PARTNERS IN HEALTH

MENTAL HEALTH, PRIMARY CARE AND SUBSTANCE USE INTERAGENCY COLLABORATION

TOOL KIT

2nd Edition, 2013

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ACKNOWLEDGEMENTS

This updated Tool Kit was developed – partially written and partially compiled – by Barbara Demming Lurie of the Integrated Behavioral Health Project (IBHP) and sponsored by the California Mental Health Services Authority's (CalMHSA) Statewide Stigma and Discrimination Reduction Initiative.

The original 2009 Tool Kit was created under the auspices of the Tides Center and the California Endowment. Questions and comments may be directed to Barbara Demming Lurie at barb@ibhp.org.

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...and the many anonymous clients who added their voice to the contents.

Launched in 2006, the Integrated Behavioral Health Project (IBHP) is an initiative to accelerate the integration of behavioral and medical health in California. To that end, we have awarded grants to community clinics and clinic consortia; established learning communities; sponsored web-based training; established a mentoring program; developed program and systems policy; conducted process and outcome research; and advocated for collaboration between the mental health, primary care and substance abuse systems for better client care. 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. Our current work is under the auspices of the Tides Center and the California Mental Health Service Authority (see separate boxes).

Visit IBHP.org for more information about collaborative care.

The California Mental Health Services Authority (CalMHSA) is an Independent Administrative and Fiscal Governments Agency focused on the efficient delivery of California Mental Health Projects. Member counties jointly develop, fund, and implement mental health services, projects, and educational programs at the state, regional, and local levels, using revenues generated by Proposition 63. One of the many programs under CalMHSA's purview is the Stigma and Discrimination Reduction Initiative, which uses a full range of prevention and early intervention strategies across the lifespan and across diverse backgrounds to confront the fundamental causes of stigmatizing attitudes and discriminatory and prejudicial actions.

http://calmhsa.org

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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

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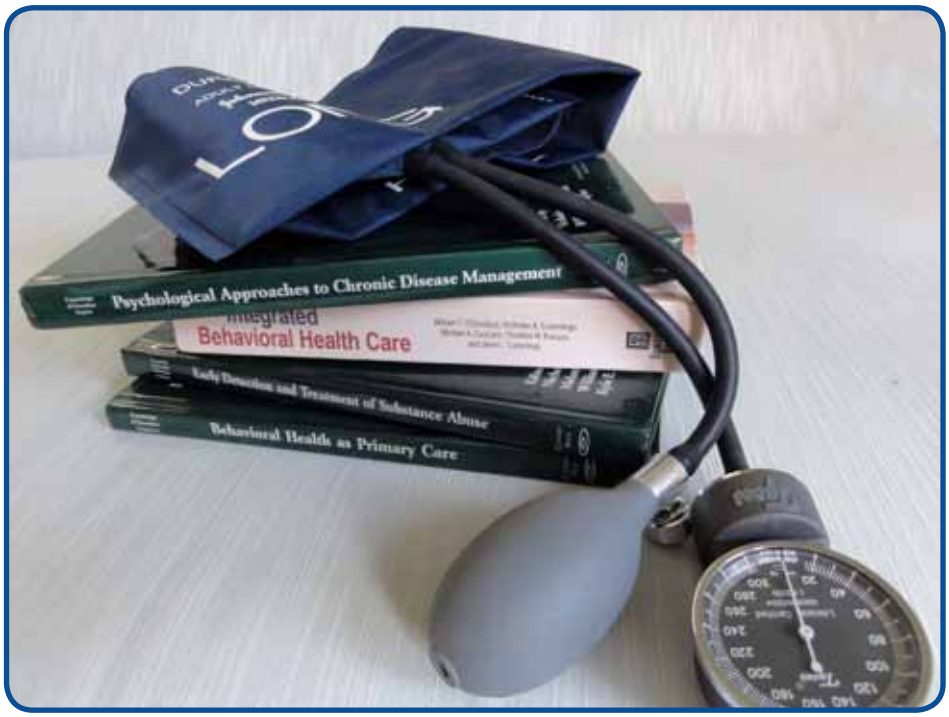
SOME BASICS



The good clinician treats the problem; the great clinician treats the patient* who has the problem.

-William Osler MD (paraphrased)

** Most medical practitioners use the term "patient," while mental health professionals tend to use "client" or "consumer," a term favored by many receiving mental health treatment. Because integration of care also means integration of language, these three terms are used interchangeably throughout this Kit.*

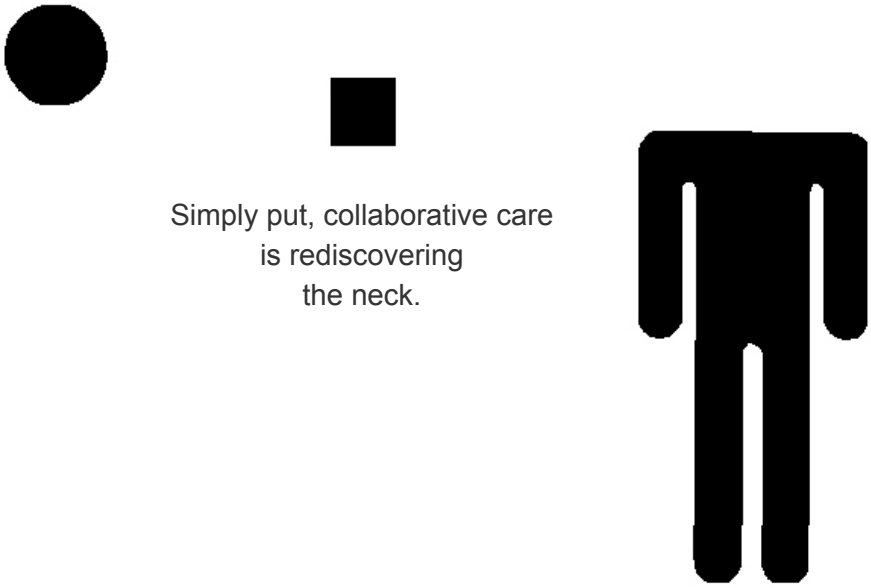
WHAT is Integrated Care?

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.*

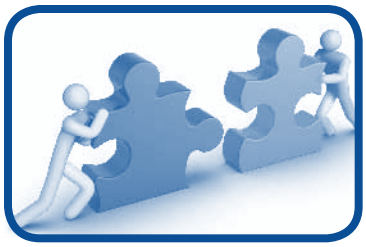
Mental Health System

Physical Health System



Simply put, collaborative care is rediscovering the neck.

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

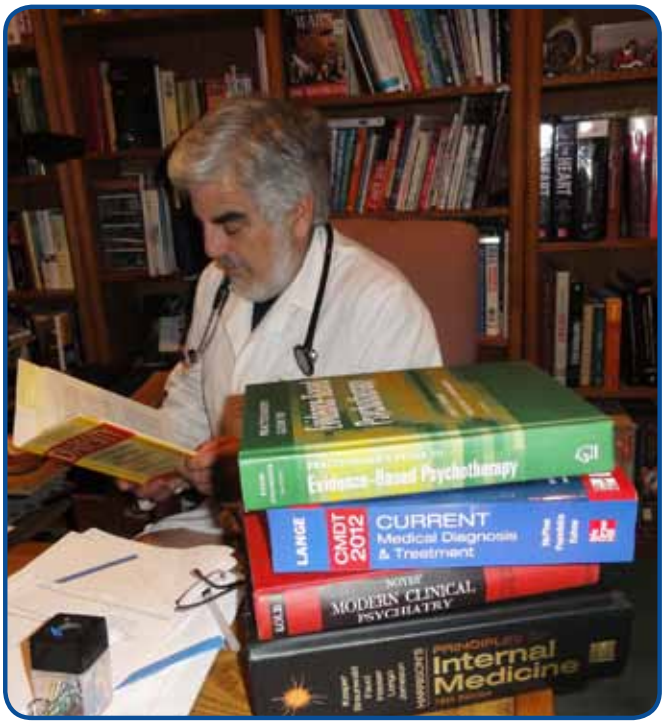


WHY Primary Care - Behavioral Health Collaboration?

Because...

- Integration of services means a more cohesive service delivery system and better continuity of care.
- Many behavioral and physical disorders are co-occurring, especially depression and chronic medical conditions.
- 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
- People with serious mental health conditions are dying on average 25 years earlier than the general population.
- Improving mental status and functioning often positively impacts physical conditions.
- There are often better mental health outcomes when physical problems are managed.
- Studies have shown that initially most people turn to primary care providers, not specialty mental health clinics, with their emotional problems.
- Health care visits often have psychosocial drivers; psychosocial stress is a major factor in triggering physical illness and exacerbating existing chronic illnesses.
- Many mental health clients have co-occurring medical disorders that go unrecognized by substance use and mental health providers.
- Both medical and behavioral professionals can get the "full picture" about the clients they're treating.
- According to research, client compliance with medical regimens like diet and smoking cessation are increased when behavioralists provide training and guidance.
- Many people being served by public behavioral health services need better access to primary care – and some with access are still not connected to a primary care provider.
- Community health centers serve people who need better access to behavioral healthcare.
- Integrated care prepares care systems to be client-centered health homes and positions them advantageously for health care reform.
- Behavioral health clinicians are a resource for assisting people with all types of chronic health conditions.
- Addressing psychosocial aspects of problems presented in primary care often results in lower overall health costs.

- Clients like the convenience of "one-stop shopping."
- Primary care is often the first-line intervention and only access for many people with mental health problems.
- Offering behavioral health services in nontraditional settings encourages participation by people wanting to avoid the stigma surrounding mental health treatment.
- It presents an opportunity to intervene early and prevent more disabling disorders.
- More people, who cannot or will not access specialty behavioral health care, can be reached.
- The primary care network is a main provider of services to minority populations and culturally diverse communities.
- It improve the skills of primary care clinicians in recognizing and treating persons with mental health conditions.
- It improves the skills of mental health professionals in recognizing and treating the psychological effects of physical conditions.
- It increases the use of behavioral interventions in primary care.
- Primary care physicians' knowledge, skill-sets and comfort-zone are expanded as a result of collaboration with mental health professionals.
- Underlying behavioral or emotional conditions can increase unnecessary medical utilization and inappropriate referrals.
- 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.
- Subclinical and clinical depression is frequently misdiagnosed or underdiagnosed in general medical populations.
- 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.
- Drug and alcohol problems are risk factors for other health conditions.
- Depression is a frequent complication of cancer, post-cardiac surgery, diabetes, post-partum, and in the treatment of any chronic and debilitating physical illness.
- Emotional factors are thought to play a role in triggering asthma attacks and exacerbations of autoimmune diseases.



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- 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.
- Compliance with medical regimens improves with sobriety.
- Mental health outcomes improve when substance use disorders are managed.
- Many clients transfer the trust and rapport they share with their physicians to the behavioral specialist he or she designates.
- 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.
- 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.
- Physicians report increased satisfaction when they have easily available back-up care for their clients' mental health needs.
- Management of emotional/behavioral disorders may positively impact adherence to treatment of physical disorders.
- 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."
- The primary care network serves a primarily poor and underserved population.
- Primary care providers have been shown to have a high level of client adherence and retention in treatment.
- 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.
- There is the opportunity for quality improvement of care within the primary care and specialty behavioral healthcare settings.
- Primary clinics are often easier for consumers to access than mental health facilities.

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

How Health Care Reform Supports Integrated Behavioral Health

The Patient Protection and Affordable Care Act (ACA, effective January 2014) provides incentives and support for the integration of behavioral, substance use and primary care services for millions of additional persons it makes eligible for health care.

Medical and Behavioral Health Homes

The ACA supports Patient-Centered Medical Homes (PCMH's), also known as "health homes," and Accountable Care Organizations (ACO's). To succeed, these models must establish:

- Integrated care teams of health professionals;
- Care coordination and information sharing;
- Health information technology (for example, quality improvement tracking of treatment outcomes).

Through Section 2703 of the ACA, SAMHSA and the Centers for Medicare and Medicaid are working together to build person-centered health homes that result in improved outcomes. The Medicaid health home option offers the opportunity to create behavioral health homes for people with serious mental health and substance use disorders. Because this option does not require these health homes to provide the full array of required services themselves -- so long as they ensure the availability and coordination of these services -- behavioral health agencies are encouraged to build local partnerships.

FQHC's Role

The ACA is committed to providing $11 billion nationwide to bolster and expand Federally Qualified Health Centers (FQHC's). FQHC's will play a significant role in the implementation of the ACA because of their emphasis on coordinated primary care, preventive services and implementation of the medical home model.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA is addressing integrated models of care by supporting programs that aim to improve the physical status of people with serious mental illnesses. Through their Primary and Behavioral Health Care Integration grants, SAMHSA provides funding to health care organizations working toward integrating primary care services into publicly funded community-based behavioral health settings.

California's 1115 Medicaid Demonstration Waiver

Effective November 2010 through October 2015, the Waiver provides approximately $10 billion in federal funds to better prepare the state's health system for national reform, including improved access to mental health services and increased incentives for integration of behavioral and primary care services. A key component is the Low-Income Health Program Coverage Expansion (LIHP), an optional, local program extending coverage to low-income adults.

The Reviews Are In...

WHAT KEY PLAYERS ARE SAYING ABOUT PARTNERSHIPS BETWEEN COUNTY BEHAVIORAL 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 Direrctor, 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

WHY BI-DIRECTIONAL, COLLABORATIVE BEHAVIORAL HEALTH CARE?

I. 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 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)*
- 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)*

> ***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**

- 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)*

> ***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**

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II. Health care visits often have psychosocial drivers. Mental health problems can stem from physical ones. 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. *(J. Unutzer et al., 2006)*
- 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**

III. 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)*
- Patients who receive care for depression in primary care clinics with routine mental health integrated teams and care processes were 54% less likely to use high-order emergency department services. *(B. Reiss-Brennan et al., 2010)*
- Adding integrated services in one study added $250 per patient to overall costs, but saved approximately $500 in additional medical costs. *(W. Katon et al., 1996)*
- When family physicians worked collaboratively with mental health professionals to treat persons on short-term mental health disability leave, their patients returned to work at higher rates than those treated by physicians alone. The average cost savings to employers was $503 per patient. *(C. Dewa, 2009)*
- 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 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)*

- 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. *(M. Dickinson et al., 2005)*
- The addition of psychological interventions for Kaiser clients with serious medical disorders resulted in a 78% reduction in their average length of hospitalization; a 67% reduction in hospitalization frequency; a 49% decrease in number of prescriptions written; a 49% decrease in physician office visits, a 45% decrease in emergency room visits and 31% decrease in telephone contacts. *(R. Lechnyr, 1999)*
- Based on an analysis of multiple published studies, interventions that provide training to primary care teams in how to manage depression most consistently produce net cost benefits, with more costly interventions generating larger net benefits. *(S. Glied et al., 2010)*

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

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

- During the year studied, Kaiser Permanente realized a $173 savings per member per month for those participating in an integrated medical care program for substance-use related medical conditions versus usual care *(Parthasarathy et al., 2003)*

IV. 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. *(S. 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 concerned 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)*

V. 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)*
- Sixty-nine percent of clients approved for services in San Diego primary clinics as part of a MHSA-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, 2011)*
- 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. *(V. 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 at 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." *(K. 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 *(R. Gross 2002)*

> ***Having mental health personnel stationed at primary care streamlines the 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**

- 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. *(K. 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). *(K. Strosahl, 1997)*
- 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)*

> ***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**

- 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)*

VI. Bi-directional and integrated behavioral health services have been shown in several studies to result in positive clinical outcomes and high client satisfaction.

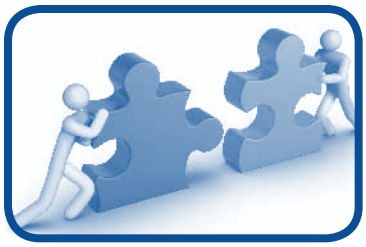
- A review of 78 articles on the effectiveness of collaborative chronic care models for mental health conditions found significant effects across disorders and care settings for depression, physical quality of life and social functioning. *(E. Woltmann, 2012)*
- Patients with serious mental illness receiving care in Veterans Affairs mental health programs with co-located general medical clinics were more likely to receive adequate medical care than patients in programs without co-located clinics based on a nationally representative sample. *(A. Kilbourne et al., 2011)*
- An analysis of 37 randomized studies of collaborative depression treatment in primary care found improved significantly outcomes at six months compared with standard treatment and evidence of longer-term benefit for up to 5 years. *(S. Gilbody et al., 2006)*
- Persons with serious mental illness receiving services in a mental health center who were randomly assigned to medical care managers (who provided communication and advocacy with medical providers, health education and assistance) received a significantly higher level of cardiometabolic services and scored higher on mental health screens than the comparable treatment-as-usual group. *(B. Druss, 2010)*

> ***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**

- 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 Chenet 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:

Level of Collaboration Indicators

Dimensions:

- Level of communication between behavioral and primary care services
- Physical proximity of primary care and behavioral services
- Ease and timeliness of accessing services between behavioral and primary care services
- Availability of expertise between behavioral and primary care services
- Amount of cross-training between mental health and primary care services
- Availability of client information/records between services
- Level of care referrals between systems
- Level of understanding of each other's roles and responsibilities between services
- Degree of sharing/blending fiscal responsibilities

BRIDGING THE CULTURAL GAP:

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

** While these descriptions apply to most primary care clinics, there are many exceptions. Some clinics offer more in-depth behavioral health care and serve persons with more severe behavioral impairments. Substance use treatment is also not included in this chart.*

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.

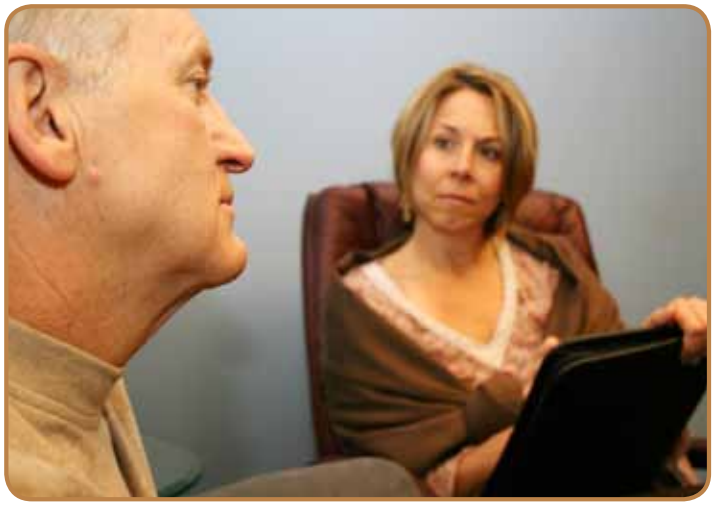
How many clients do behavioral health providers see in a given day?

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 MHSA-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. They are required to see all uninsured patients, but are not federally required to provide direct behavioral services, just referrals.

How much does a behavioral session cost?

Based on data gathered by the Council of Community Clinics in San Diego in 2009, 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

Adapted from the Rural Assistance Center and the National Association of Rural Health Clinics.

Many primary care clinics are designated as 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, and have a governing board that includes consumers.

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 services on site or by arrangement with another provider. Other services that must be directly rendered are preventative dental services, transportation services necessary for adequate patient care, and emergency services. While many FQHCs provide mental health and substance use treatment on-site, unless they receive special funding, they are only legally required to provide referrals for this type of care, as well as referrals to other specialty services. Because FQHCs have a range of behavioral health capabilities, any referrals to them should be done with their collaboration.

Are there special staffing requirements for FQHCs?

No, there are no specific requirements for staffing mix at FQHCs. However, California has restricted eligible providers who can provide Medi-Cal services. Consequently, though BSWs, MSWs, MFTs, and drug abuse counselors may be employed, their services are not reimbursable under FQHC Medi-Cal provisions. FQHCs are required to have a core staff of full time providers but there is no specific definition of core staff.

Are there requirements governing the hours an FQHC must be open?

To receive special benefits, certain FQHCs do have to meet minimum hour requirements, but in general, they just have to "provide services at times that assure accessibility to meet the needs of the population being served" per federal requirements. However, they must provide professional coverage during hours when the health center is closed.

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.

ISSUES Worth Considering in Forging Partnerships

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 clinics and health centers. 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.

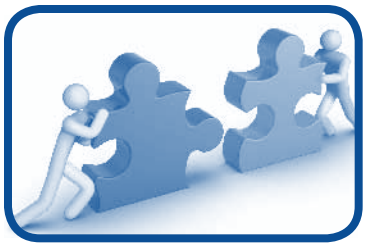
MFT'S NOT MEDI-CAL REIMBURSABLE: Exacerbating the shortage of mental health professionals in California is the fact that Marriage and Family Therapists (MFTs), are not recognized as reimbursable providers in primary care clinics. Currently, only psychiatrists, licensed clinical psychologists, and licensed 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. Conversely, setting up a primary care clinic within a mental health location may be like Cinderella's step-sister getting her foot in the shoe. 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 IN PRIMARY CARE: 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.

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, Medi-Cal 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 it.
- 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.

Quadrant IV: High Behavioral, High Physical Health Complexity/Risk – Those with severe mental illness or emotional disturbance co-occurring with one or more complex medical condition, such as diabetes or cardiovascular problems. This population can be served in both the specialty behavioral health and primary care/medical specialty systems. In addition to the behavioral case manager, there may be a disease manager working in coordination.

The Four Quadrant Clinical Integration Model

Quadrant II
BH ↑ PH ↓

- Behavioral health clinician/case manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and guidelines)
- **Outstationed medical nurse practitioner/physician at behavioral health site**
- Specialty behavioral health
- Residential behavioral health
- Crisis/ED
- Behavioral health inpatient
- Other community supports

Quadrant IV
BH ↑ PH ↑

- PCP (with standard screening tools and guidelines)
- **Outstationed medical nurse practitioner/physician at behavioral health site**
- **Nurse care manager at behavioral health site**
- Behavioral health clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty behavioral health
- Residential behavioral health
- Crisis/ ED
- Behavioral health and medical/surgical inpatient
- Other community supports

Persons with serious mental illnesses could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.

Quadrant I
BH ↓ PH ↓

- PCP (with standard screening tools and behavioral health practice guidelines)
- PCP-based behavioral health consultant/care manager
- **Psychiatric consultation**

Quadrant III
BH ↓ PH ↑

- PCP (with standard screening tools and behavioral health practice guidelines)
- PCP-based behavioral health consultant/care manager (or in specific specialties)
- Specialty medical/surgical
- **Psychiatric consultation**
- ED
- Medical/surgical inpatient
- Nursing home/home based care
- Other community supports

Behavioral Health (MHSA) Risk/Complexity: Low → High

Physical Health Risk/Complexity: Low → High

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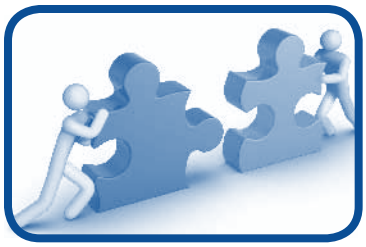

Some Types of Primary Care Behavioral Services

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%	• 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%	• 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%	• Same parameters as the General Behavioral Health Consultation Visit, but handled via telephone.
Behavioral Health Case Conference	10%*	• 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%*	• Reserved for use by consulting psychiatrist. • Provides assessment and review of pharmacological regimen.

*These services do not necessarily involve direct client contact

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GETTING STARTED on the Road to Integration

Patient-Centered Integrated Behavioral Health Care Principles & Tasks

AIMS CENTER
Advancing Integrated Mental Health Solutions

About This Tool

This checklist was developed in consultation with a group of national experts (http://bit.ly/IMHC-experts) in integrated behavioral health care with support from The John A. Hartford Foundation, The Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, and California HealthCare Foundation. For more information, visit: http://bit.ly/IMHC_principles.

