Wagner chronic care model (with focus on primary care delivery and social support) and the NCCBH four quadrant integration model.</p>	<p>Medicaid and grant funding</p>	<p>There are many stated goals, but the primary goal is to overcome inadequate access to behavioral health services and manage both the behavioral and physical health needs of Medicaid enrollees served in the state's PCCM program.</p>	<p>Standard measurements across the pilot sites have been created. Data collected from the PHQ-9 supports the project and the need for additional support.</p>

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Community Health Center, Inc. Central and Southern Connecticut	Community Health Center, Inc., a multi-site FQHC	Adolescents and adults	Co-located primary care and behavioral health services; “morning huddles” with interdisciplinary physical and behavioral health teams; “pod” workites to facilitate communication among interdisciplinary staff.	3 rd party reimbursement and grants	Co-locate mental health professionals with medical treatment providers to facilitate seamless service delivery (i.e., “warm handoff” from primary care to behavioral health services).	The prevalence of depression among diabetics and postpartum women patients has been identified.
Hogg Foundation Integration Grants Austin, Texas	The Hogg Foundation for Mental Health	Grant recipients, including community based health centers, a FQHC, a pediatric group practice and other primary care providers	Grant program to support primary care providers in implementing the collaborative care model for mental health and physical health care. Based on variations of Wagner’s chronic care model.	Hogg foundation grants	Increase access to effective mental health care and promote the adoption of collaborative care by reducing real world barriers to successful implementation.	In the process of conducting a process and outcome evaluation. Quantitative and qualitative data will be collected in the domains of mental health status, treatment costs, customer satisfaction, decreased service use, etc.
Horizon Health Services Western New York	Horizon Health Services, a state-certified provider of substance abuse and mental health services that operates 8 CMHCs	Adults and the elderly with mild to severe mental illness or addiction	Co-location of medical health services and behavioral health services. Based on a primary care model designed to screen, treat and manage medical conditions associated with mental illness and addictions.	3 rd party reimbursement, primarily Medicaid and Medicare	Provide onsite access to medical care and facilitate coordination between substance abuse, mental health and medical services providers.	Outcomes data does not currently exist.

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Kaiser Permanente Southern California Depression Care Program Southern California	Kaiser Permanente of Southern California, an integrated health system	Adults with chronic illness and non-critical mental health needs	Adopted IMPACT model of collaborative care for depression that utilizes a depression care manager along with the patient and primary care physician.	Kaiser Permanente and Medicare	Identify and effectively treat all members with a chronic illness and depression using evidence-based guidelines.	67% of depressed KPSC members showed significant improvement in PHQ-9 or GDS scores; savings of 14% per year achieved during the IMPACT study and an additional 9% for one year post-study.
Massachusetts Behavioral Health and Primary Care Integration Projects Massachusetts	Massachusetts Behavioral Health Partnership, a state Medicaid managed behavioral health provider	Adults with chronic physical illness and mental health and/or substance abuse needs	Six demonstration sites created out of partnerships between FQHCs and CMHCs to integrate behavioral health care and physical health care services. There is an emphasis on evidence-based practices and improving service delivery.	Grants, Medicaid, uncompensated care pool and the Commonwealth Health Plan	There are many stated goals, including improving the identification and treatment of behavioral health disorders, increasing efficiency and institutionalizing use of evidence based practices.	In the process of developing cross-site evaluation measures which will include both process and outcomes measures.
Rebuilding Lives PACT Team Initiative Columbus, Ohio	The Community Shelter Board, a non-profit entity created to respond to the problem of homelessness in Columbus, Ohio	Chronically homeless individuals with a severe mental disability	Several models in use including: ACT, IDDT, Housing First and Supported Employment.	Grants, Medicaid reimbursement	Implement a multi-system, multi-agency collaboration designed to seamlessly coordinate services and access to resources for chronically homeless with severe mental disabilities.	External evaluation indicated a 67% reduction in legal infractions. Clients reported receiving mental health services more often and having a better quality of life since receiving supportive housing.

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Washtenaw Community Health Organization Ypsilanti, Michigan	The Washtenaw Community Health Organization, a collaborative partnership with the University of Michigan Department of Psychiatry, county government, county mental health centers and private health clinics	Stable SPMI consumers and consumers identified to be in need of mental health consultation	Integration of bifurcated health care funding into a single policy making board. Six integrated clinics have been launched since 2003. The Wagner chronic care model is used as an underlying approach to integration, with other models also used.	Medicaid, Medicare and other 3 rd party reimbursement, local taxes, grant funds, private funds and state general funds	Create innovative best practices in the delivery of integrated health care with a medical home to Medicaid, Medicare and indigent patients	Slight increase in physical health care and medical costs, with a marked decrease in mental health only diagnoses and treatment. Drop in unemployment, homelessness and legal issues reported at one site.



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