The core principles **of effective integrated behavioral health care include a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.**

Principles of Care	We apply this principle in the care of of our patients: None	Some	Most/All
1. Patient-Centered Care			
Primary care and behavioral health providers collaborate effectively using shared care plans.	☐	☐	☐
2. Population-Based Care			
Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.	☐	☐	☐
3. Measurement-Based Treatment to Target			
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.	☐	☐	☐
4. Evidence-Based Care			
Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.	☐	☐	☐
5. Accountable Care			
Providers are accountable and reimbursed for quality care and outcomes.	☐	☐	☐

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Core components and tasks are shared by effective integrated behavioral health care programs. The AIMS Center Integrated Care Team Building Tool (http://bit.ly/IMHC-teambuildingtool) can help organizations build clinical workflows that incorporate these core components and tasks into their unique setting.

Core Components & Tasks	None	Some	Most/All
	of our patients receive this service		
1. Patient Identification and Diagnosis			
Screen for behavioral health problems using valid instruments	☐	☐	☐
Diagnose behavioral health problems and related conditions	☐	☐	☐
Use valid measurement tools to assess and document baseline symptom severity	☐	☐	☐
2. Engagement in Integrated Care Program			
Introduce collaborative care team and engage patient in integrated care program	☐	☐	☐
Initiate patient tracking in population-based registry	☐	☐	☐
3. Evidence-Based Treatment			
Develop and regularly update a biopsychosocial treatment plan	☐	☐	☐
Provide patient and family education about symptoms, treatments, and self management skills	☐	☐	☐
Provide evidence-based counseling (e.g., Motivational Interviewing, Behavioral Activation)	☐	☐	☐
Provide evidence-based psychotherapy (e.g., Problem Solving Treatment, Cognitive Behavior Therapy, Interpersonal Therapy)	☐	☐	☐
Prescribe and manage psychotropic medications as clinically indicated	☐	☐	☐
Change or adjust treatments if patients do not meet treatment targets	☐	☐	☐
4. Systematic Follow-up, Treatment Adjustment, and Relapse Prevention			
Use population-based registry to systematically follow all patients	☐	☐	☐
Proactively reach out to patients who do not follow-up	☐	☐	☐
Monitor treatment response at each contact with valid outcome measures	☐	☐	☐
Monitor treatment side effects and complications	☐	☐	☐
Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment	☐	☐	☐
Create and support relapse prevention plan when patients are substantially improved	☐	☐	☐
5. Communication and Care Coordination			
Coordinate and facilitate effective communication among providers	☐	☐	☐
Engage and support family and significant others as clinically appropriate	☐	☐	☐
Facilitate and track referrals to specialty care, social services, and community-based resources	☐	☐	☐
6. Systematic Psychiatric Case Review and Consultation			
Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving	☐	☐	☐
Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals	☐	☐	☐
Provide psychiatric assessments for challenging patients in-person or via telemedicine	☐	☐	☐
7. Program Oversight and Quality Improvement			
Provide administrative support and supervision for program	☐	☐	☐
Provide clinical support and supervision for program	☐	☐	☐
Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement	☐	☐	☐

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THE PARTNERSHIP MODEL

(extracted from "Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home" [with slight modifications], National Council for Community Behavioral Healthcare, 2009)

In a partnership model between a behavioral health organization and a full-scope healthcare home, the organizations must assure mission alignment and be deliberate about designing clinical mechanisms for collaboration, supported by structural and financial arrangements appropriate to their local environment. Ideally, the following six components will be available as part of the partnership. The first three should be in place at a minimum:

1. Regular screening and registry tracking/outcome measurement at the time of psychiatric visits

Assure regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all individuals receiving psychotropic medications—check glucose and lipid levels, as well as blood pressure and weight/BMI, recordand track changes and response to treatment, and use the information to obtain and adjust treatment accordingly.

2. Medical nurse practitioners/ primary care physicians located in behavioral health facilities

Provide routine primary care services in the behavioral health setting via a nurse practitioner or physician out-stationed from the full-scope healthcare home. Organizations implementing this model have found that adoption of primary care improvements such as open access scheduling and group visits are effective methods for engaging people in healthcare. The strategy of easy access can be used to engage individuals in their healthcare and connect them to an ongoing relationship with the full-scope healthcare home for their complex healthcare concerns. Nurse practitioners should be highly experienced, with readily available access to a supervising physician and an ongoing training/ supervision component to ensure quality of care.

3. Primary care supervising physician within the primary care facility

Identify a physician within the healthcare facility to provide consultation on complex health issues for the psychiatrist, medical nurse practitioner and/or nurse care manager if there is no primary care physician practicing at the behavioral health site.

4. Embedded nurse care manager in the behavioral health setting

Embed nurse care managers within the primary care team working in the behavioral health setting to support individuals with significantly elevated levels of glucose, lipids, blood pressure, and/or weight/ BMI. Accountabilities would include keeping the registry (glucose, lipids, blood pressure, and weight/ BMI) current and complete, longitudinal monitoring of health status and communicating the need for treatment adjustments to the primary care team, as well as coordinating care across multiple medical providers on behalf of the team. For people who have established external primary care relationships and choose not to use the primary care services available in the behavioral health setting, the nurse care manager would work to establish this team relationship with outside healthcare providers and might accompany individuals to outside medical appointments.

Nurse care managers and the primary care team would use standard protocols and curriculum to assure the following services in primary care settings:

- Intake Assessment
- Health examination
- Medication list
- Vital signs monitoring
- Preventive healthcare
- Disease specific goals
- Action plan
- Healthcare proxy
- Health education

The nurse care managers would work with individuals to connect them to the full scope person-centered healthcare home (using the behavioral health entry point as the entry point into primary healthcare as well as access to dental services), link them to enabling services, benefits counseling and peer mentors, as well as plan and co-lead with peers ongoing groups that support smoking cessation, weight management, and physical exercise.

Behavioral health care managers can be redeployed to the care management function, especially for individuals with less complex healthcare needs, after being provided with training in chronic medical conditions and care management. All behavioral health clinicians/case managers play key team roles in the following ways:

- Assuring that behavioral health treatment plans incorporate selected general healthcare goals and actions from the primary care arena;
- Working with nurse care managers on specific elements of individuals' self management plans; accompanying individuals to medical appointments;
- Linking to non-medical enabling functions; and
- Providing assistance with community resources such as housing and other supports.

For collaborative care to be effective, the respective roles and responsibilities of all members of the team should be defined, and structures put in place to support each member of the team.

5. Evidence-based practices to improve the health status of the population with serious mental illnesses

6. Wellness programs

Engage individuals in managing their health conditions. The InSHAPE program in New Hampshire includes the following methods:

- Individualized fitness and healthy lifestyle assessment
- Individual meetings with a "Health Mentor"
- Membership vouchers to local fitness centers (e.g., YMCA; Dance-exercise center; Women's fitness center)
- Motivational rewards
- Group health education/motivational "celebrations"
- Nurse evaluation and consultation

Integrated Behavioral Health Care Team Building Process

AIMS CENTER
Advancing Integrated Mental Health Solutions

This team building tool was developed based on experience helping more than 500 organizations adapt, implement, and sustain evidence-based collaborative care for common mental disorders. Our experience has taught us that for integrated care programs to succeed, clinics need to clearly define the roles of all team members and create an effective shared workflow that makes optimal use of existing staff resources and meets the behavioral health needs of the unique patient population served by each clinic.

There are 5 steps in the team building process:

1. **Individual Team Members Complete a Staff Self-assessment**
2. **Identify Gaps, Duplication of Services, and Training Needs**
3. **Create a Customized Integrated Behavioral Health Care Workflow for your Practice**
4. **Generate an Implementation Plan and Timeline Tailored to Your Practice**
5. **Track Program Outcomes and Adjust as Necessary**

There are 3 worksheets to support this team building process:

1. **Team Member Self Assessment**
2. **Task Summary by Team Member**
3. **Summary & Change Plan**

Facilitation of Integrated Care Team Building Process

First, 1 or 2 team member(s) should be identified to facilitate the team building process:

1. Tailor worksheets based on relevant collaborative care tasks
2. Distribute and collect completed Step 1 Worksheets for each team member*
3. Tabulate all team member responses by completing the Task Summary by Staff Worksheet
4. Facilitate a follow-up meeting after Team Building Worksheets are completed and tabulated, and document—during or after the meeting—the current status and change plans in the Summary & Change Plan Worksheet
5. Create an implementation plan and timeline
6. Regularly revisit the Summary & Change Plan with the team to review progress and adjust roles as necessary

**For the purpose of team building, define the integrated care team broadly: include all clinical staff who are involved (including primary care providers) and administrative staff (e.g., clinic manager)*

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STEP 1: Individual Team Members Complete a Staff Self-assessment

Identify relevant collaborative care tasks and who is currently performing each task.

- First, the team member(s) facilitating the team building process will identify all relevant collaborative care tasks—based on target patient populations, clinical conditions, etc—and will tailor the worksheets accordingly.
- Each member of the team will **complete the Staff Self-assessment Worksheet** individually.
- The worksheet lists several collaborative care tasks—for each task, individuals will answer:

  1. Is the task part of the individual's role now?
  2. If not part of the individual's role now, whose role is it?
  3. What is the organization's capacity with regards to this task?
  4. What is the individual's comfort level with this task? (respondents should answer even if they are not currently doing this task)
  5. Would the individual like training to learn or improve their capacity to perform this task?
  6. Are there other important tasks that should be on this list?

STEP 2: Identify Gaps, Duplication of Services, and Training Needs

Map out the current team structure and activities, based on responses to the individual Staff Self-assessment Worksheets to identify gaps, duplication, and opportunities for streamlining and/or more collaboration.

- The team member(s) facilitating the team building process will **complete the Task Summary by Staff Worksheet** by:

  - Writing in the staff member's role/title and/or name at the top of each column marked "Staff 1", "Staff 2", etc.
  - For each of the collaborative care tasks, mark the cell for each staff member currently performing a task.
  - If a task is completed via a partner agency or a referral, mark that cell (this information will not be on the Staff Self-assessment Worksheets; the team member leading this process will have to find out if s/he does not already know).

- Identify gaps and duplications in tasks by examining the completed worksheet. Identify opportunities to make the processes more efficient. Think about ways to collaborate effectively and discuss critical communication and 'handoff' steps.
- Think about if and where changes are needed.

STEP 3: Create a Customized Integrated Behavioral Health Care Workflow for your Practice

Systematically review—as a team—the results from the Staff Self-assessment Worksheets and the Task Summary by Staff Worksheet, in order to plan for implementation changes and document these plans.

- First, discuss the completed forms as a team. This discussion should be facilitated by the team member(s) taking the lead for this process.

  - Discuss gaps—which cells are blank?
  - Discuss duplication—which tasks are currently being performed by more people than necessary?
  - Discuss any tasks that individuals are not currently performing, but would like to start, and discuss what training or other changes are needed to facilitate this.
  - Discuss any tasks that individuals are currently performing, but would not like to continue doing and discuss possible alternative task re-assignments.

- Second, discuss the "practical ideal" you are striving for in your organization to provide the most effective care for your patients.
- Third, systematically review the list of collaborative care tasks on the Summary & Change Plan Worksheet. For each task—or set of tasks as shown in the worksheet—document who, how, when, and where the task will be completed as part of your implementation plan. This worksheet documents your current situation plus your plans for change.

  - Write in the individual(s) names who will perform each task.
  - Document how the task will be changed / accomplished. Include plans for smooth hand-offs and communication methods.
  - Document when a task is completed, in terms of patient flow (e.g., intake, initial assessment). If a task will be constrained by certain days of the week (e.g., a prescriber is only available on a certain day, or data will be entered into a registry only on certain days), indicate this.
  - Document where the task will be completed. At the clinic? At a partner agency? Through an external referral?
  - For each main category of collaborative care tasks (e.g., Identify/ Screen/ Diagnose Depression, Anxiety, & Substance Abuse), consider if there are organizational-level changes necessary for these plans. Staff training needs? Staff hires? Other needs? Additional supervision?
  - What is the implementation timeline for each of the main categories of collaborative care tasks? Note any relevant information in the appropriate section.

STEP 4: Generate an Implementation Plan and Timeline Tailored to Your Practice

- Create a quality improvement action plan with designated champions / sponsors, process owners, and a detailed timeline.
- Create materials to introduce the Integrated Care Team to patients.
- Create clinic-specific protocols for:

  - Psychiatric Emergencies (e.g., what to do if a suicidal patient presents in clinic).
  - Communication among team members (e.g., how will you ensure that recommendations from psychiatric consultants are effectively communicated to the primary care provider).

- Identify gaps and duplication in tasks by examining the completed worksheet. Identify opportunities to make processes more efficient. Think about ways to collaborate effectively and discuss critical communication and 'handoff' steps.
- Think about if and where changes are needed.

STEP 5: Track Program Outcomes and Adjust as Necessary

Revisit the Summary & Change Plan regularly (e.g., monthly) to review progress and make adjustments in the program as needed to achieve desired results. Focus reviews on:

  - Number of clients served in the integrated program.
  - Number and percent of clients who show clinical improvement as measured at the client level.
  - Number and proportion of clients who receive initial assessments, follow-up assessments, and psychiatric consultation if they are not improving as expected.

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STEP 1: Staff Self-assesment

Conditions for which you plan to provide clinical care (select all that apply)

- ☐ Depression
- ☐ Anxiety (e.g. PTSD)
- ☐ Substance Abuse
- ☐ Other Mental Disorders _____

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GETTING STARTED

Integrated Care Tasks	Is This Your Role Now?		If No, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Patients	Yes	No	Write in position title	High	Med/Low	High	Med/Low	Yes	No
Identify People Who May Need Help	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Behavioral Health Problems Using Valid Measures	☐	☐		☐	☐	☐	☐	☐	☐
Diagnose Behavioral Health Disorders	☐	☐		☐	☐	☐	☐	☐	☐
Engage Patient in Integrated Care Program	☐	☐		☐	☐	☐	☐	☐	☐
Initiate and Provide Treatment	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Perform Behavioral Health Assessment	☐	☐		☐	☐	☐	☐	☐	☐
Develop & Update Behavioral Health Treatment Plan	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Symptoms & Treatment Options	☐	☐		☐	☐	☐	☐	☐	☐
Prescribe Psychotropic Medications	☐	☐		☐	☐	☐	☐	☐	☐
Patient Education about Medications & Side Effects	☐	☐		☐	☐	☐	☐	☐	☐
Brief Counseling, Activity Scheduling, Behavioral Activation	☐	☐		☐	☐	☐	☐	☐	☐
Evidence-based Psychotherapy (e.g., PST, CBT, IPT)	☐	☐		☐	☐	☐	☐	☐	☐
Identify & Treat Coexisting Medical Conditions	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Referral to Specialty Care or Social Services	☐	☐		☐	☐	☐	☐	☐	☐
Create & Support Relapse Prevention Plan	☐	☐		☐	☐	☐	☐	☐	☐
Track Treatment Outcomes	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Track Treatment Engagement & Adherence using Registry	☐	☐		☐	☐	☐	☐	☐	☐
Reach out to Patients who are Non-adherent or Disengaged	☐	☐		☐	☐	☐	☐	☐	☐
Track Patients' Symptoms with Measurement Tool (e.g., PHQ-9)	☐	☐		☐	☐	☐	☐	☐	☐
Track Medication Side Effects & Concerns	☐	☐		☐	☐	☐	☐	☐	☐
Track Outcome of Referrals & Other Treatments	☐	☐		☐	☐	☐	☐	☐	☐
Proactively Adjust Treatment if Patients are Not Responding	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Assess Need for Changes in Treatment	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Changes in Treatment / Treatment Plan	☐	☐		☐	☐	☐	☐	☐	☐
Provide Caseload-Focused Psychiatric Consultation	☐	☐		☐	☐	☐	☐	☐	☐
Provide In-Person Psychiatric Assessment of Challenging Patients	☐	☐		☐	☐	☐	☐	☐	☐
Other Tasks Important for Our Program (add tasks as needed)	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Coordinate Communication Among Team Members / Providers	☐	☐		☐	☐	☐	☐	☐	☐
Administrative Support for Program (e.g., Scheduling, Resources)	☐	☐		☐	☐	☐	☐	☐	☐
Clinical Supervision for Program	☐	☐		☐	☐	☐	☐	☐	☐
Training of Team Members in Behavioral Health	☐	☐		☐	☐	☐	☐	☐	☐

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*In 2012, CiMH (California Institute of Mental Health) spearheaded the **Small County Care Integration Quality Improvement Collaborative.** This one-year initiative, involving the mental health departments in 13 California counties, concentrates on improving medical outcomes for persons with serious mental disorders in rural counties. Using an incremental step-by-step approach, the program helps county departments identify and implement actionable and measurable physical health goals. The following is the change concepts they developed for improving interface between physical and mental health organizations.*

THEME: Develop processes and mechanisms for mental and physical health organizations to coordinate care on a routine basis.

CHANGE CONCEPTS	CHANGE IDEAS
Identify clients' health status and PCP Coverage at behavioral health intake	a. Review charts or access data from clinical information systems to identify client's primary care doctor and their most recent health care records b. Initiate contact with PCP (primary care provider) - with client consent c. Utilize standardized protocols or tools to identify client health concerns d. Ask all clients who they see for physical health concerns and when they last saw this provider e. At intake, ask clients about and document their current health concerns f. Identify primary care providers that are comfortable treating and supporting clients who have serious mental illness by asking clients who they see and if that PCP was comfortable treating them g. Formalize process to address health and healthcare for health care discussion with all clients at intake, for example initiating discussion about health care early in the intake/assessment process
Increase the number of clients with a PCP	a. As part of intake procedures, offer clients information and assistance in getting a primary care doctor b. Train staff on primary care office culture c. Develop protocol to assign clients a PCP
Redesign the behavioral health intake to include	a. Develop informed patient consent form based on legal requirements and feedback from clients and their family members

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CHANGE CONCEPTS	CHANGE IDEAS
Releases of Information	b. Formalize procedures for providers' explanation of the consent form to clients c. Give release of information forms to clients at initial contact and ask them to have family/caregiver review with them d. Create a script for clinicians re: critical health care issues they should ask clients about at intake e. Make conversation about health concerns a routine part of each patient visit f. Use informational brochures about physical health concerns during mental health intake
Link clients to and support their effective use of primary care services	a. Ask clients about their experiences when visiting their PCP b. Assist clients to brainstorm ways to get their primary care needs met if they had a bad experience (for example: bring a friend; bring a case manager; bring a family member) c. Identify primary care providers that are comfortable treating and supporting clients who have serious mental illness. d. As part of intake procedures, offer clients information and assistance in getting a primary care doctor, for example a "warm handoff" e. Ask all clients who they see for physical health concerns and when they last saw this provider f. Develop protocol to assign clients a PCP g. Use "Primary Care Summary Visit" form

CHANGE CONCEPTS	CHANGE IDEAS
Build Relationships: Create opportunities to increase primary care providers knowledge about the prevalence of serious mental illness, how the mental health system operates, and the potential for client recovery and wellness	a. Initiate contact with primary care providers or group practices and offer information about inclusion/exclusion criteria and referral process and timeline b. Frame initial conversations around support mental health agencies can provide (For example: "How can we (mental health providers) help you?"; "How can we prepare our clients better for their primary care visits with you?"; "How can we streamline our Releases of Information so your providers can get relevant information more quickly?") c. Increase primary care providers' comfort with "psychiatric patients" by: • Offering basic training to them about mental health disorders, recovery, treatment guidelines, common evidence-based practices, mental health agency common operating procedures, etc. Training must be offered at breakfast or lunch and food provided • Assuring case managers ongoing involvement • Offering informal "curbside consultation" available by phone from a rotating on-call county psychiatrist d. Incentivize the education with CMEs and tailor the education methods to suit primary care culture (for example: offer half hour long web-based training; brown bag lunches on hot topics) e. Make meetings between clinical staff of both agencies and administrative/executive leadership of both agencies routine
Coordinate Care: Establish process to routinely share clinical information (For example labs; changes in medication; changes in physical status with primary care, specialists, or others)	a. Perform Monthly Medication Reconciliation: 1. Each agency provides a summary of medications easily accessible in medical record—should include medications from all prescribers 2. Each agency develops a protocol and procedure for routinely updating clients' medications at each visit 3. Involve client in "brown bag medication review" and educate client about the importance of reporting all prescription as well alternative/across the counter medications 4. Partnering agencies share each client's medication list on regular basis (preferred monthly/minimum quarterly. Determine sharing method (electronic/fax, etc…)

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CHANGE CONCEPTS	CHANGE IDEAS
	5. Care Coordinator insures that clients have a single medication list that is reconciled across primary care and specialty MH/SUD providers 6. Shared client registry contains "real time" updated/current medication list from primary and specialty care providers b. Create and maintain a mutually designed, bi-directional referral process and tools between primary care and mental health c. Contact primary care providers for information using simple language and asking specific questions (for example: situation, background, assessment, request SBAR) d. If there is an on-call or embedded psychiatrist in primary care, clarify the role and consult process of psychiatrist e. Establish monthly case conferences via phone or video-conference for multiple primary care and mental health care providers who share clients f. Identify clients with medical complexity and have case manager regularly attend primary care visits with them to contribute important mental health information and gather important medical information to include in mental health record g. Use "Brief Action Planning Process" with clients so they can establish health goals, communicate these goals to their primary care providers h. Utilize client support system, including willing family members, to accompany clients to primary care visit and report back information to mental health with client permission
Establish method to identify clients at high risk as a result of complex mental and physical health conditions in order to	a. Get information on health at every visit b. Include physical health conditions in eligibility criteria for more intense care coordination c. Inquire about recent hospitalizations for both mental and physical health d. Assess client's confidence for self-management e. Assess client's social support

CHANGE CONCEPTS	CHANGE IDEAS
provide more intensive services	f. Assess client's housing stability g. Create comprehensive diagnosis list of physical and mental health conditions h. Identify clients with chronic pain, chronic heart failure and chronic lung disease i. Use a risk stratification tool, such as the Care Oregon Case Management Complexity Assessment. j. Determine team roles for identification of clients for additional services k. Describe process for managing results of assessment
Manage Care: Establish a process for collaborative planning and treatment between mental health and primary care for the high risk population	a. Make routine the process of contacting primary care provider just prior to or after high risk clients have a medical appointment to discuss mutual plans for care b. Create and maintain a mutually designed, bi-directional referral process and tools between primary care and mental health c. Mutually describe information flow process between primary and behavioral health d. Attend primary care visits with clients e. Prepare clients for primary care visits (help them make record of current status and questions; encourage them to bring supporters; practice asking questions; encourage them to ask for written records) f. Have care conferences between primary care and behavioral health to discuss mutual clients g. Determine key contacts in primary care and behavioral health for each complex client

Step 1: Staff Self-assessment	NAME: ROLE/POSITION:

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Tasks for Integrated Primary Care in Mental Health Settings	Is This Your Role Now?		If No, Whose Role?	Your Organization's Capacity with This Task?		Your Level of Comfort with This Task		Would You Like Training to Perform This Task?	
Identify and Engage Clients	Yes	No	Write in position title	High	Med/Low	High	Med/Low	Yes	No
Identify Clients For Primary Care Screening	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Medical Problems : Office-Based Measurement (e.g. Weight, BP, HR)	☐	☐		☐	☐	☐	☐	☐	☐
Screen for Medical Problems : Lab Measurements (e.g. HbA1C; Lipids)	☐	☐		☐	☐	☐	☐	☐	☐
Assess if patient receives primary care with outside PCP	☐	☐		☐	☐	☐	☐	☐	☐
Identify Clients who Need Care Management	☐	☐		☐	☐	☐	☐	☐	☐
Perform Healthy Living/Health Behavior Assessment	☐	☐		☐	☐	☐	☐	☐	☐
Diagnose Medical Disorders that Need Treatment	☐	☐		☐	☐	☐	☐	☐	☐
Engage Patient in Integrated Medical Care Program	☐	☐		☐	☐	☐	☐	☐	☐
Initiate and Provide Treatment	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Facilitate Registration with Primary Care	☐	☐		☐	☐	☐	☐	☐	☐
Coordinate with Outside PCP/Asses Quality of Relationship	☐	☐		☐	☐	☐	☐	☐	☐
Develop and Update Primary Care Goals & Treatment Plans	☐	☐		☐	☐	☐	☐	☐	☐
Prescribe Medications for Primary Care Problems	☐	☐		☐	☐	☐	☐	☐	☐
Coordinate and Communicate Plans for Primary Care with Mental Health Team	☐	☐		☐	☐	☐	☐	☐	☐
Client Education about Primary Care Medications & Side Effects	☐	☐		☐	☐	☐	☐	☐	☐
Health Behavior Change Counseling: Smoking Cessation	☐	☐		☐	☐	☐	☐	☐	☐
Health behavior change counseling: Weight Management/Nutrition	☐	☐		☐	☐	☐	☐	☐	☐
Health behavior change counseling: Increase Physical Activity/Exercise	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Referral and Coordination with Specialty Medical Care	☐	☐		☐	☐	☐	☐	☐	☐
Track Treatment Outcomes	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Track Treatment Engagement & Adherence of Medical Care using Registry	☐	☐		☐	☐	☐	☐	☐	☐
Reach out to Clients who are Non-adherent or Disengaged from Medical Care	☐	☐		☐	☐	☐	☐	☐	☐
Track Office-Based Measurement (e.g. Weight, BP, HR)	☐	☐		☐	☐	☐	☐	☐	☐
Track Lab Measurements (e.g. HbA1C; Lipids)	☐	☐		☐	☐	☐	☐	☐	☐
Track Required Other Measurements (ex NOMS)	☐	☐		☐	☐	☐	☐	☐	☐
Track Medication Side Effects & Concerns	☐	☐		☐	☐	☐	☐	☐	☐
Track Outcome of Referrals	☐	☐		☐	☐	☐	☐	☐	☐
Assess Need for Changes in Primary Care Treatment	☐	☐		☐	☐	☐	☐	☐	☐
Facilitate Changes in Treatment if Client Primary Care Problems Not Improving	☐	☐		☐	☐	☐	☐	☐	☐
Provide Caseload-Focused Primary Care Consultation	☐	☐		☐	☐	☐	☐	☐	☐
Provide In-Person Medical Assessment of Challenging Clients	☐	☐		☐	☐	☐	☐	☐	☐
Continue to Assess for Need of Integrated Primary Care Services	☐	☐		☐	☐	☐	☐	☐	☐

Provide Effective Program Support	Yes	No		High	Med/Low	High	Med/Low	Yes	No
Coordinate Communication Among Team Members (Both Mental Health and Primary Care)	☐	☐		☐	☐	☐	☐	☐	☐
Administrative Support for Medical Care Program (e.g. Scheduling, Resources, etc)	☐	☐		☐	☐	☐	☐	☐	☐
Clinical Supervision for Program/Accountability for Medical Care Program Outcomes	☐	☐		☐	☐	☐	☐	☐	☐
Training of Team Members in Primary Care	☐	☐		☐	☐	☐	☐	☐	☐

RECOMMENDATIONS FOR INTEGRATED PRIMARY CARE SERVICES DELIVERED IN MENTAL HEALTH CENTERS

(courtesy of Multnomah Mental Health and Addiction Services Division, Oregon; Joan Rice, joan.m.rice@multco.us)

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

Action Steps:

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

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

Action Steps:

- Evaluate patient caseload size and Clinical Care Manager FTE needed at each CMHC
- Evaluate options for utilization of medical RN versus LPN
- Evaluate credentialing / training requirements for the Clinical Care Manager position under FFS
- Work with agencies to identify space and equipment available and/or needed for Clinical Care Manager
- Develop Verity start-up and ongoing costs for each patient enrolled and tracked in CMTS web-based registry to fund the Clinical Care Manager position.
- Develop job duties/descriptions for Clinical Care Managers including but not limited to:
    - Enroll patients and perform ongoing monitoring and documentation in the CMTS web-based registry
    - Support individuals with chronic health conditions and/or with abnormal laboratory values or other health risks noted in routine metabolic screening
    - Perform phlebotomy for lab tests
    - Longitudinal monitoring of health status/outcomes and communicating the need for treatment adjustments to the patients' primary care team and psychiatric providers
    - Coordinate patient care across multiple medical providers on behalf of the team
    - Establish relationships with outside healthcare providers and may accompany individuals to outside medical appointments
    - Work with individuals to connect them to the full-scope primary care PCHHs, link them to enabling services, benefits counseling, and peer mentors
    - Plan and co-lead ongoing wellness groups that support smoking cessation, weight and chronic disease management, nutrition, and physical exercise. Work with Peer Wellness Coaches to conduct these wellness programs (See Recommendation #7)

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

Action Steps:

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

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

Action Steps:

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

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

Action Steps:

- Ensure the web-based registry will allow tracking of prescribing providers' compliance with lab protocols
- Evaluate using pay-for-performance and/or case rate mechanism to encourage and ensure prescribing providers comply with lab protocols – order appropriate tests, review results in a timely manner, and make treatment adjustments and/or coordinate care with patients' PCPs accordingly

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

Action Steps:

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

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

Action Steps:

- Sign the 10x10 *Pledge for Wellness,* thereby expressing organizational commitment to promoting wellness and reducing preventable early mortality for people with mental health problems by 10 years in the next 10 years.
    - The pledge can be signed online at *http://www.10x10.samhsa.gov*.
- Sponsor AMH-approved peer delivered service training program for Certified Peer Specialists. Once certified as Peer Specialists, their services can be encountered to Medicaid (Billing code H0038)
- Sponsor training program for Certified Peer Specialists to become "Peer Wellness Coaches" as a part of integrated care teams in CMHCs
    - Consider using Peer Wellness Coach curriculum developed by Benton County (See Appendix L)
    - Develop job duties/description for Peer Wellness Coach including but not limited to:
        - Under supervision of Nurse Care Manager, work one-on-one with clients identified as having physical health needs to help them achieve wellness goals, participate in wellness programs, and engage in physical healthcare services
        - In partnership with Nurse Care Manager, co-facilitate wellness programs and support groups
        - Assess clients' strengths and needs in relation to physical ,emotional, and holistic wellness
        - Provide encouragement and outreach to clients and help address barriers to

achieving wellness goals
- Complete documentation of services and participate in outcome measurement

- Determine payment rates/models for sustaining Peer Wellness Coaches at CMHCs
- Consider adopting MHASD-sponsored evidence-based wellness program such as the In SHAPE Lifestyles

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

Action Steps:

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

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

Action Steps:

- Work with MCCP Consulting to develop payment methods and cost projections.

The **CLIENT** Perspective

PROMOTING ENGAGEMENT OF BEHAVIORAL HEALTH CLIENTS IN HEALTH CARE SETTINGS

Many studies underscore the fact that the stigma faced by people with mental health problems in our society affects their willingness to seek out and be receptive to both mental and physical health care. Some health care providers are uncomfortable treating people with serious mental illness and, in some instances, this atmosphere of nonacceptance and discomfort is communicated – directly or indirectly - to these patients. A survey of 1,300 people with mental health problems found that during physical health visits, many experience being treated as less believable and less competent than other clients and are spoken to impatiently (Wahl, 1999).

There is also some disconnect in how primary care providers and mental health clients perceive their interaction during a visit. For example, in a survey of more than 2,000 consumers and primary care providers, 71% of the providers said they make joint decisions with their patients, but only 39% of the patients said the doctor asked their preferences. Sixty-nine percent of the providers said they explain medication side effects, but only 16% of the patients said they were told (cited by Bergeson, 2009).

To better engage these individuals, it's important to know what they want from health providers – aside, of course, from compassion, respect and good medical care:

WHAT MENTAL HEALTH CONSUMERS SAID THEY WANTED FROM THEIR PRIMARY CARE PROVIDERS

(based on a national Depression and Bipolar Support Alliance survey)

- ✓ Allow us two minutes to talk before interrupting.
- ✓ Explain the illness and its importance and impact in words that we can understand.
- ✓ Provide us with information we can read written in language we can understand.
- ✓ Explain what the medication will do and what we should watch for, and address our concerns about it.
- ✓ Link our treatment to our recovery goals – to what we care about.
- ✓ Don't assume that just because we have a mental health problem our symptoms are all in our head.
- ✓ Offer and encourage participation in free peer support groups.
- ✓ Consider hiring consumer peer specialists in your practice.
- ✓ See us as a whole person, not just a physical or mental illness.

One of the primary drivers behind the integrated behavioral health movement is the fact that receiving mental health treatment in a primary care clinic is a less stigmatizing and more normalizing experience for the clients than accessing specialty mental health. But, according to clients' reports, stigma still dwells within primary care too sometimes.

SOME MENTAL HEALTH CLIENTS REPORT FEELING STIGMATIZED BY THEIR HEALTH PROVIDERS. A FEW REASONS WHY…

- The orientation of primary care is reactive - which doesn't fit well with clients who may be reluctant or unable to seek help.
- Physicians inexperienced in or uncomfortable with mental health work may resist intensifying their engagement with a client by actively asking about symptoms. (M. Phelan, 2001)
- With their cramped schedules, primary care physicians often do not have the time to discuss clients' psychological issues.
- The discomfort and apprehension that primary care staff sometimes feels when dealing with mental health clients are communicated subtly – and on occasion not so subtly – to the clients themselves.
- Short consultation times make it difficult for doctors to conduct complete physical assessments, especially in vague or suspicious patients.

WHY STIGMA SHOULD MATTER TO CARE PROVIDERS:

- **MEDICATION ADHERENCE:** The more the perceived stigma, the less the medication adherence among outpatients with major depression. (Sirey et al., 2001)
- **DROP-OUTS:** Perceived stigma is a predictor of treatment discontinuation among older outpatients with depression. (Sirey et al., 2001)
- **NO SHOWS:** Latinos who report high levels of perceived stigma are more likely to miss scheduled appointments. (Vega et al., 2010)
- **ACCESS:** Stigma is a strong barrier to people accessing needed mental health care. (Mental Health Association Poll, Chamberlin, 2004)
- **PHYSICAL HEALTH:** People seen as having a mental disorder are less likely than others to get the physical care they need even when they seek it out. Those with schizophrenia are less likely than the general population to receive basic health checks like cholesterol and blood pressure measurements (Roberts, et al., 2007) and substantially less likely to undergo cardiovascular procedures (Druss et al., 2000). Those with co-occurring mental disorders and diabetes are less likely to be admitted to the hospital for diabetic complications than those without mental disorders (Sullivan et al., 2006).
- **HEALTH REFORM:** Enhancing the patient care experience is one of the Centers for Medicare Medicaid's "triple aim" objectives.
- **QUALITY CARE:** A welcoming environment is consistent with good patient care. (no cite is really needed for this one!)

What the Clients Say About Their Health Care Experience

Excerpts from the "Listening" video produced by the California Mental Health Directors Association Social Justice Advisory Committee, sponsored by Santa Clara County Mental Health.

- **"There's been a long-standing awareness among clients in primary care clinics that doctors assume that we're not reliable witnesses to our own health care."**
- **"There are so many physical health problems that cause symptoms similar to those labeled as mental health conditions. Without doing the proper checks on physical health problems, and social and environmental problems that people have, it's all too easy to reduce them to a biological brain problem that's considered a mental illness. And that's a huge problem."**
- **"I wish they would tell me other ways to deal with my symptoms instead of just trying to prescribe a pill for it. I feel like they go to prescriptions first."**
- **"There are so many alternative and holistic approaches….The single-minded heroic pill approach that has become so popular since the decade of the brain is a terrible path for western medicine. It reduces so many of our mental problems to a simple biological issue which is a terrible oversimplification at best."**
- **"Shared decision-making is recognized as giving a much fuller spectrum of options and making a strong effort to apprise people of all the risks and benefits that are known for a particular treatment."**
- **"I got really scared because who would take a list of meds for something they haven't even been educated about."**
- **"When you walk into a visit with the psychiatrist, they have nine minutes for you. They recommend a particular drug or two or three and if the client has any questions, the answers are terse and gloss over some of the most important risks…"**
- **"Sometimes people in mental health think your brain is broken and they treat you like that."**
- **"I feel like I'm being rushed out and don't have time to tell them what's happening. They just want to treat what I initially said. But if I say something else is happening, they say I need to make another appointment. But I say 'I'm here. At least let me tell you.'"**
- **"They should look the patient in the eye. Take the time to listen and not be distracted. Listen to what's really going on with that person."**

SO HOW DO YOU RATE STIGMA-WISE? TAKE THIS ATTITUDES ASSESSMENT FOR HEALTH CARE PROFESSIONALS BY YOURSELF SO YOU CAN BE TOTALLY HONEST.

(taken from Kassam et al: "The development and psychometric properties of a new scale to measure mental illness related stigma be health care providers: The opening minds scale for health care providers," BMC Psychiatry *2012 12:62)*

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.					
2. If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain or headache), I would likely attribute this to mental illness					
3. If a colleague with whom I work told me that had a managed mental illness, I would be as willing to work with him/her.					
4. If I were under treatment for a mental illness, I would not disclose this to any of my colleagues.					
5. I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.					
6. I would see myself as weak if I had a mental illness and could not fix myself.					
7. I would be reluctant to seek help if I had a mental illness					
8. Employers should hire a person with a managed mental illness if he/she is the best person for the job.					
9. I would still go to a physician if I knew that the physician had been treated for mental illness.					
10. If I had a mental illness, I would tell my friends.					
11. It is the responsibility of health care providers to inspire hope in people who have mental illness					
12. Despite my professional beliefs, I have negative reactions towards people who have mental illness.					
13. There is little I can do to help people with mental illness					
14. More than half of people with mental illness don't try hard enough to get better.					
15. People with mental illness seldom pose a risk to the public.					
16. The best treatment for mental illness is medication.					
17. I would not want a person with a mental illness, even if it were appropriately managed, to work with children					
18. Healthcare providers do not need to be advocates for people with mental illness					
19. I would not mind if a person with a mental disorder lived next door to me.					
20. I struggle to feel compassion for a person with mental illness.					

Scoring: For questions 1, 2 ,4, 5, 6 ,7 ,12 ,13, 14, 16, 17, 18, and 20: Strongly disagree=1; Disagree=2; Neither=3; Agree=4 and Strongly Agree=5. For questions 3, 8, 9, 10, 11, 15, and 19: Strongly agree=5; Disagree=4; Neither=3; Agree=2 and Strongly agree=1. The higher the score, the more stigmatizing the attitude. Compare yourself to 781 healthcare providers who completed this assessment: Their mean score was 57.5 and their range was 41-96.

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> ***"Primary care isn't good about stigma. They just treat the disease and they think you're the disease."***
>
> –Alice W., mental health and primary care client

PERSON-CENTERED VS. ILLNESS-CENTERED TREATMENT

Courtesy of Mark Ragins, M.D., The Village

PERSON CENTERED	ILLNESS CENTERED
The relationship is the foundation	The diagnosis is the foundation
Begin with welcoming – outreach and engagement	Begin with illness assessment
Services are based on personal suffering and help needed	Services are based on diagnosis and treatment needed
Services work towards quality of life goals	Services work towards illness reduction goals
Treatment and rehabilitation are goal driven	Treatment is symptom driven and rehabilitation is disability driven
Personal recovery is central from beginning to end	Recovery from the illness sometimes results after the illness and then the disability are taken care of
Track personal progress towards recovery	Track illness progress towards symptom reduction and cure
Use techniques that promote personal growth and self responsibility	Use techniques that promote illness control and reduction of risk of damage from the illness
Services end when the person manages their own life and attains meaningful roles	Services end when the illness is cured
The relationship may change and grow throughout and continue even after services end	The relationship only exists to treat the illness and must be carefully restricted throughout keeping it professional

Clients' Take on Integrated Care

It makes a difference that somebody's there for me with open arms, knowing that this is happening to me and I'm not just faking it. If something goes wrong with me, he's there.

-Anonymous

I received integrated care because I have diabetes due to zyprexa and obesity. At [primary care clinic], all providers were aware of my condition, so when I go to get care from any of them, they all know what to do. If I wasn't working with integrated care, I could be working with people who could potentially harm me because they don't see the whole picture.

–Alice W.

I was diagnosed with diabetes and wasn't stable enough to accept this diagnosis. My doctor recommended a psychiatrist. I was resistant at first but went anyway. But I decided I didn't need to continue because psychiatrists were for crazy people and I wasn't crazy. I stopped taking my medications and started a downward spiral. I almost become homeless. I started losing my eyesight. I was ready to give up and prayed to God to let me die. When I came to the [primary care] clinic for my diabetes, I was given PH-Q 9 and OASIS screens but refused to fill them out because I wasn't crazy. But they said they were just part of clinic procedure and given to everybody, so I did it. Because of my high scores, I was referred to the care manager. She explained the integrated program, explained depression and anxiety, and let me know there was hope for me. I think that's what made the difference. She was talking about collaboration between professionals. She asked me to allow them to help me get my life back. I asked if she thought I was crazy and she smiled and told me only if I continued not to get help, because only a crazy person wouldn't take advantage of this program. I liked the confidence that she spoke with and felt she really cared. I poured my heart out to her. She introduced me to the woman who became my therapist. I call her Mama Rachel because she'll keep calling me until I returned her calls. She always knows what's going on with me because my therapist keeps her informed. I have never seen anything like this. I wish I had before and after pictures so you could see the difference in me. I can't imagine where I'd be if it weren't for the great team that pulled together to keep me from falling through the cracks.

–Joanne G.

Of 3,000 uninsured clients diagnosed with mental illness, 90% preferred that their medical and mental health providers communicate with one another about their health care.

–L. Mauksch, *Journal of Family Practice,* January, 2001

I feel better understood. I don't have to explain as much in detail because all my providers are on the same page with me. I feel like I'm being heard. Having my team promotes honest communication.

-Katheryn H.

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CONSUMER RECOMMENDATIONS FOR INTEGRATED CARE SERVICES

(Courtesy of Multnomah Mental Health and Addiction Services Division, Oregon; Joan Rice, joan.m.rice@multco.us)

Considerations for ↓ Integrated Healthcare ↓

Consumer Choice

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

Relationships with Providers

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

Behavioral/Physical Health Cultural Differences

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

Recommended Elements from Community Mental Health Centers (CMHC) to Incorporate into Primary Care ↓

Recommendations to help consumers obtain primary care

- Option for case manager or advocate to attend appointments
- "Warm hand-offs" between PCP and CMHC providers
- Different gender PCPs available
- Incentives for participation in wellness groups
- Reminder calls for appointments
- Augmentation of mental health services - don't move people comfortable receiving care there
- Flexibility into scheduling
- Ability for family members to see same PCP

Provider Education Needed

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

Consumer Education Needed

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

Medication Management

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

Essential Services

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

Alcohol and Drugs

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

SAMHSA-HRSA
Center for Integrated Health Solutions

Workflow Design:

A Focus on the Experience of the Recipient of Services

Questions to consider in designing workflow related to the engagement, enrollment, retention, service planning, and service delivery processes. Created by Anthony Salerno, PhD

In an integrated system of care, understanding the initial and ongoing experience of the client as s/he moves throughout the organization's policies, procedures, and activities is key to designing workflow systems that engage and respond to the felt needs of recipients. The best way to understand the effect of a particular policy and procedure on a client is to go through the process yourself. Some organizations have done just that and found the process invaluable. An organization's workflow that aligns with the aims of the PBHCI initiative involves closely examining the following questions related to key processes and procedures.

1. The initial screening and admission process: Who makes the initial contact with the client? Where and when does it take place? How are clients informed about the organization's services including access to primary care services? What are we trying to accomplish at our first meeting with a client? Do we include peers in this process? What information is gathered? How are clients oriented to the environment and the people in the setting? Are clients introduced to others?
    - Ask yourself: What would I like to have happen at my very first contact with the organization? How do we initially engage and inform clients? How can we find out if clients like our current workflow around screening and admission?

2. Getting to know my treatment team: How do clients meet the members of their treatment team? Who informs the client about the members of the treatment team? Who is the main go to person for the client? How do clients get to know their primary care team members if they choose to enroll? Does the client meet every member of the team?

3. Deciding to enroll in the PBHCI initiative: How do clients make a decision to enroll? What information is provided? What information would you want in order to make an informed decision? Are clients provided any written information that they can share with others if they so choose? Are peers involved in supporting the client to make an informed decision?

4. Service Planning: How does the organization provide information about all the services available to the client? Who works with the client to make informed decisions about which services are needed and most importantly, wanted? In what way does the client participate in the identification of needs and services? What contribution does the client make directly to the documentation of the service plan? How is information communicated (e.g., just verbally or with written information?)

5. Service Delivery: For each service provided including primary care, describe the who, what, when, where and how of each service. How does a client access the service? Who is involved? What is the role of each team member in the provision of services? What happens if the client decides to stop a service? Dislikes a service? Changes their mind about the need for the service?

   How does the client access primary care services? What steps are involved in assisting a client to get their initial physical exam? How are the results communicated to the client and the members of the treatment team? What are the steps involved if the person's exam reveals the need for follow up care? Who arranges it? Who provides support to the client? How are the results shared with the client and the treatment team?

   How are clients informed about wellness related services and activities? Are peers involved? Who assists the client to make informed decisions about wellness activities? If a client avoids all the wellness activities, what steps might the program take? Are these the steps you would want taken?

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE
SAMHSA
HRSA

IBHP Integrated Behavioral Health Project

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Introducing the Care Management Team and the Integrated Care Model

This template, developed by the University of Washington's AIMS CENTER, can be used to introduce the integrated care team to primary care clients. The template includes placeholders for photographs, names and contacts of team members.

Your Integrated Care Team

YOU

What is the patient's role?

You are the most important person on the team! You will get the best care if you participate actively with your primary care physician (PCP) and your care manager (CM). Tell them what is working for you and what is not working for you. Work with your team to track your progress using a simple checklist. Let them know if you have questions or concerns about your care. If you take medication, know what it is and take it as prescribed.

PCP Name and Photo

What is the primary care provider's role?

The primary care provider (PCP) oversees all aspects of your care at the health clinic. He or she will work closely with the other members of the care team to make sure you get the best care possible. The PCP will make and / or confirm your diagnosis and may write or refill prescriptions for medications. The PCP works closely with your care manager to stay informed about your treatment progress. The PCP may also consult with the team psychiatrist if there are questions about the best treatments for you.

CM Name and Photo
Telephone (xxx) xxx-xxxx
Email janed@email.rog

What is the care manager's role?

The care manager works closely with you and the PCP to implement a treatment plan.The care manager answers questions about your treatment. He or she will check-in with you to keep track of your treatment progress and can help identify side effects if you are taking medications. The PCP and the care manager work together with you if a change in your treatment is needed. The care manager may also provide counseling or refer you for counseling if that is part of your treatment plan.

Team Psychiatrist Name and Photo

What is the team psychiatrist's role?

The psychiatrist is an expert consultant to the primary care provider and the care manager. The team psychiatrist is available to advise your care team about diagnostic questions or treatment options, especially if you don't improve with your initial treatment. The care manager meets and consults regularly with the team psychiatrist to talk about the progress of patients in the program and to think about treatment options. With your permission, the team psychiatrist may meet with you in person or via telemedicine to help inform your care

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MENU of Collaborative Approaches

SHOP FOR IDEAS HERE

COUNTY MENTAL HEALTH - PRIMARY CARE - SUBSTANCE USE COLLABORATION APPROACHES

Collaboration between county mental health departments and primary care clinics to coordinate delivery of both mental and physical health to their clients can take as many forms as there are county systems. Scan the menu to see which ones mesh best with your own system of care. For examples of how counties have implemented these approaches, see the next section: Examples of How Counties Have Implemented Collaboration Approaches.

PROVIDING SERVICES FOR BEHAVIORAL HEALTH CLIENTS IN PRIMARY CARE SETTINGS	
1.	The mental health agency out-stations mental health workers at primary care sites and assumes related personnel costs.
2.	Primary care providers agree to deliver services to stabilized clients with serious mentally illness and, in return, the mental health agency offers support services, consultation and ease of transitioning the client back to the mental health system when needed.
3.	The mental health agency contracts with primary care to provide services to a circumscribed target population (e.g., seniors, high utilizers, etc.) or to address a specified problem.
4.	The mental health agency contracts directly with local primary care consortia who, in turn, coordinate the provision of agreed-upon mental health services by member primary care clinics.
5.	Primary care clinics purchase behavioral services from the mental health agency.
6.	Primary care clinics arrange with the mental health agency to be reimbursed through mental health, rather than via the usual primary care funding streams.
7.	The mental health agency contracts with select primary care providers to become full-service partners.
8.	The mental health agency provides personnel at a primary care site to directly deliver care management or otherwise subsidizes a primary care-based care coordinator for the clinic's seriously mentally ill population.

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9.	The mental health agency subsidizes a behavioral care clinician hired and employed by the primary care clinic.
10.	The mental health agency sends personnel to the neighboring primary care clinic for client evaluation and placement when requested.
11.	The mental health agency contracts with primary care for mental health services and with a third party for case management support.
12.	The mental health agency pays for a public benefits advocate stationed at the primary care site.
13.	The mental health agency directly schedules primary care appointments for clients.
14.	The mental health agency provides free psychiatric consultation services to primary care providers.
15.	To increase care access for underserved groups, the mental health agency contracts with primary care to promote their services in the local community.
16.	Telepsychiatry is used to provide psychiatric consultation to health care providers.
17.	The mental health agency makes assessment and triage services available to primary care providers.

BRINGING PHYSICAL HEALTH INTO MENTAL HEALTH SETTINGS	
18.	The mental health agency offers wellness-related activities and other programs to promote physical health and encourage healthy lifestyles.
19.	Primary care physicians or other health professionals provide health care within a mental health setting.
20.	The behavioral health agency takes steps to identify clients' physical health problems and make appropriate referrals.
21.	The mental health agency determines if clients have a current health provider and initiates contact to coordinate care.
22.	The mental health agency develops a comprehensive database of local primary care providers, specifying which accept Medi-Cal.
23.	The mental health agency provides stipends for mental health peers to become certified as health navigators.

BRIDGING THE GAP: MEETING IN THE MIDDLE	
24.	Multiple agencies co-locate and coordinate to form a health care home for the client to address the spectrum of client health problems.
25.	Mental health and primary care providers team up to provide mobile outreach services.
26.	Staff from primary care clinics and the mental health agency meets regularly to discuss individual cases and problem-solve.
27.	The mental health and primary care providers establish referral criteria specifying what clients are considered appropriate for each other's services. *[See the FORMS Section for a copy of sample Referral Forms.]*
28.	The 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, etc.
29.	The mental health agency and partnering primary care clinics exchange health information electronically.
30.	Release of information forms that encompass primary care are obtained from clients.
31.	Care professionals coordinate and reconcile medications that clients may be getting from different providers.
32.	Client peers are used to promote mental and physical health and substance abuse recovery.
33.	A pharmacist is used to coordinate physical and mental health.
34.	Out-stationed mental health and primary care providers provide services at school-based health centers.
35.	Mental health and substance abuse services are coordinated.
36.	The Mental Health Department contracts with primary care providers on a pay-for-performance basis.
37.	The mental health agency teams up with the county substance abuse program to establish community assessment service centers.

38.	Primary care clinics can directly access 23-hour crisis intervention services provided by the mental health agency.
39.	Mental health personnel straddle primary care and mental health clinics, splitting their time between each and facilitating inter-agency transitions.

SPREADING THE WORD: TRAINING AND CROSS-EDUCATION	
40.	Mental health and primary care providers engage in cross-training and conferences to enhance mutual understanding and knowledge.
41.	The mental health agency contracts with primary care provider to educate other providers about the integrated model.
42.	Both the mental health agency and the primary care providers collaborate in work-force development by working with schools of social work, nursing, psychology and medicine.
43.	The mental health agency offers on-going behavioral health education for primary care providers or vice versa.
44.	The mental health agency provides funding for primary care clinics to conduct in-house staff training regarding mental health assessment, psychotropic medication and behavioral treatment.
45.	College or university supplies student behavioral health staff to primary care clinics as part of their training program.

Examples of How These Collaboration Approaches are Being Implemented in California

(see previous five pages for summary of approaches)

I. PROVIDING SERVICES FOR MENTAL HEALTH CLIENTS IN PRIMARY CARE SETTINGS

1. The 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.

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 arranged access to more intensive mental health services should clients need it.

CASE STUDY – SAN MATEO COUNTY

San Mateo County developed an Interface Team eleven 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.”

To ensure health care for their clientele, San Mateo County Behavioral Health contracts for 1.3 nurse practitioners to provide services at three mental health clinics.

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. A drug and alcohol counselor is also available by appointment when needed. Up to ten treatment sessions for mental health care and 20 for substance abuse counseling are permitted at the primary care clinic under the Division's Pathways to Health funding arrangement. Clients needing more intensive mental health treatment must be referred to the Mental Health Division by the primary care provider.

CASE STUDY - LOS ANGELES COUNTY

To coordinate care and share clinical information about patients who would benefit from both physical and mental health services, the Los Angeles County Dept of Mental Health has co-located staff in six LA Department of Health facilities and plans to increase that number. Health providers initially screen patients for possible mental health needs. Patients screening positive are referred to the co-located mental health clinical social workers for a mental health assessment. As part of the referral, health providers furnish the social workers with patient demographics, medical diagnosis, and reasons for referral. Health staff completes a "warm hand off" by taking the patient to meet the co-located mental health staff or by asking the staff to come to the patient exam room. Patients who are classified as having moderate or mild mental health needs receive mental health services onsite in the co-located facilities, while those with more severe mental health problems are referred to the countywide network of mental health providers and services. A mechanism to track referrals from primary care providers to onsite mental health professionals has been developed at the co-located sites. The Mental Health Department informs health staff of the disposition of the referral including the services provided, general findings, mental health diagnosis, medications prescribed, and treatment plan overview.

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.

Example: Using the Strosahl model, **San Francisco County** Community Behavioral Health Services implanted two behavioralists – MFT's, psychologists, or social workers - and two behavioral assistants in ten primary clinics across the county to conduct brief assessments and counseling. Two were already employed by Behavioral Health Services at the time and two were expressly hired for this role.

2. **Primary care providers agree to deliver services to stabilized clients with serious mental illness and, in return, offer support services, consultation and ease of 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.

SAN DIEGO COUNTY
CASE STUDY I

The Areta Crowell Center, a community-based psychosocial rehabilitation services for adults, is transitioning stable clients with serious mental disorders to three participating family health centers through a Mental Health Services Act-funded integration demonstration pilot called ICARE, which began in 2011. An RN care coordinator implanted in the Crowell Center provides health assessments to clients and links eligible adults to one of three health centers, where a primary care provider continues to manage their physical and mental health care. The Crowell Center created a private exam room for these assessments, while the Family Health Centers provided office space for the project manager and a work area for peer support staff to use when not in clinics. The Crowell Center provided training to physician champions about how best to support their transitioning clients. The discharge planner at the Crowell Center works with the client to determine which of the three primary care sites is the best match, and works with that site coordinator to transfer care. Health staff makes a notation in the schedule and give priority to these clients. Once a client signs a release of information, the Crowell Center sends a copy of the medical record to Health Center, which has a shared medical record for both physical and mental health. The organizations have signed an MOU agreeing to the referral and treatment process.

CASE STUDY II

In 2007, nine primary care clinics in San Diego County began participating in the Mental Health and Primary Care Integration Project, funded by the Mental Health Services Act. All participating primary care clinics provide therapy and medication management services for up to one year to persons with serious mental health problems who have a social security number. A psychiatrist conducts an assessment and provides medication management, while a licensed social worker, psychologist, MFT or intern provides therapy. A maximum of 24 visits are allowed for children and youth, including family therapy when needed. Additional medication visits are also allowed. Adults and older adults are allowed a maximum of 12 visits, including medication visits. The cost of medications is covered for up to 90 days from issuance of first prescription, after which the patient is referred to pharmacy assistance program for longer term medication needs. After one year of services, those needing additional treatment/services are transitioned to traditional county-contracted specialty mental health providers.

3. The mental health agency contracts with primary care to provide services to a circumscribed target population (e.g., seniors, high utilizers, etc.) or to address a specified problem.

Example: **Los Angeles County** Mental Health has contracted with select primary care clinics for depression intervention geared to seniors using the IMPACT model of service delivery. It also contracted with Eisner Pediatric and Family Medical Center, a primary care clinic, to deliver Medi-Cal mental health outpatient services to children, including individual and family therapy, psychiatric services, rehabilitation, and case management.

Example: **Stanislaus County** Behavioral Health and Recovery Services contracted with two community health centers with the goal of providing increased access to mental health services, especially for the county's indigent and/or minority populations. In the first year of this arrangement, the contractors increased the Behavioral Health Service's capacity by 23%; more than 70% of those served via the contract did not have current or past mental health services.

Example: With funding provided by the **Los Angeles County** Department of Mental Health, staff from Amanecer, a mental health counseling service, come twice weekly to Eisner Pediatric and Medical Center (a FQHC) to assess and treat uninsured clients with moderate mental health impairments referred by Eisner physicians.

Example: With funding from a MHSA Innovations grant from **Yolo County** Mental Health, CommuniCare Health Centers hired a social worker to provide counseling to uninsured primary care patients in need of it.

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

Example: The Council of Community Clinics, a **San Diego County** consortium of primary care clinics, received funding from County Behavioral Health through their emergency preparedness Regional Special Projects 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 to multiple clinic sites via videoconferencing during a disaster.

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

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

CASE STUDY – SAN DIEGO COUNTY

Using MHSA Community Service and Support funds, San Diego County Mental Health Services awarded a contract to the Council of 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 access 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, 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.

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

5. Primary care clinics purchase behavioral services from the mental health agency.

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

6. Primary care clinics arrange with the mental health agency to bill under mental health, rather than via the usual primary care funding streams.

Example: Behavioral Health Services of the **San Francisco** Department of Public Health developed 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 Medicaid 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.

7. The mental health agency makes select primary care providers full-service partners.

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

CASE STUDY – SHASTA COUNTY

As a full-service partner, Hill Country Community Clinic, a primary care provider, was awarded initial MHSA funds to deliver "whatever-it-takes" services to ten persons with serious mental disorders and intensive services to 25 additional 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 MHSA 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.

Example: In **Los Angeles,** Tarzana Treatment Center, which operates a psychiatric hospital, residential and outpatient alcohol and drug treatment centers, and family medical clinics, has become a full service partner as part of the continuum of care established through an MHSA contract.

8. The mental health agency provides personnel at primary care site to directly deliver care management or otherwise subsidizes a primary care-based care coordinator for the clinic's seriously mentally ill population.

Example: Through **Nevada County** Behavioral Health funding, Sierra Family Health, a primary care clinic, hired a case manager to link clients to services in the community. 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.

Example: Using MHSA Innovations revenue, the **Yolo County** Alcohol, Drug and Mental Health Department funds a care coordinator based at CommuniCare Health Centers to track patients with co-occurring physical and behavioral health problems.

Example: **Orange County** has created a program to add case management and mental health services in community clinics and health centers.

9. The mental health agency subsidizes a behavioral care clinician hired and employed by the primary care clinic.

Example: **Nevada County** Behavioral Health is subsidizing one day per week for a Sierra Family Medical Clinic behavioral clinician, hired and supervised by Sierra Family, who is providing care there. He is paid by the Clinic for the other working days.

10. The mental health agency sends personnel to the neighboring primary care clinic for evaluation and placement when requested.

Example: A physician from **Tehama County** Mental Health goes to a nearby primary care clinic on request to carry out warm hand-offs, conduct mini-assessments and, if indicated, walk clients over to the crisis unit.

11. The mental health agency 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.

12. The mental health agency pays for a public benefits advocate stationed at the primary care site.

Example: With MHSA Innovations money, **Yolo County** Alcohol, Drug and Mental Health Department funded a full-time SSI benefits advocate at CommuniCare Health Centers.

13. The mental health agency directly schedules primary care appointments for clients.

Example: **Shasta County** Mental Health Services directly books clients into assessment slots provided by Shasta Community Health Center – not as referrals, but as set appointments. These appointments are reserved for persons with mental health problems not serious enough to warrant admission into the county mental health program.

14. The mental health agency 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** 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.

15. To increase care access for underserved groups, the mental health agency partners with primary care to promote their services in the local community.

Example: In **San Diego County,** the Council of Community Clinics received MHSA 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.

Example: **Merced County** Mental Health and Alcohol Services contracted with Golden Valley Health Center for three cultural brokers/"promotoras" to publicize and promote their services within the community.

16. Telepsychiatry is used to provide psychiatric consultation to health care providers.

Example: In **San Diego County's** SmartCare Program, psychiatrists are available to primary care physicians through teleconference and email (via HIPAA compliant e-Consults) to consult on issues relating to diagnosis and psychotropic medications. In another San Diego program, psychiatric consultations are available on-demand 40 hours per week through a daily open phone hour and through e-Consults. A clinical triage officer also provides behavioral health triage recommendations.

17. The mental health agency 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 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.

II. BRINGING PHYSICAL HEALTH INTO MENTAL HEALTH SETTINGS

18. The mental health agency offers wellness-related activities and other programs to promote physical health and encourage healthy lifestyles.

CASE STUDY – MODOC COUNTY

Modoc County Mental Health has as its objectives: increasing their clients' primary care visits; increasing their exercise; lowering their body mass index where indicated; increasing their consultation with primary care; and documenting client vitals. Among the health encouragement activities they sponsor is an evening aquatic exercise class held twice weekly at a local pool. They also organized a walking event, promoted with raffle prizes, healthy snacks, and other

incentives. At the walk, clients were encouraged to sign up for a walking club established by the provider. Incentives, like the opportunity to win supermarket gift certificates, are offered to clients for participation in exercise and smoking cessation sessions.

Example: **San Bernardino County** is bridging the mental and physical arenas by creating a "Holistic Campus", incorporating yoga, sweat lodges, acupuncture and other nontraditional, culturally-based approaches.

Example: **Imperial County** Mental Health has obtained "800 NO BUTTS" material and has contacted the County Public Health and Tobacco Coalition as resources. A case manager and peer member use the SMART Recovery facilitator guide, downloaded from the Internet, to run smoking cessation support groups in English and Spanish. They have also hired instructors from a local gym to conduct weight reduction and Zumba fitness classes.

Example: **Plumas County** Mental Health is holding group sessions to provide tobacco awareness, smoking cessation and dietary changes

Example: **Trinity County** revamped their intake procedure to included discussions about physical care and recovery.

Example: **Mendocino County** Mental Health is utilizing the Stanford "Personal Medication Card" and WRAP (Wellness Recovery Action Plan) to support clients in tracking, evaluating and monitoring their personal wellness.

19. Primary care physicians or other health professionals provide health care within a mental health setting.

Example: **Plumas County** Mental Health installed a primary care provider to conduct routine physical exams and address noncomplex medical issues for mental health clients at their Drop-In Center.

Example: With funds received from a SAMHSA integration grant, **San Diego County** paired county-contracted mental health and primary care clinics to focus on whole-person care. An RN nurse care manager placed in the mental health setting assesses clients' basic health by providing a standard screening four times per year and drawing blood for lab tests annually. In one mental health clinic, a nurse practitioner provides some treatment services on-site. Primary care goals are incorporated into mental health treatment plans. The Mental Health Services is in charge of fiduciary matters and the Council for Community Clinics is responsible for project management for the program, which is funded from 2009 to 2013.

Example: Mental Health Services of **San Joaquin County** has embedded a physician assistant in their Older Adult Services to provide targeted medical care for behavioral health clients who are diabetic.

Example: In **San Francisco County,** a blending of services is achieved by the stationing of health workers at mental health clinic sites and behaviorists at community health centers for consultations and direct services.

Example: The Effort primary care clinic in **Sacramento County** has established a clinic within a county-contracted mental health agency to provide on-going physical health services for that agency's clients.

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

Example: A county-operated mental health clinic in **Riverside** has established, within its facility, a functional primary care site staffed by a nurse practitioner. Clients are both assessed and followed by the nurse practitioner unless their condition warrants a higher level of care, in which case they are referred to the county primary care clinic.

Example: In **Alameda County,** Lifelong Medical Care, a large primary care agency with ten clinics, recently opened a satellite clinic within the County Mental Health's largest clinic. Their staff is embedded into the mental health team.

CASE STUDY – SAN FRANCISCO COUNTY

Tom Waddell, a primary care clinic that is part of San Francisco County's public health system, originally outstationed nurse practitioners at two county-operated or contracted mental health clinics - South of Market twice weekly and Tenderloin for half-day per week. Their objectives were 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. South of Market transported patients to their medical appointments if needed

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".

In 2011, a SAMHSA integration grant greatly expanded the interface between these two clinics and the blended services they provide.

20. The behavioral health agency takes steps to identify clients' physical health problems and make appropriate referrals.

Note: *The Small County Care Integration Learning Collaborative (SCCI) of CIMH has been instrumental in helping behavioral health departments in many of California's rural counties to identify and implement actionable and measurable medical goals for their clients. Examples of participants' activities are included below:*

Example: **Mono County** Mental Health is trying to measure and record their clients' blood pressure and weight at each visit. If either is high, clients are encouraged to make primary care appointments – or appointments are made for them at the time of visit. Their intakes now encompass physical health care as well as mental health issues.

Example: In addition to taking their clients' blood pressure, weight and body mass index (BMI) at each visit, **Tehama County** staff inquire about their physical health, including allergies, diabetes, and pulmonary function. Referrals are made to primary care where indicated, either by advising the clients to make an appointment or by making appointments for them. An intake form, covering mental as well as physical health, is given to clients annually to complete.
Example: Madera County Mental Health initiates referrals to their health educator coordinator if the clients' BMI is over 30 and/or they have high blood pressure.

Example: At intake, information regarding **Plumas County** Mental Health clients' physical health status, current medications, and life-style choices are documented. Clients' blood pressure, BMI, and A1C are scanned into the electronic health record so that the information is available to the psychiatrist, nurses, and clinical staff electronically. Treatment plans include linkages and referrals to primary care services when needed. Clients' primary care activity is tracked as part of case management.

Example: **Modoc County** Mental Health is taking and recording their clients' blood pressure, weight, blood sugar level and other measures, which they share with the clients' primary care provider. Results are also shared with the clients themselves, which appears to be a motivational factor for change.

Example: **Calaveras County** Mental Health screens clients at the start of treatment to determine health needs. If indicated, they set the client up with a primary care provider. They have taken steps to determine which primary care providers in the area are also comfortable treating mental health clients with more complicated clinical presentations.

CASE STUDY – MONO COUNTY

Clients seeking services at Mono County Mental Health funded through a CMSP contract are asked to complete a questionnaire indicating whether 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.

21. The mental health agency determines if clients have a current health provider and initiates contact to coordinate care.

Example: **Madera County** has partnered with health plan payers (Health Net and Anthem) to identify where and if their clients are receiving physical health care.

22. The mental health agency develops a comprehensive database of local primary care providers, specifying which accept Medi-Cal.

Example: **Amador County** Mental Health has compiled a listing of Medi-Cal primary care providers and has mailed out brochures to these practitioners informing them of the mental health services they offer and their desire to coordinate these services with primary care.

Example: **Imperial County** Mental Health developed a list of local primary care providers to whom their clients can be referred. Clients are asked if they have a primary care provider. If so, the name is added to the client's record. If not, clients are provided with the list and encouraged to make an appointment.

23. The mental health agency provides stipends for mental health peers to become certified as health navigators.

Example: **Mendocino County** Mental Health sponsors peers' participation in a Health Navigator certification program offered by Sonoma State University. The program, involving 160 hours of class time and 50 hours of fieldwork, trains graduates to support patients with information and resources for basic needs and help them navigate complex medical systems.

III. BRIDGING THE GAP: MEETING IN THE MIDDLE

24. Multiple agencies co-locate and coordinate to form a health care home for the client to address the spectrum of client health problems.

Example: In **Riverside County,** a county-operated mental health clinic embeds a nurse practitioner-run primary care clinic and, in a reciprocal arrangement, county mental health personnel are implanted in a county primary care clinic. Eligible clients can choose to have both their mental and physical health needs taken care of at either of these agencies instead of going to two separate clinics if they wish.

Example: **Contra Costa County** is building a new health center in which multi-disciplinary teams work in concert to provide mental health, substance abuse and homeless services as one entity with a single assessment and uniform case management.

CASE STUDY – LOS ANGELES COUNTY

The Center for Community Health (CCH), based in the heart of Los Angeles' homeless area, offers medical, dental, vision, HIV, substance abuse and mental health care along with pharmacy case management and housing services all under one roof. CCH provides these services through partnerships with county departments and private agencies. Both CCH and outstationed Los Angeles County Department of Mental Health (DMH) staff provide mental health services, with specialty mental health evaluations provided by DMH. Pharmacists from the University of Southern California provide medication management consultations to support the primary care team. CCH has also taken over a substance treatment agency, thus bringing these services under their direction and thereby improving access to both outpatient and residential treatment services.

25. Mental health and primary care providers team up to provide mobile outreach services.

Example: **Los Angeles County** Mental Health Department deploys a mobile integrated and multi-disciplinary team of mental health, primary care and substance abuse professionals along with housing and benefits eligibility specialists, and specially trained peer/family/parent advocates to provide outreach and care to individuals with mental illness and their families who are homeless, in a shelter, or recently in permanent supportive housing.

26. Staff from primary care clinics and the mental health agency meets regularly to discuss individual cases and problem-solve.

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

Example: Though there is no formal shared care plan for clients, a physician assistant from **Tehama County's** Mental Health Division meets weekly for mutual client case conferencing with a physician from the nearby health clinic. The assistant educates the primary care provider regarding mental health, diagnosis and management. A shared medical history form is now used by both providers.

27. The mental health and primary care providers establish referral criteria specifying which clients are considered appropriate for each other's services. *[See the FORMS Section for a copy of sample Referral Forms.]*

Example: A universal referral form was developed with mutual input from the **Napa County** Mental Health Department and Clinic Ole, a local primary care provider. The form asks for the reason for referral; current working diagnosis; allergies; current medications; and, most importantly, whether a release of information is attached. Napa County Mental Health is also trying out the MORS (Milestones of Recovery) scale to determine whether clients are stable enough to be transitioned to primary care.

Example: Through a memorandum of understanding, **Yolo County** Alcohol, Drug and Mental Health Department and CommuniCare Health Centers established mutually agreed on criteria for referral to each other's services, as well as the circumstances that would trigger a termination of services and a referral back. *(See the Yolo County MOU in the Forms Section.)*

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 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.

Example: **Humboldt County** Department of Health and Human Services negotiated an agreement with Open Door Community Health Center specifying which agency, depending on the clients' level of physical and mental health needs, will be the primary caregiver for identified populations.

28. 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, etc.

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.

Example: A psychiatric nurse practitioner in **Modoc County** Mental Health is in place part-time to liaison with a local hospital so bi-directional communication can occur.

29. The mental health agency and partnering primary care clinics exchange health information electronically.

Example: **Plumas and Trinity's** electronic health record allows for the tracking of their client contacts with primary care providers.

Example: **Napa County** is developing "Cloud" technology to establish an electronic repository for mutually agreed upon client information which both primary care Clinic Ole and the Napa County Mental Health Services can input and access.

Example: With input from the diverse partnering agencies located at the Center for Community Health in **Los Angeles County,** a shared electronic health record was established.

Example: **Modoc County** Mental Health transmits the clients' blood pressure, weight, blood sugar level and other measures to the clients' primary care provider via the PECSYS electronic system.

30. Release of information forms that encompass primary care are obtained from clients.

Example: Several counties, including **Trinity, Napa, Orange, Shasta** and **Riverside** have developed universal HIPAA-compliant release forms that cover release of information between primary care, mental health and substance abuse agencies. Trinity Mental Health, among others, has redesigned their intake process to include explaining and obtaining consent forms that cover release of information to and from primary care. *(See Information Sharing section for forms.)*

31. Care professionals coordinate and reconcile medications that clients may be getting from different providers.

Example: By gaining access to Department of Justice/Bureau of Narcotic Enforcement database, **Tehama County** providers have been able to intervene with clients attempting to obtain multiple prescriptions leading to potentially lethal doses of controlled medications. Primary and mental health services have also been collaborating together to coordinate medications and address poly-pharmacy.

32. Client peers are used to promote mental and physical health and substance abuse recovery.

Example: **Orange County** Behavioral Health Services is employing trained consumer mental health workers, supervised by licensed mental health staff, to provide behavioral care at primary care clinics and conversely, using consumers to coordinate and monitor physical health care at behavioral sites.

Example: **San Mateo County** Mental Health employs trained consumers and family members as health and wellness coaches, partnering them with nurse care managers and nurse practitioners to help clients manage their health conditions. Peers play a key role in care management by assisting clients with communication and advocacy with medical providers, health education and support.

CASE STUDY- ALAMEDA COUNTY

Putting their Health Care Innovation Award to work, Lifelong Medical Center in Alameda is subcontracting with the Independent Living Center to recruit and train peer health coaches, who are themselves people with mental and physical disabilities. The peers will be embedded in the clinic's staff and supervised by the Independent Living Center. As regular member of the patients' interdisciplinary care team, they are partnered with the nurse care manager to follow patients, help them live independently, support changes in lifestyle, and monitor medication adherence and side effects. Peers are encouraged to support patient self-advocacy -- helping participants make better informed choices to insure they maintain control of their own healthcare and wellness. They also provide training to Lifelong staff about the patient perspective.

Example: **Los Angeles County** Department of Mental Health plans to use the Peer-Run Integrated Services Model (PRISM) and alternative peer-run crisis houses for people with co-occurring mental health and substance use disorder needs. Interventions are provided by persons with lived experience.

Example: CommuniCare Health Centers in **Yolo County** employ recovered substance users as outreach workers, therapists and advisory board members. Roughly half their substance abuse staff is in recovery themselves. Peer substance abuse counselors accompany a physician assistant and a social worker each week to homeless shelters to promote the clinic's services and enroll interested patients.

Example: **Madera County** Mental Health Department, using MHSA Innovation funding, employs a team of trained peers and hospital staff stationed at the Madera Community Hospital Emergency Department to engage clients and their families experiencing a crisis. The team also provides these services when clients are discharged from hospitalization.

Example: Assuming that mental health clients receiving care in primary care settings could benefit from a stronger connection to other consumers with lived experience, **Sonoma County** has incorporated peers into their service delivery. They help design the integration program, collaborate with clients to create individual care plans and develop and deliver a community health education curriculum.

Example: **Riverside County** Mental Health employs 60 full-time peer specialists as care navigators, some working in a collaborative health facility to facilitate transitions and warm hand-offs. They help acquaint clients with treatments being offered, facilitate processing, assist with health care visits and offer support, encouragement and advocacy.

Example: Peer staff from Manzanita Services, a client-run peer support program in **Mendocino County,** received stipends from the Mental Health Department to attend the Sonoma State University Patient Navigator Certificate Program.

33. A pharmacist is used to coordinate physical and mental health.

Example: Contracted pharmacists coordinate the mental and physical care of **Madera County** Mental Health Department's clients by working with both primary care and mental health and staff. Pharmacists refer clients in need of physical health services to primary care and also transition stabilized mental health clients receiving only medication to a medical home.

34. Out-stationed mental health and primary care providers provide services at school-based health centers.

Example: The **Los Angeles County** Mental Health Department is using funds to support 16 integrated school health center sites which include staff from outside mental health and primary care providers.

35. Mental health and substance abuse services are coordinated.

Example: **Napa's** Clinic Ole is trying out a warm hand-off from primary care to a drug and alcohol counselor in instances where the primary care provider suspects substance abuse but doesn't want to be confrontational. The counselor works with the clients and tries to convince them to enter a program. Mental Health is starting a substance abuse warm-handoff as well.

Example: Physical health questions are embedded into a substance abuse assessment used by the Atlanta Substance Abuse Clinic in **Riverside County.** Positive responses trigger a referral to the collaborating primary care clinic. Conversely, the primary care clinic is screening their clients for substance abuse and referring those who screen positively to the substance abuse clinic.

Example: **Kern County** Mental Health Department contracts with a primary care provider, Clinica Sierra Vista, to provide substance abuse outpatient services for persons with co-occurring mental health and substance abuse disorders.

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.

Example: The Co-Occurring Disorders Court pilot program, created to supervise criminal defendants diagnosed with both a mental illness and a substance abuse disorder, integrates mental health and substance abuse treatment services. Implemented in 2007, the program is funded by the **County of Los Angeles** Homeless Prevention Initiative, the Mental Health Services Act and a SAMHSA grant. The latter provides funding for short-term residential services for the participants.

CASE STUDY – LOS ANGELES COUNTY

SAMHSA's Primary and Behavioral Health Care Integration initiative provided funding for 93 agencies throughout the country, including a four-year grant to Tarzana Treatment Centers, an integrated behavioral health agency serving the Antelope Valley, San Fernando Valley, and Long Beach in Los Angeles County. These grants were focused on integrating primary care services for people with serious mental illnesses and co-occurring substance use disorder. Services provided by grantees include facilitation of screening and referral for primary care prevention and treatment needs; providing and/or ensuring that primary care screening, assessment, treatment and referrals are provided in a community-based behavioral health agency; developing and implementing a registry/tracking system to follow primary health care needs and outcomes; offering prevention and wellness support services; and establishing referral and follow-up processes for physical health care requiring specialized services beyond the primary care setting.

36. The Mental Health Department contracts with primary care providers on a pay-for-performance basis.

CASE STUDY – ALAMEDA COUNTY

Alameda Behavioral Health is offering fixed payments to participating primary care for measurable achievements of specific tasks. The amount the clinics can earn is dependent upon which tasks they successfully accomplish. Tasks include: having key staff attend AIMS-sponsored training on integrated behavioral health care; identifying the careload (caseload) target population and the behavioral health conditions to be addressed; identifying and using assessment tools and data/tracking methods; identifying the behavioral health professional responsible for the careload; implementing registries; and meeting other service and outcome thresholds, such as documenting medication information in the registry for at least 50% of the patients. *(For more information, see Alameda County Integrated Pay-for-Performance Draft in the MOU section of this Tool Kit.)*

37. The mental health agency teams up with the county substance abuse program to establish community assessment services centers.

Example: In **Los Angeles County,** Community Assessment Service Centers (CASC's) act as the entry point for county residents seeking alcohol and other drug treatment and recovery services. The Mental Health Department system navigators participate in team meetings, discussing and facilitating enrollment of persons with co-occurring mental health and substance disorders into mental health-operated programs.

38. Primary care clinics can directly access 23-hour crisis intervention services provided by the mental health agency.

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.

39. Mental health personnel straddle primary care and mental health clinics, splitting their time between each and facilitating inter-agency transitions.

Example: **Butte County** Behavioral Health Department hired Integrated Mental Health Clinicians who divide their work week between a primary care clinic and a county mental health agency. Their main function is to cement collaboration and facilitate patient flow between the two providers.

IV. SPREADING THE WORD: TRAINING AND CROSS-EDUCATION

40. 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 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.

41. The mental health agency contracts with primary care provider to educate other providers about the integrated model.

Example: **Nevada County** Mental Health has used MHSA 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.

Example: In 2011, CCHN, a subsidiary of **San Diego's** Council of Community Clinics, contracted with County Behavioral Health Services to implement an Integration Institute over 26-months to promote shared population management of behavioral and physical illness through working relationships of paired behavioral health and primary care organizations. The Institute provides support of these providers via learning communities comprised of two to three of these provider pairings.

42. Both the 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."

43. The mental health agency 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.

44. The mental health agency 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.

45. College or university supplies student behavioral health staff to primary care clinics 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.

Information Sharing Between Behavioral Health and Primary Care

Medical information-sharing laws are extremely complex. The information contained in this section is offered as reference only. Agencies are advised to consult with their own legal counsel regarding compliance with confidentiality requirements.

Communication between all treatment providers is the foundation upon which integrated care rests. But a formidable impediment to crucial inter-agency information-sharing – one cited by both behavioral and medical providers across the State – is the lack of clarity around confidentiality provisions. Multiple interpretations of state and federal statutes have lead to uneven, sometimes contradictory information-sharing policies throughout California.

While the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) appears to allow two health providers treating the same individual to share information, its complicated provisions, coupled with the additional layer of State confidentiality statutes has left many providers reluctant to do so. Added to the complex mix is Section 42 Part 2 Code of Federal Regulations, a more stringent set of rules governing release of drug abuse and alcohol treatment information.

Organized Health Care Arrangements

To ensure they are comporting with HIPAA's labyrinthine information-sharing provisions, some partnering agencies have established Organized Health Care Arrangements per HIPAA Section 160.103, thereby opening the door to cross-agency information disclosure. The law describes an organized health arrangement as:

1. *"A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;*
2. *An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:*
   - *Hold themselves out to the public as participating in a joint arrangement; and*
   - *Participate in joint activities that include at least one of the following:*

- *Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;*
- *Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or*
- *Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk."*

According to the HRSA and SAMHSA-sponsored Center for Integrated Health Solutions (CIHS), *"to become an OHCDS (Organized Health Care Delivery System), the respective chief executive officers send letters to each other confirming their intent to hold themselves out as an OHCDS and identifying the utilization review or quality assessment and improvement activities in which they will jointly participate. To solidify this arrangement organizations then often change their privacy statements to reflect the OHCDS and may add language to all consents to treatment reflecting their partnerships and with whom they will be sharing healthcare information."*

Providers need to check with their in-house counsel and with their County Counsel about the legalities surrounding health information exchange.

Exchange of Substance Use Information *(courtesy of CIHS):*

42 CFR Part II defines the parameters for sharing substance information for organizations that hold themselves out as substance abuse treatment providers. The Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment actively addresses issues related to the sharing of substance abuse treatment information under 42 CFR Part II. However, if organizations enter into a Qualified Service Agreement (QSA), they are often required to share needed substance abuse information for healthcare coordination.

The rules are complex, so it is suggested that you access key resources in this area including SAMHSA's Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchanges (http://www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf) and The Confidentiality of Alcohol and Drug Abuse Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Drug Abuse Programs, June 2004 (http://www.samhsa.gov/healthprivacy/docs/samhsapart2-hipaacomparison2004.pdf.). The latter, a valuable review of the linkages between HIPAA and 42 CFR Part II, helps agencies understand the elements of a Qualified Service Agreement.

CIHS provides free technical assistance. To contact them, email integration@thenational council.org or call 202 684-7457

INFORMING PATIENTS OF THEIR RIGHTS REGARDING SHARING OF INFORMATION BETWEEN AGENCIES

(taken from the State of California's ehealth Privacy 360)

1. What is a Health Information Organization (HIO)?

An HIO is a third party company that enables the health care provider to transfer or exchange your health information to other health care providers or health-related entities who need your information to be able to treat you. HIOs are used to exchange your health information when the health care provider may not have the technical capability to securely exchange information and HIOs have special software programming that will allow them to transfer your information securely.

2. Do I have access to my medical information that is held or kept by either my health care provider or a HIO?

You are entitled to get copies of your own health information, by law. If you want copies of your health information, ask your health care provider with whom you have a direct care relationship how you would be able to access or to get copies of your information. You may be able to either access and print your health care information online or request hard copies of your information to be provided to you. Since most HIOs do not have a direct relationship with each individual patient, it is unlikely that you will be able to obtain your medical information directly from a HIO. Some HIOs' role is only to transmit the medical information between entities and not to store it; therefore, they would not be able to access it for individuals' requests.

3. How do I give permission or consent to let others such as my doctors to see my medical information through a HIO?

Generally, providers who use HIOs to exchange your health information do ask patients for their consent in order to allow the patients' information to be exchanged through the HIO. The two most common types of consent are: "Opt In" and "Opt Out". If you are asked to give Opt-In consent, you will be asked to sign a written (paper or electronic) form giving your permission for your information to be exchanged through the HIO. If you are given Opt-Out consent, you should be provided with information about the HIO and given a period of time to exercise your opportunity to refuse to let your information be exchanged. In order to opt out, you must usually either send in a form by mail or else click on a certain box on a website to make clear that you do not want your information to be exchanged through the HIO. Some providers in California might have a no-consent policy. A No Consent model is appropriate when the HIO does not have access to any health information.

4. How long does my permission/consent last with a health care provider or HIO?

This will depend on the policies of your health care provider. It also depends on the procedures the participating organizations of a HIO follow. It may last until you revoke your consent or you may be asked to sign a new consent periodically (such as, annually). However, once your health information has been viewed or exchanged through a HIO, it cannot be retracted which means the information already viewed or exchanged cannot be taken back or deleted out of the system. Providers who have relied on this information to make decisions about your health must be able to retain a record. If you revoke your consent, then your health information will not be able to be further viewed or exchanged through the HIO.

5. What happens in an emergency if I am not able to consent?

In an emergency situation where you are not able to communicate with the treating health care provider (even if the treating health care facility is not your own health care provider), they would be able to receive your health information directly from your health care provider and treat you without your consent. If your health information is exchanged through a HIO, accessing your health information would depend on if you provided prior consent for the HIO to exchange your information. If you refused consent through your health care provider to have the HIO exchange your information prior to the emergency, then none of your information will ever be available, even in a life-threatening emergency. Some health care providers and HIOs have systems under which emergency providers can obtain access to your information under a "break-the-glass" scenario. Under the "break-the-glass" scenario, an emergency physician is able to exercise his/her professional judgment and obtain your information even if you did not give consent if it will help the physician to treat you.

6. What is the difference between an authorization and consent?

An authorization is a very specific term that is used in HIPAA (the federal laws that govern confidentiality of medical information) to describe permissions for use and disclosure of your health information that falls outside of treatment, payment, and health care operations. The authorization provision in HIPAA requires your provider or health plan to obtain your permission before they use your health information for anything that you might not be aware of that was not listed on the Notice of Privacy Practices, such as, marketing. Consent for your information to be accessed or exchanged through a HIO is specific to the electronic exchange of your health information. By giving your consent, you are not consenting to uses and disclosures of your information. It is simply a means to acknowledge that you were informed about the use of a HIO to obtain your health information.

7. I did not receive a consent form to sign for the electronic exchange of my health information, but noticed the Notice of Privacy Practices now states that my data may be exchanged through a HIO. Will I receive a consent form too?

You should receive a Notice of Privacy Practices upon a first visit to a physician or admission to a hospital. As specified by HIPAA, these notices describe how your protected health information is to be collected, used, and disclosed. Some providers will only use the NPP to notify you of their ability to electronically exchange your health information. Others may use a consent form and others yet may use a combination. If you are unclear about what your NPP states you may ask your provider how your data is being used and shared electronically.

8. Will I know if my health information was misused?

Under HIPAA requirements, you have the right to receive a list of instances where your health information was disclosed and for what purposes. If your information was misused or inappropriately disclosed it should also be logged at your provider's organization. This would be considered a request for "Accounting of Disclosures" as stated and required in HIPAA. If there was a breach of your electronic health information you would be notified by the entity that breached your information. Refer to Questions and Answers 23, 24, and 25 for more information regarding breach of health information. If you believe that a person, agency or organization covered under HIPAA violated your (or someone

else's) health information privacy rights, you may file a complaint with that person, agency, or organization or with the federal Office for Civil Rights. The Notice of Privacy Practices that you received from the provider will have information about who to contact. Individuals found in violation of HIPAA can be civilly and criminally prosecuted. For more information, see: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

9. Can I request changes to my health record or other information included in the HIO?

If you notice that your health care provider has outdated or incorrect information in your health record, you may request an amendment, or changes, to your record as one of your rights under HIPAA the provider who created the record. Deletions of records are not generally permitted as providers who have made decisions about your health based on those records must maintain them

Sample of HIPAA Provisions in a Services Contract

(courtesy of Sierra Health Medical Clinic)
Inclusion of this sample should not imply endorsement of the contents. Clinics are encouraged to consult their own legal council.

If and to the extent, and so long as, required by both the provisions of 42 U.S.C. § 1171, et seq., enacted as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 U.S.C. Parts 160 – 164, enacted as the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and those regulations promulgated thereunder, including any subsequent amendments made thereto, Contractor does hereby assure County that Contractor will appropriately safeguard Protected Health Information made available to or obtained by Contractor.

In implementation of such assurance and without limiting the obligation of Contractor otherwise set forth in this Agreement or imposed by applicable law, Contractor hereby agrees to comply with applicable requirements of law relating to Protected Health Information and with respect to any task or other activity Contractor performs on behalf of County, to the extent County would be required to comply with such requirements.

The agreement of Contractor set forth in the two preceding sentences, and the additional provisions relating to permitted and required uses and disclosures thereof that shall from time to time be provided to Contractor by County in accordance with applicable law, constitutes a contract between County and Contractor establishing the permitted and required uses and disclosures of such Protected Health Information by Contractor.

If one or both parties to this agreement are "Covered Entities" within the meaning of 45 C.F.R. 160.103, the Covered Entity will comply with all requirements for Covered Entities in accordance with the rules and regulations promulgated under the HIPAA and HITECH Acts. In the event Contractor is determined to be a "Business Associate" within the meaning of 45 C.F.R. 160.103, then in amplification, and not in limitation, of the provisions of this Agreement, including this Section of this Agreement, Contractor agrees that Contractor shall:

1. Not use or further disclose such information other than as permitted or required by this Agreement. Contractor shall not, except as necessary for the proper management and administration of the Contractor to carry out the legal responsibilities of the Contractor for performance of Contractor's duties under this Agreement, and as applicable under law, use, reproduce, disclose, or provide to third parties, any confidential documents or information relating to the County or patients of the County without prior written consent or authorization of the County or of the patient. If Contractor uses such information for the purposes set forth above, it will only do so if the disclosure is required by law or Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which Contractor disclosed it to the person. Contractor shall also ensure that the person notifies Contractor of any instances of breach of confidentiality such person is aware of. Contractor shall ensure that its personnel, employees, affiliates, and agents maintain the confidentiality of patient health information and business of the County. As a Business Associate of the County, as that term is used under the HIPAA and HITECH Acts, the contractor shall abide by the HIPAA Privacy Rule and other Protected Health Information disclosure requirements of 45 CFR 164.504(e).

2. Not use or further disclose the information in a manner that would violate the requirements of applicable law. The County and Contractor acknowledge that Section 13404 of the HITECH Act creates a statutory obligation for Business Associates of Covered Entities to use and disclose Protected Health Information only if the use and disclosure is in compliance with the requirements of 45 C.F.R. 164.504(e), which establishes the standards and implementation specifications for Business Associate agreements, including the prohibition of Business Associates from using or disclosing Protected Health Information in a manner that is inconsistent with the HIPAA Privacy Rule and the privacy and security requirements of the HITECH Act.

3. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such Protected Health Information that it creates, receives, maintains, transmits or destroys on behalf of County in a manner that is consistent with the standards required under the HIPAA and HITECH Acts;

4. In the event that Contractor becomes aware of any use or disclosure of Protected Health Information that is not authorized by this Agreement, it will report that event to the County within twenty-four hours of becoming aware of the unauthorized use or disclosure;

5. Ensure that any subcontractors or agents to whom Contractor provides Protected Health Information received from County agree to the same restrictions and conditions that apply to Contractor with respect to such information;

6. Make available Protected Health Information in accordance to applicable law;

7. The above requirements apply equally to all electronic records. Contractor shall not release any electronic information without complying with all above requirements;

8. Contractor will maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Protected Health Information in a manner consistent with HIPAA and HITECH Act standards. Contractor will report any security incident of which it becomes aware, including breach of confidentiality, integrity or availability of Protected Health Information to customer within twenty-four hours of its discovery of the breach, and will comply with all applicable breach notification requirements as provided under the HIPAA and HITECH Acts. Contractor shall take prompt corrective action to cure any breach or action pertaining to the unauthorized disclosure of Protected Health Information;

9. Make Contractor's internal practices, books, and records relating to the use and disclosure of Protected Health Information received from County available to the Secretary of the United States Health and Human Services for purposes of determining Contractor's compliance with applicable law (in all events Contractor shall immediately notify County of any such request, and shall provide County with copies of any such materials);

10. Incorporate any amendments or corrections to Protected Health Information when notified pursuant to applicable law. Contractor agrees that this Agreement may be amended from time to time by County if and to the extent required by the provision of 42 U.S.C. § 1171, et seq., enacted by HIPAA and regulations promulgated thereunder, in order to assure that this Agreement is consistent therewith; and

11. Authorize termination of the Agreement by County if County determines that Contractor has violated a material provision of the HIPAA and/or HITECH Acts.

USE OF REGISTRIES AND OTHER METHODS OF INTER-AGENCY COMMUNICATION

What is a Registry?

The tool used to collect and access information about a specific group of patients is often referred to as a registry. Simply stated, a registry is a mechanism for keeping all pertinent information about a specific group of patients at one's fingertips.

What Can a Registry Do For Us?

The information can be used to schedule visits, labs, education sessions, as well as generate reminders and guidance of the care of patients (both in groups and individually) and, in general, facilitate communication and help providers in the decision support of patient care. It also allows the organization to collect and track important clinical information like diagnoses, medications, activity goals and referrals, to track quality improvement initiatives (by use of measures), and to identify and refine improvement efforts.

What Are Some Electronic Records Systems and Registries Commonly Used?

It is sometimes possible to track needed information through an electronic records system without having to create a separate registry, though clinics report mixed success with doing so. Avatar and Anasazi are the electronic records systems most widely used by California clinics, along with, to a lesser extent, NetSmart, Insyst, ShareCare and Welligent.

The most popular commercial registry systems in the state are i2iTracks and PECSys. Other hosted systems include DocSite and Crimson Care Registry. The Chronic Disease Electronic Management System (CDEMS) is available for free, but does not come with training or technical support.

What Are Some Measures to Track with an Electronic Registry?

- demographics (name, record number, address, age, gender, etc.)
- chronic conditions/co-occurring disorders
- latest lab values (e.g. lipid panel, HbA1c)
- latest record of health practices (e.g. smoking, diet)
- blood pressure/other health assessments
- body mass index (BMI)
- HDL/LDL
- screening results (such as PHQ-9, CAGE, AUDIT, GAD-7, etc.)
- dates of last assessment
- medications
- other lab results and diagnostic tests
- risk factors
- consultations
- latest referral types, dates, and completion
- education
- latest mental health assessment
- mental health goals

How Can We Prepare for Implementing a Registry?

- An electronic registry only serves a purpose if it is integrated into the daily delivery system operations. To successfully launch the registry, a team approach is suggested, including providers, nurses, medical records, front-line support staff (clerical, medical assistants), information systems techs (if available), and administration.
- Cross-training on the use of your registry is critical – successful teams often have at least one back-up person familiar with data entry and reporting procedures, with the goal to have all team members trained in data entry and reporting.
- No matter which registry is decided on, the following will ease the implementation:
  - Determine your population of focus.
  - Obtain a list of all patients with the condition your improvement project will focus on within your population of focus (Many centers are able to review demographics and their billing data for all patients with applicable codes to get started).
  - Pick ten patients from your list to be a sample, and review their charts for the data that is of interest.

What About Using "Cloud" Technology to Exchange Information Between Agencies?

Clinic Olé, a primary care clinic in Napa County, California, is experimenting with the use of "The Box" (www.box.net) to communicate with the County Mental Health Department. But because this system is designed for collaboration – inviting in participants – additional security provisions are needed to make it a HIPAA-compliant virtual safety deposit box. Posting client documents on the site is predicated on the client's signed consent. All participants must obtain a license for use, must receive training with respect to confidentiality, disclosures and consent and must log in with a user name and password. There is a built-in tracking system, so if someone were to invite a nonsecured individual to access the site, a monitor would be alerted.

The Beacon program in San Diego has a federal grant to establish a health provider intercommunication system, described as a hub and spoke model with each participating agency being a spoke. The data is stored with the providers, but the central hub enables the communication of data between them, even if their electronic records systems are not compatible. The three phases to establishing the program have been: a) setting up connections and getting data bases populated; b) gaining patient consent; and c) getting users to access the system.

The National Council, also working aggressively on information-sharing between primary care and mental health, has established a protocol that provides a baseline for sharing information among providers.

What is Direct Secure Messaging?

It's essentially a secure and encrypted email system. One difference between it and regular email, aside from the secure transmission, is that before they can use it, participants have to be authorized to get an account.

- portions of the above have been modified from "Creating an Electronic Registry of Your Patients", HealthCare Communities, Healthcare Communities Knowledge Base Article, 2009 and from the Health Disparities Collaborative Prework Manual, 2005

EXPLAINING THE BENEFITS OF ELECTRONIC INFORMATION-SHARING TO PATIENTS

(taken from the State of California's Privacy 360)

Information is Available in an Emergency: If you are in an accident and are unable to speak to health care providers, they can quickly find the information about your health history, medications you are taking, and other health issues to make informed decisions to treat you faster.

Information is Protected in Disasters: If you are in an area affected by a disaster, like a hurricane or earthquake, your health information can be stored safely in electronic form in an electronic health record system and can be quickly accessed by providers caring for you. Also, information can be backed-up (saved) on a regular basis which prevents loss of your critical health information during times of disaster.

Easier Access and Retrieval of Health Information: Your health information sits in multiple locations including provider offices, hospitals, pharmacies, and labs. When needed, information from each of these locations may be accessed by an authorized health care staff at any one of your provider offices or in an emergency room.

Improved Care/Reduced Medical Errors: Access to information about care you receive elsewhere gives your health care providers a better, more complete picture of your health. That means your health care providers can make sure the treatment they provide doesn't interact badly with other treatment you may be receiving. For example, when you can't remember what medications you are taking, through electronic exchange of health information your health care providers will be able to see what other medications you were prescribed by another doctor, so that they will know the right medications or treatment to give you instead of doing something that might be harmful.

Increased Safety/Reduced Duplication: Because health care providers can see what tests you have had and the results, they don't always have to repeat the tests. Especially with x-rays and certain lab tests, this means you are at less risk from radiation and other side effects. It also means you pay less for your health care in co-payments and deductibles when tests are not repeated.

Improved Tracking for Protection: When your health information is shared electronically, information about access to your record is stored electronically. This can include the identity of those who accessed your record, the date of access, the types of information accessed, and the reason your record was accessed. This makes it easier to enforce laws and regulations governing access when using electronic records than it is with paper records.

Patient Information Sheet Explaining Electronic Information Sharing

(courtesy of the State of California's Privacy 360)

CONSENT

How Your Information Will be Used. Your electronic individual health information will be used by [Name of Provider Organization/HIE] Health Information Exchange (HIE) **only** to:
• Provide you with medical treatment and related services
• Evaluate and improve the quality of medical care provided to you and all patients

The decision to participate in the [Name of HIE] HIE is voluntary. No health care provider participating in the HIE will deny you medical care and your insurance eligibility will not be affected by your choice to participate or not participate.

The benefits of the electronic exchange of individual health information are:

- Improved quality of care based on more complete information regarding your past condition(s) and treatment,
- Improved coordination of care between all of your health care providers,
- Decrease in the duplication of care or provision of unnecessary care, and
- Decrease of delays in treatment.

Some potential risks associated with the electronic exchange of individual health information include:

- Unauthorized disclosure of your individual health information, and
- Identity theft if there is a breach of your health care provider's electronic files.

PURPOSE

The purpose of giving permission to electronically exchange your individual health information is to allow all aspects of your medical history to be taken into account when determining your current and future care. As a result of increased access to information, your providers can make well-informed decisions in your medical care which should result in improved care at hospitals, physician offices, labs, pharmacies, etc. Additionally, allowing your electronic health information to be exchanged should help with the protection of the public as a whole such as in the event of an epidemic (for example the H1N1 virus) or other public health crises.

TYPES OF INFORMATION INCLUDED IN THIS CONSENT

What Types of Information about You Are Included? If you give consent, [Name of Provider Organization] may access ALL of your electronic health information available through the [Name of HIE] HIE. This includes information

created before and after the date of your Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or illicit drug use
- Contraception and abortion (family planning)
- Genetic (inherited) conditions or tests for these
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

Where Health Information About You Comes From. Information about your health comes from places that have provided you with health care. These may include hospitals, physicians' offices, pharmacies, clinical laboratories, Medi-Cal, and other organizations that exchange health information electronically. A complete list of current Information Sources is available from [Name of Provider Organization, or HIE, as applicable]. The list of participating organizations may change in the future.

Who May Access Information About You, If You Give Consent? Individuals legally allowed to access your electronic individual health information would be allowed to view your records. An example of those who may access information about you: doctors and other health care providers who serve on [Name of Provider Organization]'s medical staff and who are involved in your medical care; health care providers who are covering or on call for [Name of Provider Organization]'s doctors; hospitals, clinics, pharmacies, labs, other licensed providers, health information organizations (HIOs), and health care staff members who carry out activities permitted by this Consent Form as described in the Consent paragraph above.

Penalties for Improper Access to or Use of Your Information. There is some risk associated with the electronic exchange of individual health information. There are penalties for inappropriate access to or use of your electronic health information for non-clinical reasons/purpose. If at any time you suspect that someone has accessed your electronic individual health information inappropriately, call [Name of Provider Organization] at: _____; or visit [Name of Provider Organization]'s website, Office of Civil Rights' website www.hhs.gov/ocr/, California Department of Public Health's website www.cdph.ca.gov, or the California Office of Health Information Integrity's (CalOHII) website www.calohi.ca.gov. You can also reference California Civil Code Sections 56.35 and 56.36.

Re-disclosure of Information. Electronic health information about you may be re-disclosed by [Name of Provider Organization] to others only to the extent permitted by state and federal laws and regulations. This is also true of health

information about you that exists in a paper form. Some state and federal laws provide special protections for certain kinds of sensitive health information, including HIV/AIDS, drug and alcohol treatment, contraception and abortion (family planning), genetic (inherited) conditions or tests, mental health conditions, and sexually transmitted diseases. These special requirements must be followed whenever people receive these kinds of sensitive health information. [Name of Provider Organization/HIE] and persons who access this information through the [Name of HIE] must comply with these requirements.

Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to [Name of Provider Organization]. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from [Name of Provider Organization]. In the event that you withdraw your consent, your individual health information will continue to be stored electronically, but will not be accessible through [Name of the HIE].

Effective Period. Your Consent Form will remain in effect until you withdraw your consent.

Note: Providers who access your electronic individual health information through [Name of HIE] while your consent is in effect may copy or include your information in their own electronic health records system. Even if you later decide to withdraw your consent, they are not required to remove it from their records.

Copy of Form. You are entitled to get a copy of your Consent Form after you sign it.

Sample Patient Consent for Electronic Information-Sharing

(provided by the State of California's eHealth Privacy 360)

Patient Consent Form for Electronic Exchange of Individual Health Information	For Provider Use: MRN_____

PLEASE READ THIS ENTIRE DOCUMENT BEFORE SIGNING THE CONSENT FORM.

Please provide the following information:

_____

PATIENT NAME Last First Middle

PREVIOUS NAME(S) _____ **GENDER:** M__F___

_____

STREET ADDRESS/P. O BOX

CITY _____**STATE** _____ **ZIP CODE** _____

PHONE NUMBER (OPTIONAL) _____

DATE OF BIRTH (MM)_____(DD)_____(YYYY)_____

CONSENT: I understand that if I give consent below, I am allowing [Name of Provider Organization] to release and/or access ALL of my electronically available individual health information. Electronically available individual health information may include information from my health care providers, including hospitals, physicians, clinics, pharmacies, labs, and other licensed providers, as well as a third party organization (called a Health Information Organization (HIO)) that assists in the exchange of my information.

PURPOSE: I understand that my individual health information that is electronically disclosed to health care providers may be used to provide me with medical treatment, assess/improve the quality of my medical care, and to facilitate public health reporting. Examples of health care providers include, but are not limited to, the following: physicians, nurses, hospitals, clinics, pharmacies, labs, other licensed providers, heath care staff, and HIOs.

TYPES OF INFORMATION INCLUDED IN THIS CONSENT: I understand that this consent permits [Name of Provider Organization] to access and disclose ALL of my electronically available individual health information, including but not limited to, information related to drug/alcohol abuse, HIV/AIDS testing, status or treatment; genetic diseases or genetic tests; family planning/reproductive care; sexually transmitted diseases; mental health, emergency care records, nursing notes, laboratory results, pathology reports, x-ray reports, films, and all other individual health information as allowable under applicable law.

YOUR SIGNATURE: I understand that my consent becomes effective upon signing this form and will remain in effect until I submit a written request to revoke it. I understand that I have the right to withdraw or revoke this consent in writing at any time, except to the extent that the electronic

health information has already been released to another entity. This consent permits access to and disclosure of my individual health information created both before and after the date I sign this form.

My Consent Choices:

☐ ***I GIVE CONSENT FOR [Name of Provider Organization] to release and/or access ALL of my electronic health information through health information organization(s) in connection with providing me any health care services, including emergency care.***

☐ ***I DENY CONSENT FOR [Name of Provider Organization] to release and/or access any of my electronic health information through health information organization(s) EXCEPT in the event of a medical emergency.***

☐ ***I DENY CONSENT FOR [Name of Provider Organization] to release and/or access any of my electronic health information through health information organization(s) even in the event of a medical emergency.***

Signature of patient or authorized representative:
If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____
Date

If signed by someone other than the patient, print name and indicate relationship:

_____ _____ _____
Authorized Representative *Relationship* *Date*

Address of authorized representative signing this form (please print):

_____

Phone number of authorized representative signing this form:

_____

Signature of witness:

Witness required only for telephone consent, physical inability to sign, or signature by mark. Telephone consent is subject to verification of identity.

_____ _____ _____
Witness *Relationship* *Date*

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CLIENT RELEASE OF INFORMATION FORM • Page 1

(courtesy of Riverside County Department of Mental Health and CIMH's Care Integration Initiative)

County of Riverside
Authorization for Use and/or Disclosure of Patient Health Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document (both pages) before signing.

Patient Name:_____ Date of Birth:_____

Patient Address:_____

I hereby authorize:	**To release information (*specified below*) to:**
_____ (Health Care Provider / Organization to **release** information)	_____ (Health Care Provider / Organization to **receive** information)
_____ (Address)	_____ (Address)
_____ (City, state, zip code)	_____ (City, state, zip code)
_____ (Phone Number) _____ (Fax Number)	_____ (Phone Number) _____ (Fax Number)

I authorize the release of the following health information *(select only one of the following)***:**

- ❑ All health information about my medical history, mental or physical condition and treatment received; OR
- ❑ Only the following records or types of health information (including any dates):

_____

_____

NOTE: The following types of information will not be released unless specifically authorized.

I specifically authorize the release of the following health information (*initials required if any of the following boxes are checked*)**:**

- ❑ Mental health treatment information Initial:_____
- ❑ HIV test results Initial:_____
- ❑ Alcohol / drug treatment information Initial:_____

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

County of Riverside
Authorization for Use and/or Disclosure of Patient Health Information

PURPOSE: The requested use or disclosure of my health information is for the following purposes:
(1) To provide and coordinate my health care treatment and services; and
(2) To improve the quality of health care that I receive.

EXPIRATION: This Authorization expires one year from the date of my signature unless a different date is specified here _____ (*date*).

REVOCATION: I understand that I may cancel this Authorization at any time, but I must do so by submitting my request for revocation to the Health Care Provider / Organization authorized to release the information. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I understand that I do not have to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits.

I understand that I have a right to receive a copy of this Authorization.

I further understand that information disclosed by this Authorization, may be redisclosed (given to) another person or agency and may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving my health information by this Authorization to disclose it, unless a new authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I have read both pages of this Authorization and agree to the use and disclosure of health information specified above.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Patient's Legal Representative (if applicable) Date Signed

_____ _____
Print Name of Patient's Legal Representative Relationship to Patient

INSTRUCTIONS (INTERNAL USE ONLY)

Re: County of Riverside Authorization for Use and/or Disclosure of Patient Health Information

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Riverside County staff with job functions that include providing the above-referenced Authorization Form to the patient or patient's legal representative shall review these instructions.

1. **Purpose:** The Authorization Form can only be used when the requested use or disclosure of the patient's health information is for the following purposes:

   (1) To provide and coordinate the patient's health care treatment and services, and

   (2) To improve the quality of health care that the patient receives.

   The Authorization Form **cannot** be used for any other purpose(s).

2. **Health Care Provider / Organization:** Since the release of health information pursuant to this Authorization is for the purpose of health care treatment and services, the person / entity designated in the Authorization to release and/or receive the patient's health information must be a Health Care Provider / Organization.

3. **Copy to Patient:** When the Authorization has been requested by Riverside County for its own uses and disclosures, Riverside County must provide the patient with a copy of the Authorization.

4. **Psychotherapy Notes:** The Authorization Form cannot be used to release psychotherapy notes. A separate authorization is required for the release of psychotherapy notes.

   "Psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. (45 C.F.R. § 164.501)

5. **Mental Health Treatment Information, HIV Test Results, Alcohol / Drug Treatment Information:**

   Riverside County must not release mental health treatment information, HIV test results and/or alcohol or drug treatment information, unless specifically authorized by the patient or patient's legal representative (i.e. the appropriate box(es) are checked with initials provided).

6. **Revocation:** The manner of revocation is **not** limited to written request since LPS patients and patients of federally funded Substance Abuse Programs may revoke their authorization verbally.

7. **Riverside County Substance Abuse Program:** When a Riverside County substance abuse program releases alcohol / drug treatment information pursuant to the Authorization Form, the information disclosed must be accompanied by the following written Legal Notice pursuant to 42 CFR 2.32:

LEGAL NOTICE REGARDING PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (42 C.F.R. § 2.32)

8. **LPS Patients (Either Voluntary or Involuntary Recipients of Services):**

   LPS information or records may be disclosed in communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. [Cal. Welf. & Inst. Code § 5328(a)]

   Consent Required. However, the consent of the LPS patient (or his/her guardian or conservator) must be obtained before LPS information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or responsibility for the patient's care.

   Approval Required. When the LPS patient designates persons to whom information or records may be released, the approval of the physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient is required.

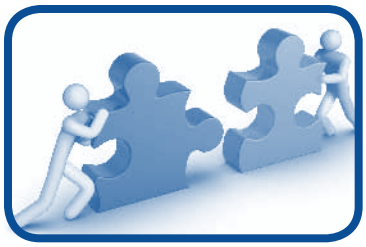
   Note. LPS Act does not compel physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him/her in confidence by members of a patient's family. [Cal. Welf. & Inst. Code § 5328(a) and (b)]

Additional Instructions:

County of Riverside: Authorization for Use and /or Disclosure of Patient Health Information

(Universal Consent/Release of Protected Health Information)

1. In completing the Authorization Form, whenever possible, fill in the name of the Health Care Provider/ Organization that will provide the broadest release of the patient's health information possible for both the entity that is identified to release and to receive the information. Below this name, enter the specific name and location that the health information is to be transmitted to. For example:
   a. Obtain authorization for release and receipt of the health information to "RCDMH Clinics and Programs" rather than to "Dr. X" or "X Clinic". Below this fill in, "Dr. X or X Clinic" along with the address and phone number of the specific location that the information should be transmitted to.
   b. Obtain authorization for release and receipt of the health information from "Riverside County Health Systems (outpatient primary care clinics that are operated by Riverside County) rather than from "X Family Care Center". Below this fill in, "Dr. X or X Clinic along with the address and phone number of the specific location that the information should be transmitted to.
2. There are two parts to the release:
   a. To obtain general release of health information, the patient must first either authorize release of all health information or only specific types of health information by checking the appropriate box.
   b. To obtain release of health information that is under special protection, the patient must specifically authorize the release of mental health treatment information, HIV test results and/or alcohol/drug treatment information. This requires that the appropriate boxes are checked and initialed by the patient for the release of specially protected health information to be valid.
3. For the authorization for release of all substance abuse program health information, along with the authorization form, the substance abuse clinic or program must provide the written Legal Notice to the receiving entity, which specifically prohibits redisclosure of this information. (See instructions attached to the form.)



FINANCES

Funding Streams for Mental Health and Substance Use Services in California

Funding Stream	Description and Revenue Amount
Medi-Cal	Funds specialty mental health services provided through a Medi-Cal carve-out to a county Mental Health Plan, and SUD services provided through a Medi-Cal fee-for-service carve-out program. • $3.4 billion annually on mental health • $406 million annually on SUD, with $167.2 million for the specialty Drug Medi-Cal program
Substance Abuse and Mental Health Services Administration (SAMHSA)	Supports treatment and recovery services • $250 million annually from the Substance Use Prevention and Treatment Block Grant • $53 million annually from the Community Mental Health Block Grant • $198 million annually from other formula/discretionary grant funds
Realignment	Includes sales tax and vehicle license fees from 1991 legislation and the recent 2011 package of bills that transfer from state to local responsibility various behavioral health services including Drug Medi-Cal, EPDST, Medi-Cal Mental Health Managed Care, and others. Increasingly used for local matching funds to draw down Medi-Cal federal dollars.
Mental Health Services Act (MHSA)	Provides funding for community mental health services, which requires a state maintenance of existing funds and prohibits supplanting state or local funds. Increasingly used for local matching funds to draw down Medi-Cal federal dollars. • $6.9 billion statewide since its inception in 2004
Early Periodic Screening, Diagnosis, and Treatment (EPDST) Program	Provides Medi-Cal recipients under age 21 with medically necessary mental health services, which has been delegated to county Mental Health Plans. The eligibility and scope of services is determined by state and federal policy.
AB 3632 Services	Provides mental health services necessary for children to benefit from special education under the responsibility of county mental health departments that are beyond the capacity of the school's counseling and guidance services
Healthy Families	Provides services to children with serious emotional disturbances. AB 1494, which moves children in Healthy Families to Medi-Cal no sooner than January 1, 2013, will result in eligibility for EPDST services and will require a time-limited, problem-specific evidence-based treatment.
CalWORKs	Includes funding for both substance use and mental health services for program recipients to whom a barrier to employment exists

Sources: Technical Assistance Collaborative and Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment Final Report*, DHCS, February 2012 and Kelch DR, *The Crucial Role of Counties in the Health of Californians: An Overview*, California HealthCare Foundation, March 2011. Contained in the *Status Report on Integrating Health and Behavioral Health Services in LA County*, Oct. 2012

Courtesy of...

FINANCING INTEGRATED CARE IN CALIFORNIA'S FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

Financing integrated Healthcare in California — **as of October 12, 2012**

CPT Code		Diagnostic Code	Federally Qualified Health Centers (FQHC)					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt	May be used only with physical health diagnosis	Yes	MD, PA, ANP	Y	01*	MD, PA, NP	*See Note A
	99211-99215 Est. Pt		Yes		Y	01	MD, PA, NP	
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	Non-physician mental health practitioners Psychologist only at this time; excludes CSW	Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
	96151 Reassessment		Yes		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
	96152 Individual Int.		Yes		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
	96153 Group Int.		Yes		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
	96154 Family + Patient		Yes		N			
	96155 Family w/o Pt		No		N			
Telemedicine	90801- Assess/ Psych.Eval		Yes	-Physician -Nurse Practitioner -Physician Assistant -Clinical Nurse Specialist -Clinical psychologist* -Clinical social worker* *Cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. May	Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	Use "GT" modifier with all telehealth procedure codes.
	90804 -09		Yes		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	90805, 90807, 90809 MD, PA, NP only.
	90862 Med Mgmt		Yes		N			
	99201 – 99205				Y	01	MD, PA, NP,	

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	New Pt		Yes	not bill or receive payment for: 90805, 90807, and 90809.			Clinical Psychologist, Clinical Social Worker	
	99211 -99215 Est. Pt.		Yes		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
	99241-99245		No[1]		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
	99251 -99255		No		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
	F-U Inpt Consul - limited		Yes		N			
	F-U Inpt Consul – intermediate		Yes		N			
	F-U Inpt - Complex		Yes		N			
	Initial 30 min		Yes		N			
	Initial 50 min		Yes		N			
	Initial 70 min		Yes		N			
	Facility Fee		Yes		Y	Q3014	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	
Substance Abuse Codes	90804 – 90815		Yes	Physicians and non-physicians such as clinical social worker, & clinical psychologists licensed by the state	Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	90805, 90807, 90809, 90811, 90813, 90815 MD, PA, NP only
	90847,90853, 90857		Yes		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	Exclude 90857
	AOD Assess		Yes		N			
	BH Screening		Yes					
	BH Counseling		Yes					
	AOD Group		Yes					
	IOP Services		No					
Mental Health	90801 -90815	Used with BH Diagnosis Codes	Yes	Physicians and non-physicians, such as clinical social workers & clinical psychologists licensed by the state	Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social Worker	90805, 90807, 90809, 90811, 90813, 90815 MD, PA, NP only
	90847, 90853, 90857,90772, 90862,90865, 90887, 96101		Yes		Y	01	MD, PA, NP, Clinical Psychologist, Clinical Social	Exclude 90857, 90772, 90865, 90887

[1] Medicare Manual Update, Publication 100-04 notes that CPT 99241-99245 has been discontinued effective 1/1/10. These codes are to be replaced by CPT 99201-99215. Likewise, CPT 99251-99255 has been replaced by

							Worker	90862 MD only. 96101 MD, Clinical Psychologist only.
	BH Coun&Ther		Yes		N			
	MH Assess		Yes		N			
	Crisis Stab.		No[2]		N			
Two Services in One Day Billable at the FQHC?					**N - See Note B for exception**			
Case Mgmt			No		N			

[2] No separate billing code for crisis stabilization services, however, Medicare does permit a psychiatrist to bill for extended appointments under other CPT codes.

FUNDING FOR CALIFORNIA'S COMMUNITY MENTAL HEALTH CENTERS (CMHCs)

CPT Code		Diagnostic Code	Community Mental Health Centers (CMHC)					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt	Used only with physical health diagnosis						
	99211-99215 Est. Pt							
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	No	Non-physician mental health practitioners Psychologist only at this time; excludes CSW	N			
	96151 Reassessment		No		N			
	96152 Individual Int.		No		N			
	96153 Group Int.		No		N			
	96154 Family + Patient		No		N			
	96155 Family w/o Pt		No		N			

(continued on next page)

Telemedicine	90801- Assess/ Psych.Eval		Yes	-Physician -Nurse Practitioner -Physician Assistant -Clinical Nurse Specialist -Clinical psychologist* -Clinical social worker* *Cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. May not bill or receive payment for: 90805, 90807, and 90809. Note: When a CMHC serves as an originating site, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.	Y	CPT	Psychiatrist, Psychologist*	* See Note C for credential description. Use "GT" modifier with all telehealth procedure codes.
	90804 -09		Yes		Y	CPT	Psychiatrist, Psychologist	
	90862 Med Mgmt		Yes		N			
	99201 – 99205 New Pt		Yes		Y	CPT	Psychiatrist, Psychologist	
	99211 -99215 Est. Pt.		Yes		Y	CPT	Psychiatrist, Psychologist	
	99241-99245		No		Y	CPT	Psychiatrist, Psychologist	
	99251 -99255		No		Y	CPT	Psychiatrist, Psychologist	
	F-U Inpt Consul - limited		Yes		N			
	F-U Inpt Consul – intermediate		Yes		N			
	F-U Inpt - Complex		Yes		N			
	Initial 30 min		Yes		N			
	Initial 50 min		Yes		N			
	Initial 70 min		Yes		N			
	Facility Fee		Yes		Y	Q3014	Psychiatrist, Psychologist	
nce Abuse	90804 – 90815		Yes	Physicians and non-physicians such as clinical social worker, & clinical psychologists licensed by the state	Y	CPT	Psychiatrist, Psychologist	90805, 90807, 90809, 90811, 90813, 90815 Psychiatrist only
	90847,90853, 90857		Yes		Y	CPT	Psychiatrist, Psychologist	Exclude 90847, 90857
	AOD Assess		Yes		N			
	BH Screening		Yes		N			
	BH Counseling		Yes		N			
	AOD Group		Yes		N			
	IOP Services		No		N			

(continued on next page)

Mental Health	90801 -90819		Yes	Physicians, CSW's, clinical nurse practitioners, clinical nurse specialists, and psychologists licensed by States	Y	CPT	Psychiatrist, Psychologist	90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819 Psychiatrist only
	90821 -90824		Yes		Y	CPT	Psychiatrist, Psychologist	90822, 90824 Psychiatrist only.
	90826 -90829		Yes		Y	CPT	Psychiatrist, Psychologist	90827, 90829 Psychiatrist only.
	90845,90847, 90853,90857, 90865,96101		Yes		Y	CPT	Psychiatrist, Psychologist	Exclude 90845, 90847, 90857, 90865.
	90862		y		Y	CPT	Psychiatrist	
	Crisis Services				N	CPT		
Case Mgmt					N			

Sources:

California Department of Health Care Services, Medi-Cal,Rural Health Clinics & Federally Qualified Health Centers.
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural_o01o03.doc

California Department of Health Care Services, Medi-Cal, Rural Health Clinics & Federally Qualified Health Centers: Billing Codes
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ruralcd_o01o03.doc

California Department of Health Care Services, Medi-Cal, Medical Services, Telemedicine
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc

California Department of Health Care Services, Medi-Cal Rates as of 09/15/2012
http://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp

California Department of Health Care Services, Medi-Cal, Specialty Mental Health Services
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/spec_m01o03a07.doc

CHANGES TO CPT CODES FOR PSYCHIATRY AND PSYCHOTHERAPY IN 2013

Chart prepared by the National Council for Community Behavioral Healthcare, www.TheNationalCouncil.org

2012 Code	Action Taken	2013 Code		Report with		Report w/ Code for Interactive Complexity (90785)
Diagnostic Procedures						
90801: psychiatric diagnostic evaluation	Deleted	**90791**: psychiatric diagnostic evaluation (no medical services)	+	n/a	+	When appropriate
		90792: psychiatric diagnostic evaluation with medical services (or E & M new patient codes)	+	n/a	+	When appropriate
90802: interactive psychiatric diagnostic evaluation	Deleted	**90791** or **90792**	+	n/a	+	**90785**
Psychotherapy						
90804: outpatient psychotherapy, 20-30 min.	Deleted	**90832:** psychotherapy, 30 minutes	+	n/a	+	When appropriate
90805: outpatient psychotherapy with E*M service, 20-30 min.	Deleted	Appropriate **E&M code**	+	**90833**: 30 min add-on	+	When appropriate
90806: outpatient psychotherapy, 45-50 min.	Deleted	**90834**: psychotherapy, 45 minutes	+	n/a	+	When appropriate
90807: outpatient psychotherapy with E&M service, 45-50 min.	Deleted	Appropriate **E&M code**	+	**90836**: 45 min add-on	+	When appropriate
90808: outpatient psychotherapy, 75-80 min.	Deleted	**90837:** psychotherapy, 60 minutes	+	n/a	+	When appropriate
90809: outpatient psychotherapy with E&M services, 75-80 in.	Deleted	Appropriate **E&M code**	+	**90838:** 60 min add-on	+	When appropriate
Interactive Psychotherapy						
90810: interactive psychotherapy, 20-30 min.	Deleted	**90832:** psychotherapy, 30 min.	+	n/a	+	**90785**
90811: interactive psychotherapy with E&M, 20-30 min.	Deleted	Appropriate **E&M code**	+	**90833:** 30 min. add -on	+	**90785**
90812: interactive psychotherapy, 45-50 min.	Deleted	**90834:** psychotherapy, 45 min.	+	n/a	+	**90785**
90813: interactive psychotherapy with E &M, 45-50 min.	Deleted	Appropriate **E&M code**	+	**90836:** 60 min add-on	+	**90785**
90814: interactive psychotherapy, 75-80 min.	Deleted	**90837:** psychotherapy, 60 min.	+	n/a	+	**90785**
90815: interactive psychotherapy with E&M, 75-80 min.	Deleted	Appropriate **E&M code**	+	**90838:** 60 min. add-on	+	**90785**
Other						
(None)	New code	**90839**: psychotherapy for crisis, first 60 minutes	+	**90840:**		No
90857: interactive group psychotherapy	Deleted	**90853:** group psychotherapy (other than multiple family group)	+	n/a	+	**90785**
90862: pharmacological management	Deleted	Appropriate **E&M code**	+			No

(courtesy of MaineHealth)

Mental Health Provider (MHP) in Primary Care Start-up: Reimbursement Focus		
Function	**Task**	**Reimbursement**
Pre-Hire – to clarify the financial arrangements and how best to bill		
Preparation for Practice Staff	• Meet with key practice staff (physicians and practice managers) to discuss role of MHP and begin buy-in • Meet with practice Leadership to obtain go-ahead and financial support • Identify both physician and practice manager champion • Identify person(s) who will coordinate the hiring and start-up process for each agency involved	• Include Practice reimbursement and coding staff in early discussions • Clarify rules related to each facility • Understand the services being delivered and goal for those services e.g. Psychotherapy vs. E/M codes or Health and Behavior vs. Psychotherapy

Contract for Services	• Clarify financial responsibilities
	  ○ Who will employ staff?
	  ○ Who will bill?
	  ○ How will supervision and other programmatic and indirect costs be reimbursed?
	  ○ What revenue is expected and how where will this go?
	  ○ What service expectations will be identified in the contract?
		• Clarify billing and coding related to service delivery
		• Discuss service and program with commercial insurance reps to set expectations and clarify issues

Billing	• Determine what codes will be used to bill – *Question of use of E&M codes for Psych NP* • Determine who will do the billing and how they will interact with MHP • If Mental Health codes will be billed, will billing staff need additional training?	• Train staff to do behavioral health billing • Train on integration model • Identify resources needed for billing/coding • Set up meeting to monitor progress • Plan for internal audit
Hire MHP – Credentialing and preparation for billing		
Hire/Identify MHP	• Formulate basic job description, advertise, and/or interview • Discuss different expectations of integrated practice • Obtain references • Plan to hire pending pre-hire requirements (below)	• Begin credentialing process during hiring process • Help the clinician understand the link between service and credentialing
For Psych NP - New graduate	• *Must complete schooling* • *Must pass test – and have written verification* • *Must get license – and have written verification* • *(Process can take several months)* • *Will require more intensive supervision and potential review of cases for 2 year period*	• *Clarify whether services will be medical and/or mental health for Psych NP*

From MaineHealth Mental Health Integration program. Mary Jean Mork, LCSW, morkm@mmc.org

Licensing	• *Clarify adult or child (or both) – if applicable to MHP* • *Clarify status of Psych NP license* • Get letter from licensing and/or other verification	
Psych NP Certification	• *Copies of ANCC certification will need to go to hiring and practice agencies*	
Psych NP Medical Staff Credentialing	• *Must be credentialed with each organization for which they will be seeing patients*	• *Credentialing process*
Insurance Panel Enrollment	• Medicaid ○ *For Psych NP - supervising psychiatrist may not need to be enrolled in the receiving agency, as the Psych NP is not working under a psychiatrist – rather they are working under the physician in the practice* • Medicare • Private Insurers	• Credentialing process • *Clarify MaineCare expectations around supervision of Psych NP. Will a psychiatrist have to be "enrolled" for that organization as the NP supervisor, or not?* • *For Psych NP, need to clarify whether credentialed under Medical or Behavioral Health, or both. Has become issue with use of E/M codes. May also be issue with LCSW's using Health and Behavior codes.*
Malpractice Insurance	• *Needs an insurance certificate from the employing agency indicating that Psych NP is covered in each organization where patients will be seen*	

Supervision	• *For Psych NP*
	  ○ *Determine which medical provider will be the supervising physician*
	  ○ *Determine which psychiatrist will be the supervising psychiatrist*
	  ○ *Write and submit a plan of supervision, if required for "new" psych NP - Plan of supervision must cover all agencies where patients will be seen*
	• For LCSW/LCPC – Identify supervisor. If multiple supervisors, clarify role of each and how coordination will occur. If Provider Based practice, must follow the Medicaid rules for supervision which require a psychiatrist.	

Orientation of MHP and Pre-Patient – practice and preparation for billing		
Computer Access and training for EMR	• Determine computer access needs • Secure token, if needed for remote access • Set-up training	
Space needs	• Office or exam room availability	

From MaineHealth Mental Health Integration program. Mary Jean Mork, LCSW, morkm@mmc.org

Staff support needs	• *Need for MA or other staff support for new patients for Psych NP?* • What are the office work-flows affected by a new provider?	• Identify staff needed for behavioral health billing.
Scheduling	• Clarify who will schedule, length of visits, etc. • Orient MHP to scheduling process	• Work with billers and coders for prior authorization, where needed
Physician (and other provider) "Shadowing"	• Arrange for MHP to "shadow" the physician for some time period in order to learn more about practice and provider • Other behavioral health staff? • *Other NP's in practice?*	
Consent to Treat and Release of Information Considerations	• Consent to treat forms inform patient about the MHP service • Privacy notice is reinforced • Release of any records that go out from the practice need specific release, and/or care with standard release – review of standard release • Practice staff must be trained on release of information for mental health and/or substance abuse	

Correct Billing and Coding	• Orient and train MHP on billing and coding requirements:
	  ○ Link to service delivery
	  ○ Offer sample documentation
	  ○ Connect to billing/coding staff
	  ○ Arrange for regular support and review
		• Connect billing/coding staff to MHP
		• Coordinate audit or reviews of service, documentation and billing
		• Plan to track first bills
		• Set up meeting to monitor progress especially early on

Community Resource Orientation	• Continuum of services and referral processes • Common understanding of what the service is (and is not) in relation to community mental health needs • Beginning connections with collateral agencies • Visits to other agencies, as able	
Consultation, Documentation And Medical Records	• Referral form for physicians to use when referring to MHP – if applicable • Consult, assessment and progress note to meet billing requirements • Clarity about what information the MHP should share with providers in practice, and best and most timely way to communicate • Supervision in place around	• Clarify expectations around billing/coding on same day • Clarify new or ongoing patient status • Clarify any differences between medical and behavioral service and billing • Clarify documentation requirements for the services

From MaineHealth Mental Health Integration program. Mary Jean Mork, LCSW, morkm@mmc.org

	documentation questions • Procedures for practice staff that identify access to mental health portion of record	
Ongoing Support to MHP and Practice – monitoring reimbursement and continuous improvement		

Tracking of Reimbursement	• What services are being delivered? What is being billed?
	• Use of Tracking Sheet
	• Review of actual reimbursement
	• Contract review and refinement
		• Practice level information available on:
		  ○ Services delivered
		  ○ Charges billed
		  ○ Payment received
		  ○ Charges denied, and reasons for denials
		• Any problems

Marketing the Service	• Clarification of who will "market" the service before starting and as the MHP is building the practice	
Ongoing Support for Integration	• Communication with champions – how is it going? • Meeting with practice staff to reinforce integrative practice, trouble shoot and provide ongoing support • Regular and ad hoc supervision available to MHP during the start-up process	• Regular meetings between MHP, practice management , and billing/coding staff around any problems or confusion • Regular meetings to monitor reimbursement • Random sampling of claims
Community Resource Connection	• Building on connections with collateral agencies • Visits to other agencies, as able	
Supervision	• Set up schedule for supervision • Supervisor documents process and general content of supervision. ○ Frequency, focus and performance indicators • Provide ongoing supervision around documentation to meet reimbursement requirements	• Track bills to see that services are properly coded and receiving reimbursement

From MaineHealth Mental Health Integration program. Mary Jean Mork, LCSW, morkm@mmc.org

COORDINATING Medication

One important element in coordinating care is reconciling medications that clients may be getting from different providers. Behavioral health and primary care agencies treating the same client may inadvertently be prescribing duplicate medications or initiating harmful drug combinations. A "brown bag review" affords physicians the opportunity to identify and/or avoid medication errors, harmful drug interactions and inadvertent polypharmacy. It also assists clients in taking their medications correctly and gives them the opportunity to ask questions and verify what they should and should not be taking.

To record medications, the Napa Integration Health Care Project uses a form with the headings below. Another medication documentation form can be found on the next page.

Patient Name: VM ID:	Date	Allergies	Note Change CURES Alert	Start/Stop Changes entered into Patient record
Medication/ Dosage/ Directions	Indications	Prescriber	Date	

Here's the suggested procedure, adapted from the AMA:

1. Clients are asked to bring in all medications they are taking – both prescription and over-the-counter, as well as vitamins, supplements and herbal remedies – on their next visit to their doctor.
2. Clients are thanked for complying with the request and then asked, for each medication:
   - How do you take that?
   - What for?
   - Are you taking any new medication since our last visit?
   - Have you stopped any since our last visit?
   - How many of these pills do you take each day?
3. To confirm and further their understanding, the clients are asked, after the instructions have been given:
   - Can you go over what we talked about?
   - Was anything unclear?
4. The provider then clarifies the instructions as needed, updates the chart and provides the client with a medication list.

Medication Review Form · Brown Bag Program

(courtesy of OHA)

Date:_____

Patient Name_____ Sex: M F

Telephone Number_____ Age:_____

Special counseling considerations_____

Reported Medicine Allergies_____

Please list ALL medications that you are currently taking (prescriptions, over-the-counter medications, other)

_____ _____

_____ _____

_____ _____

For Pharmacist Use

	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5
Drug Name					
Dosage					
SIG on Label					
MD Name					
Exp. Date					
Reported Medical Problem					
How long taken?					
Still taken?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Date of last MD visit					
Patient knows purpose of drug	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Compliance w/SIG	Yes / No / Partial	Yes / No / Partial	Yes / No / Partial	Yes / No / Partial	Yes / No / Partial
Side Effects?					
OTCs					
Improper Administration	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Over/Under Use	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Expired	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Follow-Up Needed?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

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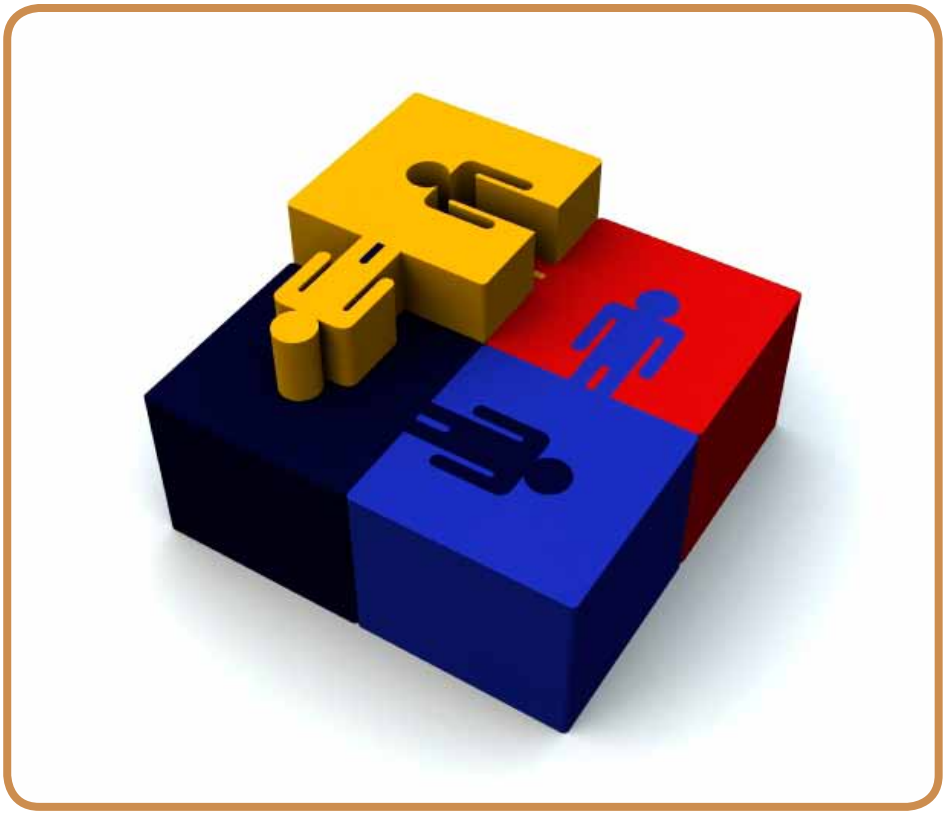
SAMPLE
Job Descriptions



Mental Health Provider in Primary Care
Core Competencies

(courtesy of MaineHealth)

- Identifies problem quickly and accepts the patients point of view
- Limits the number of problems identified and applies patient strengths and resources to the problem
- Is change-focused and measures outcomes at every visit
- Focuses on functional outcomes
- Able to address motivational factors and readiness to change
- Accepts patient's level of readiness to change and emphasizes patient role in change
- Interventions can be understood and supported by other primary care team members
- Effectively co-manages patient care with team members
- Shows understanding of relationship of medical and psychological systems within the cultural context of the individual patient
- Shows knowledge of psychotropic medicines and adherence strategies
- Adheres to evidence based pathways for behavioral health conditions, e.g. pain, depression, obesity

Mental Health Providers should not	***Mental Health Providers should***
▪ Prefer specialty Mental health care ▪ Prefer treating psychiatric disorders ▪ Like to spend an hour with a patient ▪ Perform best in a quiet working environment ▪ Want to be in charge of patient care ▪ Lack training in behavioral and brief interventions	▪ Become intrigued with the idea of helping a patient "function" better ▪ Be comfortable with noise and rooms with sinks (and uncomfortable furniture) ▪ Want to take a team approach to patient care ▪ Have training in behavioral and brief interventions ▪ Be willing to help a patient of any age ▪ Think it's better to spend 10 minutes with a patient than zero

From: "Integrating Primary Care and Behavioral Health Services: A Compass and a Horizon". Kirk Strosahl, Ph.D and Patricia Robinson Ph.D. for the Collaborative Family Healthcare Association 9th Annual Conference, and

Robinson, P. & Reiter, J. (2006) *Behavioral Consultation and Primary Care: a Guide to Integrating Serivces.* New York: Springer

Skills Required for Mental Health Providers Integrated into Primary Care

(courtesy of MaineHealth)

1. Focused Assessment
2. Time Efficiency
3. Decisiveness with Limited Data
4. Cognitive-Behavioral Expertise
5. Skills for Enhancing Motivation to Change
6. Appreciation for a Population Health Focus
7. Good Communication with Physician Colleagues
8. Ability to Function as a Team Member
9. Tolerance for Position in a Hierarchical System
10. Flexible Hours/Availability
11. Understanding of Medical Conditions, Procedures and Medications

Key Factors in Establishing a Mental Health Service in Primary Care

1. Get Your Foot in the Door
2. Be a Team Member
    a. See all patients referred
    b. View referring physicians as your primary customers
    c. Communicate well
3. Build Key Relationships
    a. Sit in with physician colleagues
    b. "Act like" a primary care provider
    c. Assist coworkers
4. Persist in "Marketing" Mental Health Provider Services
    a. Designate a "Problem of the Week"
    b. Conduct daily check-ins
5. Be Available
6. Learn the Primary Care Culture
    a. Adopt the Primary Care pace
    b. Adopt a "Population Health" perspective
    c. Give feedback promptly and succinctly
7. Attend to Ethical Issues
8. Plan Around Financial Issues

From:
Gatchel, R. & Oordt, M.(2003) *Clinical Health Psychology and Primary Care: Practical Advise and Clinical Guidance for Successful Collaboration.* Washington, DC: American Psychological Association

BEHAVIORAL HEALTH CONSULTANT 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.

Skills Required for Mental Health Providers Integrated into Primary Care

(courtesy of MaineHealth)

1. Focused Assessment
2. Time Efficiency
3. Decisiveness with Limited Data
4. Cognitive-Behavioral Expertise
5. Skills for Enhancing Motivation to Change
6. Appreciation for a Population Health Focus
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8. Plan Around Financial Issues

From:
Gatchel, R. & Oordt, M.(2003) *Clinical Health Psychology and Primary Care: Practical Advise and Clinical Guidance for Successful Collaboration.* Washington, DC: American Psychological Association

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 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.

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].

TURNING POINT COMMUNITY PROGRAMS, INC.
JOB DESCRIPTION FOR HOIT PROJECT

JOB TITLE: HEALTHY OUTCOMES INTEGRATION TEAM (HOIT) REGISTERED NURSE

The Nevada County Healthy Outcomes Integration Team (HOIT) is a three-year, federally-funded grant project which will utilize a Registered Nurse to help mental health clients access health care services. These services will help clients achieve health, wellness, and recovery through the development of a person-centered health care home. The Registered Nurse will help clients to access effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes.

SUMMARY: Responsible for helping coordinate care between mental health, primary care, and substance abuse services to promote health, wellness, and recovery for HOIT participants.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned, as needed:

Direct Service

- Provides oversight and coordination of services with HOIT Service Coordinators.
- Conducts physical and behavioral health assessments and coordinates additional mental health services to promote health and well-being and prevent more restrictive levels of care.
- Assists participants to learn and practice a healthy lifestyle, including nutrition, exercise, and other healthy activities.
- Collects health indicators and supports HOIT Service Coordinators in collecting lab work to assess participant outcomes.
- Administers drug screening tests, as appropriate.
- Provides nursing support to HOIT participants in the community, as needed (i.e., providing an injection to a participant).
- Sets up medications according to established protocols in preparation for medication support services.
- Monitors adverse reactions to medications and helps ensure participants report these back to his/her prescribing physician.
- Processes doctors' orders according to program-specific procedures, including obtaining refill requests from pharmacies in order to ensure continuation of treatment.
- Carries out a variety of treatment or special project activities under the direction of professional staff.
- Acts as an advocate for participants, upholding consumer-driven/strength-based philosophy, to achieve participant satisfaction.
- Provides patient education and family support regarding medication information and other health care needs.

Linkage

- Refers participants to, and coordinates services with, community social, health, and behavioral health services; follows up to ensure continuity of care.

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Meetings/Trainings

- Participates in team meetings and agency coordination meetings.
- Acts as a resource by providing training to staff members regarding any medical- or nursing-related information as needed, either in an individual or group setting.
- Teaches participants, family members, and HOIT Service Coordinators about medications, side effects, drug interactions, and other health issues.
- Attends staff meetings unless approval for non-attendance is secured by the Program Director.
- Attends monthly nurses' meeting unless approval for non-attendance is secured by the Nursing Director.

Communication and Continuity of Care

- Communicates in a professional manner, as a representative of TPCP and HOIT, with outside agencies (Pharmacies, doctors' offices, FQHCs, labs) for the purpose of providing continuity of care.
- Collaborates with the Psychiatrists, Primary Care Physicians, and other staff to provide comprehensive care to participants, keeping them informed of relevant information.
- Establishes and maintains cooperative working relationships with those contacted in the course of work.

Documentation and Quality Improvement

- Prepares thorough documentation and maintains accurate and systematic records.
- Conducts a routine inventory of medications and medical supplies from the pharmacy.
- Drives on agency business including safely transporting medical supplies and waste using own personal vehicle.
- Possesses knowledge of and adheres to the TPCP procedures related to medications found in the Operations and Procedures Manual.
- Adheres to all Medi-Cal and Medicare regulations including documentation requirements.
- Documents all services in compliance with Medi-Cal and Medicare standards, established County guidelines, and current computerized documentation programs.
- Maintains confidentiality and HIPAA standards in all aspects of job performance.
- Ensures compliance with State nursing licensing standards.
- Keeps abreast of current medical information and pertinent professional developments by attending workshops, conferences, etc. in accordance with nursing licensing renewal requirements.
- Adheres to and upholds all agency policies.
- Meets the standard for consistent attendance (not more than a 5% absence rate per month) by reporting on time and ready to work and by the judicious use of paid sick leave and avoiding any situations resulting in the need to dock pay for time not worked.

QUALIFICATION REQUIREMENTS: To perform this job successfully, a participant must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable participants with disabilities to perform the essential functions.

MINIMUM QUALIFICATIONS:

BSN with two (2) years of experience in psychiatric nursing with preferred medical/surgical experience or home health care.

LANGUAGE SKILLS:

- Ability to communicate effectively orally and in writing.

CERTIFICATES, LICENSES, REGISTRATIONS:

- Possesses a valid California Registered Nurse's License.
- Keeps First Aid, Certification, and CPR current.
- Possesses a valid California driver's license, current vehicle insurance and driving record acceptable to Turning Point's vehicle insurance company and the Vehicle Driving and Maintenance Policy.
- Possesses and maintains a safe and reliable form of vehicular transportation excluding motorcycles.

OTHER SKILLS AND ABILITIES:

- Knowledge of and commitment to principles and goals of community mental health.
- Knowledge of and commitment to principles and goals of the "self-help model."
- Knowledge of and commitment to principles and goals of the "consumer-driven wellness and recovery model."
- Knowledge of psychosocial rehabilitation.
- Ability to work effectively in stressful situations.
- Ability to handle multiple tasks and prioritize.
- Ability to exercise appropriate judgment and decision-making.
- Ability to be flexible and adaptable.
- Knowledge of differing cultural, religious and social beliefs about family, physical and mental health.
- Ability to utilize basic computer software including word processing.

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TURNING POINT COMMUNITY PROGRAMS, INC.
JOB DESCRIPTION FOR HOIT PROJECT

JOB TITLE: HEALTHY OUTCOMES INTEGRATION TEAM (HOIT) SERVICE COORDINATOR III

The Nevada County Healthy Outcomes Integration Team (HOIT) is a three-year, federally-funded grant project which will utilize Service Coordinators to help mental health clients access health care services. These services will help clients achieve health, wellness, and recovery through the development of a person-centered health care home. Service Coordinators will help clients to access effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes.

SUMMARY: Responsible for providing support services to support participants in improving their health and wellness, living a self-directed life, and striving to reach their full potential.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned, as needed:

Direct Services

- Welcomes participants into the HOIT project, schedules appointments, and provides peer support services to promote health and wellness across mental health, primary care, and substance use services.
- Teaches wellness skills and promotes healthy lifestyles among HOIT participants (e.g., adequate nutrition, cooking, yoga, relaxation, and healthy activities).
- Assists participants in practicing a healthy lifestyle, including adequate nutrition, regular exercise, and other healthy activities.
- Provides rehabilitative services that focus on recovery and wellness, and are consistent with the vision and philosophy of HOIT.
- Supports participants in developing age-appropriate health and wellness skills, including money management, personal hygiene, and job readiness.
- Assists participants to develop WRAP plans.
- Assists HOIT team members in preparing, administering, and implementing Integrated Health Care Plans.
- Performs work functions independently, with personal responsibility, while maintaining the HOIT Team vision and values.
- Coordinates services and assists participants in completing all required forms and information, including evaluation data, health history, financial information, and other periodic measures of health and wellness.
- Participates and assists in the delivery of grant activities, including evaluation activities.
- Completes all charting, evaluation data forms, and other paperwork, in a timely manner.
- Assists in developing and maintaining effective communication between participants enrolled in HOIT and other community partners.
- Consults with, and meets regularly, with HOIT participant's family, HOIT team members, or other significant persons with the participant's consent.
- Provides support to other staff members, as needed.
- Provides information to HOIT staff responsible for treatment coordination.

- Assists in establishing participant's eligibility for Medi-Cal or other benefits and advocates for continuation of benefits, when appropriate.
- Carries out a variety of treatment or special project activities under the direction of professional staff.

Linkage, Collaboration, and Advocacy

- Links participants to all HOIT team services, including primary care, mental health, and substance use disorder treatment services.
- Links participants to community services, as needed.
- Establishes and maintains cooperative working relationships with those contacted in the course of work.
- Advocates for HOIT participants in all areas of services, and helps them apply for and receive services, and empower them to achieve their chosen goals.

Meetings/Trainings

- Meets regularly with HOIT participants at Turning Point, NCBH, FQHC, community agencies, or in other community locations, to assist participants to achieve their goals.
- Attends all team and agency staff meetings unless prior approval for non-attendance is obtained.
- Attends trainings, as directed.

Compliance

- Adheres to and upholds the policies and procedures of Turning Point Community Programs and Nevada County Behavioral Health.
- Complies with confidentiality requirements, including confidentiality of information about participants.
- Prepares thorough documentation and maintains accurate and systematic records.
- Documents all Medi-Cal and Medicare activities in charts within specified time frames, and in compliance with Medi-Cal standards

General

- Drives on agency business using personal vehicle.
- Meets the standard for consistent attendance (not more than a 5% absence rate per month) by reporting on time and ready to work and by the judicious use of paid sick leave and avoiding any situations resulting in the need to dock pay for time not worked.

QUALIFICATION REQUIREMENTS: To perform this job successfully, a participant must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable participants with disabilities to perform the essential functions.

EDUCATION AND/OR EXPERIENCE:

Graduation from a four-year college or university with a Bachelors degree in Social Work, Psychology, or other related field preferred. Lived experience receiving mental health and/or substance use treatment, or family member of a person receiving mental health services, may be substituted for the educational requirements. Other qualifying experience may also be substituted for education, upon approval of the Director.

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LANGUAGE SKILLS:

- Ability to communicate effectively orally and in writing.

CERTIFICATES, LICENSES, REGISTRATIONS:

- Valid California driver's license, current vehicle insurance and driving record acceptable to Turning Point's vehicle insurance company and the Vehicle Driving and Maintenance Policy.
- Possesses and maintains a safe and reliable form of vehicular transportation, excluding motorcycles.

OTHER SKILLS AND ABILITIES:

- Knowledge of and commitment to principles and goals of community mental health.
- Knowledge of and commitment to principles and goals of the "self-help model".
- Knowledge of and commitment to principles and goals of the "consumer-driven recovery and wellness model".
- Knowledge of principles, techniques and trends in counseling, psychotherapy, clinical case management, and various treatment modalities.
- Knowledge of psychosocial rehabilitation's treatment and programming.
- Ability to work and communicate with staff, participants, families, community agencies and professionals.
- Ability to perform crisis intervention strategies.
- Ability to work effectively under stress and conflict.
- Ability to exercise appropriate judgment and decision-making.
- Ability to be flexible and adaptable in any given situation.
- Ability to work as a member of a team.
- Ability to work under time deadlines and pressures.
- Ability to work with minimal supervision.
- Ability to use basic computer software including word processing.

PEER HEALTH COACH

(based on the New York Association of Psychiatric Rehabilitation Services description of their program)

- Peer Health Care Coaches help to encourage and reinforce improved client self-health management via a variety of strategies, including motivational rewards, group health education/ motivational celebrations, healthy food or nicotine patch vouchers, exercise club vouchers and the like.
- Duties:
- By fostering trusted relationships with clients, help engage other new clients in a health care relationship.
- Assist clients to adhere to a treatment plan and follow through with recommended treatments.
- Foster motivation and hope.
- Promote health care through outreach to the community.
- Help individuals improve personal stress management and avoid unhealthy stress-driven responses like poor sugar-based nutrition, alcohol and drug abuse, smoking and idle avoidance.
- Support clients on a broad range of topics including lifestyle factors for health and wellness, metabolic syndrome, smoking cessation, nutrition, exercise, oral health and medication side effects.
- Encourage and reinforce improved self-health management.
- Help clients advocate for themselves with various systems of care, support or entitlements.
- Encourage and assist clients to engage with to a broad range of community supports, including family and friends, religious institutions, 12 step groups and social, health and/or mental health service organizations and support groups.
- Anticipate difficult times, red flags and warning signs leading to possible relapse of health, mental health or substance abuse recovery and, in conjunction with the health care team, develop personal strategies to take effective action.
- Act as a role model that clients can emulate.
- Develop accepting and reliable relationships with members of the health care team.

(courtesy of San Mateo County, CA) (abridged)

PEER WELLNESS COACH COMMUNITY WORKER I-
ENGLISH & CHINESE, SPANISH OR TAGALOG PREFERRED

THE POSITION

Behavioral Health & Recovery Services (BHRS) is seeking a dynamic Peer Wellness Coach Community Worker I-English & Chinese, Spanish or Tagalog Preferred-Unclassified (Community Worker I) for an integrated behavioral health and primary care program, Total Wellness. Total Wellness aims to reduce disparities in access to health care for people with mental illness and alcohol and drug addictions, as well as improve their physical health outcomes through chronic disease prevention, early intervention, health care coordination, and disease management strategies. The Peer Wellness Coach will work with a multidisciplinary team of medical and behavioral health professionals, and others to improve physical health outcomes of BHRS consumers.

The current vacancy is in the Total Wellness Team and fluency in both Chinese (Mandarin/ Cantonese) and English, OR Spanish and English, OR Tagalog and English is preferred.

Duties and responsibilities include, but are not limited to, the following:

- Provide assistance and supporting services to enrolled clients and staff.
- Provide assistance and encouragement to clients considering enrollment in Total Wellness.
- Assist other grant personnel by establishing and maintaining contact with enrolled clients.
- Assist in planning and implementing health and wellness education and support groups.
- Assist clients to obtain any public benefits, including health benefits, for which they are eligible.
- Make appointments and keep clinical records.
- Assist with grant-specific data collection.
- Provide transportation services for enrolled and prospective clients.
- Organize and facilitate Wellness Support Groups, including drop-in information groups and structured groups leading to client development of Total Wellness plans.
- Serve on committees or confer with other agencies or departments regarding needs of the community or of individual clients.
- Develop immediate solutions to emergency problems and expedite delivery of needed services.
- Upon request, refer clients to other departments or agencies for appropriate treatment.
- Speak to consumer groups or to other agencies regarding Total Wellness resources and programs.
- Perform outreach to provide health and wellness education and information to individuals.
- Assist professional medical staff with treatments and procedures as allowed by individual training/certification.
- Perform measurements and patient screening tests.
- The Ideal Candidate will be:
- A consumer of behavioral health services.

- Experienced in providing peer support services for people with mental illness and medical conditions.
- Experienced with mental health and alcohol and other drug related services.
- Experienced working with seriously mentally ill clients with complex needs and/or co-occurring challenges.
- Understanding the needs of their community and advocating for resources and services.
- Interacting and communicating effectively with people with mental illness from diverse communities, some of which include the African American, Asian, Filipino, and Hispanic/Latino communities.
- Understanding of medical issues of consumers of behavioral health services.
- Interested in modeling and promoting a healthy lifestyle for people with serious mental illness.

QUALIFICATIONS
Driver License: Minimum knowledge of and skill in using public transportation. Some positions require possession of a class C California driver license or the ability to provide suitable transportation, as approved by the appointing authority.

Language Requirement: Some positions may require the ability to speak, read and write fluently in both Chinese (Mandarin/Cantonese) and English, OR Spanish and English, OR Tagalog and English.

Experience and Education: Any combination of education and experience that would likely provide the required knowledge and skills is qualifying. A typical way of gaining the knowledge and skills is experience which has provided first-hand knowledge of the problems, needs, attitudes, and behavior patterns of the community served.

Knowledge of: Problems, needs, attitudes and behavior patterns of the community served; resources, residents and problems of the area served.

Skill/Ability to: Exercise good judgment and tact; relate and communicate effectively with members of the community served; and function as a team member and to benefit from supervision and training; interpret agency programs and policies to members of the community served; and analyze problems, formulate plans and put them into effect with a minimum of supervision.

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(courtesy of Benton County Health Services, Corvallis, Oregon and Multnomah Mental Health and Addiction Services Division, Oregon)

Peer Wellness Coach Training

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

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

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

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

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

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

Wellness Coach Training Curriculum

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

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

III. Chronic Conditions
   a. Overview of Chronic Diseases and their Impact on health
      1. Heart Disease
      2. Pulmonary Disease

3. Diabetes
4. Out of class activity: Take home quiz

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

V. Principles of Person Centered Medical Home
a. Principles of the Person Centered Medical Home model
b. Team Based
1. Who's who and what do they do
c. Ethics
Out of class activity: Take home quiz

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

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

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

IX. Work on Group Project

X. Group Project Presentations
Wrap-Up, Course Evaluation, Presentation of Certificates

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

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

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

DIRECTOR, PHYSICAL AND INGREGRATED HEALTHCARE PROGRAMS (PRIMARY CARE)

Courtesy of Joan Kenerson King, Senior Integration Consultant, National Council for Community Behavioral Healthcare • ***Page 1***

Department: Administration **Reports to:** Chief Executive Officer; Exempt

I. Job Summary

The person in this position is responsible for the administrative, management and day-to-day operations of the agency's physical and integrated healthcare programs. He/she develops, directs and supervises the physical and integrated healthcare programs and is responsible for establishing and monitoring healthcare, quality improvement and efficiency targets and outcomes. This person acts as consultant to the Chief Executive Officer and other Executive Leadership regarding physical and integrated healthcare and works with other key staff in areas of quality improvement, grants management and other as indicated.

II. Job Duties

1. Supervises staff FTE assigned to the Physical and Integrated Healthcare Programs in all non-Medical functions. Works as consultant to the Medical Director regarding medical issues within the programs.

2. Provides leadership to grant, Medicaid and insurance programs within the Programs and consults internally as indicated.

3. Evaluates clinical, efficiency, fiscal, productivity and quality outcomes of the Programs and designs and implements quality and other improvement activities.

4. Provides oversight and assists with day-to-day operations of the Programs.

5. Establishes and maintains relationships with payers including Medicaid and non-Medicaid entities and foundations with interest/involvement in physical and integrated healthcare with Aged, Blind and Disabled and other population groups. As indicated, works with such entities regarding pilot healthcare models.

6. Assists in the development and implementation of an electronic medical and health record designed to meet integrated healthcare standards and requirements and federally required "Meaningful Use." Assures staff use of the electronic record to best meet needs of patients and the organization.

7. Performs assignments as directed by the Chief Executive Officer regarding the management and operation of the Physical and Integrated Healthcare programs.

8. Acts as consultant to the Medical Director, Director of Pharmacy and Clinical Directors regarding the operations of the physical and integrated healthcare programs, benefits of consumer/patient participation in integrated care and monitoring and management necessary to assure optimal benefit to patients.

9. Gathers, maintains and disseminates information on a national, state and local scope regarding physical and integrated healthcare and models of service provision. Provides staff consultation, training and development regarding services, models and consumer healthcare impact.

10. Participates in administrative, clinical and planning meetings as required; leads such activity as assigned.

11. Works with Grants Manger and Executive Leadership Staff regarding grant and other opportunities for funding of the physical and integrated healthcare programs.

12. Provides other functions as might be requested from Chief Executive Officer and Executive Leadership Staff. Such activity may include working with the Director of Human Resources regarding the development and approval of Continuing Education Units for education and training for Counselors, Social Workers and Marriage and Family Therapists.

III. Job Specifications

A. Qualifications

Person must be a graduate of an accredited College or University with a Master's Degree in Psychology, Social Work, Counseling, Nursing or other related mental health specialty; must hold a current independent license with supervisory specifications and have at least 7 years of upper administrative/ management experience. Prior work and knowledge in integrated and physical healthcare preferred. The person in this position must have conceptual and program development skills, excellent oral and written communication abilities and demonstrated human relations and team building experience and skill.

B. Supervisory Responsibilities and Level of Authority

Person in this position directly supervises administrative and operations FTE assigned to physical and integrated healthcare programs and consults with the Medical Director regarding Medical supervisory issues. The Director of Physical and Integrated Healthcare Programs reports directly to the Chief Executive Officer.

C. Scope and Complexity of Job Duties

Duties require excellent judgment, initiative and abilities necessary for the successful operation of the Programs. Knowledge of physical and integrated healthcare and federal and state physical and integrated healthcare policy and programs for ABD and indigent populations is critical to this position.

D. Interpersonal Relationships within the Agency and Community

This is a highly visible position. A significant degree of judgment, negotiation, relationship building and interpersonal skill is required. Ability to work among/across racial, cultural and socio-economic populations and with professionals and non-professionals is required. The person needs to have the ability to build and encourage team work and support agency goals as well as administrative and line-staff employees.

E. Working Conditions and Environment

In emergency situations, could be exposed to unpredictable and assaultive clients/patients. Exposure to communicative disease/illness could occur. Travel will be required as well as occasional evening or week-end hours.

F. Level of Supervision

As needed

G. Special Populations Served

SMD adults, older adults, adults with dual diagnosis including mental illness with drug/alcohol addiction and development disabilities, adults with HIV/AIDS and other communicable diseases, and adult sex offenders. Adolescents are also served by the organization.

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SHAKING HANDS

Agreements, MOU's, & Contracts

NOTE: *Inclusion of sample agreements or any other sample forms in this Tool Kit does not constitute an endorsement of the contents or a recommendation of usage. They are presented here as examples for reference only.*

Collaborative Agreement Checklist

IBHP Integrated Behavioral Health Project

FOR AGREEMENTS BETWEEN MENTAL HEALTH, PRIMARY CARE AND SUBSTANCE ABUSE SERVICES

Prepared by Barbara Demming Lurie, barb@ibhp.org

	Not Needed	Need to Decide
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) (*What will be the population to be served by each agency and what, if any, population will the agency not serve*?)		
Scope of work for each partner		
Designation of point persons responsible for coordinating services *(referrals; utilization; etc.)*		
Productivity standards (*Will there be quotas or expected numbers of persons to be treated and/or units of service to be delivered?)*		
Professional credentialing and standards (*Are the qualifications of staff delivering services to be specified and, if so, what will they be?)*		

	Not Needed	Need to Decide
Funding sources (*What is the anticipated payer mix for services delivered (e.g., MediCal, MediCare, uninsured, etc.?)*		
Costs, billing and reimbursement (*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?)*		
Ancillary service expenses, including cost and time for:		
• 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 (*What support staff and equipment will be provided by the collaboration partner and what is expected to be self-supplied?)*		
Referral criteria and procedure from primary care to county mental health		
Referral criteria and procedure from county mental health to primary care		
Referral criteria to substance use services		
Referral criteria from substance use services to primary care		
Referral criteria from substance use services to mental health		
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)*		

	Not Needed	Need to Decide
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		
Handling of client preferences		
Criteria for termination of client services		
Client information-sharing between agencies and access to records *(use of registries; type of electronic record-keeping, etc.)*		
Confidentiality provisions (*What regulations and policies apply and how will they be followed?)*		
Provisions for out-stationed staff (if any):		
• Who will be responsible for hiring?		
• Who will provide clinical supervision?		
• Who will oversee nonclinical matters such as work hours, absences, etc?		
• How will payment for their services be handled?		
• Where and when will work space be provided for them?		
• What level staff are needed to perform the needed functions?		
• How will staff support be handled?		
• Who will be responsible for their data entry?		
• Who will order and pay for supplies for them?		
• Who will be responsible for amending job responsibilities		
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		

	Not Needed	Need to Decide
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 *(what data is to be collected; who collects it and how often)*		
Program reviews -frequency and scope (*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?)*		
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.)*		
Substance use consultation/services available		
Ancillary medical services available to county mental health clients		
Communication expectations *(case conferences; joint meetings etc.)*		
Ancillary mental health services available to primary care patients		
Treatment approach and policies *(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?)*		
Space and physical plant requirements *(offices; record storage; exam rooms, waiting areas; etc.)*		
Professional training needs and requirements (*What will staff training needs be – both clinical and administrative - and how will cross-training be provided?)*		
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		

	Not Needed	Need to Decide
Special considerations for children/youth		
Medication procurement, management and dispensing responsibilities		
Equipment and supplies		
Provision of care management/coordination within the clinic/agency		
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 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?

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Enhancing the Continuum of Care:

Integrating Behavioral Health and Primary Care through Affiliations with FQHCs

The authors of these materials include attorneys at the law firm of Feldesman Tucker Leifer Fidell LLP. The sample documents offer general guidance based on Federal law and regulations. These materials do not replace, and are not a substitute for, legal advice from qualified legal counsel. The items listed in this document are examples of requirements and recommendations that should be considered by CMHCs and FQHCs entering into affiliation agreements. This list represents the authors' view of good practices in attempting to meet the requirements of Federal law, regulation, and guidance. Items listed as recommended may otherwise be required under state law.

CHECKLIST OF CONSIDERATIONS FOR AFFILIATION AGREEMENTS

Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) are increasingly affiliating to provide their patients with comprehensive and integrated primary and behavioral health services.

This checklist is intended to guide discussions among partnering CMHCs and FQHCs drafting comprehensive affiliation agreements that are compliant with federal laws, regulations and guidance.[1] Although there is a broad range of affiliation models, this tool specifically addresses key terms pertaining to:

- >> referral arrangements;
- >> co-location arrangements; and
- >> purchase of services arrangements.

For additional information, please visit the National Council Resource Center for Primary Care and Behavioral Health Collaboration at www.thenationalcouncil.org/resourcecenter.

REFERRAL AGREEMENT

What is a referral arrangement?

A referral arrangement is a partnership under which a provider agrees to furnish services to those patients who are referred to it by another provider. The referring provider agrees to utilize the other provider as its preferred, albeit not exclusive, provider of choice for particular services. There is no change in location or purchase of services. Each party is only accountable for the services it directly furnishes to patients.

Referral relationships may serve as a useful precursor to a more collaborative model, providing both parties with the opportunity to evaluate the partnership prior to implementing a co-location or purchase of services arrangement.

What are referral arrangement options for CMHCs and FQHCs?

- >> FQHC refers its patients to the CMHC for behavioral health services; and/or
- >> CMHC refers its patients to the FQHC for primary and preventive care services.

Must the affiliation arrangement be in the form of a written agreement?

A written agreement is critical to demonstrate compliance with various federal (and often state) laws, regulations and guidance, and helps to articulate roles and responsibilities for both of the partnering organizations. Furthermore, the Health Resources and Services Administration (HRSA), the federal agency that oversees the FQHC program, generally requires evidence of FQHC affiliation relationships as part of all grant applications (i.e., New Access Point, Expanded Medical Capacity, Service Expansion) and for designation as an FQHC.

Checklist of Considerations for Referral Agreements between CMHCs and FQHCs

For purposes of this checklist, the CMHC or FQHC referring the patient is the "Referring Entity," and the CMHC or FQHC providing the referral services is the "Referral Provider."

PRELIMINARY CONSIDERATIONS
Have the CMHC and FQHC evaluated whether the Referral Provider has sufficient personnel and facility space to see additional patients?
PROVISIONS REGARDING SERVICES
Does the agreement specify the manner by which the referral will be made and managed (e.g., development of a referral protocol and procedures for tracking patients and ensuring appropriate follow-up care)?
Does the agreement describe the division of services between the Referring Entity and the Referral Provider (e.g., which entity will perform the initial screening, which entity will make initial appointments, etc.)? (This provision is recommended, but not required.)
Does the agreement describe the process by which the parties will share medical notes/records regarding diagnosis and treatment for continuum of care purposes, and that the Referral Provider will furnish feedback and results to assist the Referring Entity in providing follow-up? (This provision is recommended, but not required.)
OBLIGATIONS OF THE REFERRAL PROVIDER
Does the agreement contain a provision stating that to the extent that referred patients receive services from Referral Provider, such individuals are considered patients of Referral Provider?
If the FQHC is the Referring Entity, does the agreement specify that the CMHC agrees to accept all patients referred to it by the FQHC, regardless of ability to pay, subject to capacity limitations? (This provision is required if the FQHC is the Referring Entity. The CMHC may wish to include a similar provision. Note that FQHCs are statutorily required to serve all patients in its service area regardless of ability to pay.)
Does the agreement specify that the Referral Provider will be solely liable for all services provided by it and its health care professionals?
Does the agreement specify that the Referral Provider will be responsible for billing and collecting all payments from appropriate third party payors, funding sources, and, as applicable, patients, for its services?
Does the agreement contain assurances that the Referral Provider and each of its employees/contractors providing services pursuant to the Referral Agreement: • are appropriately licensed, certified and/or otherwise qualified to furnish the services, with appropriate training, education and experience in their particular field? • will furnish services consistent with the prevailing standards of care? • are not excluded from participating in Medicare, Medicaid and other federal health care programs? • will furnish services in accordance with applicable federal, state and local laws and published and final regulations?
Does the agreement specify the process by which the Referral Provider will refer patients back to the Referring Entity for the clinically appropriate follow-up care? (Note that the Referring Entity must furnish and pay/bill for any appropriate follow-up care provided by the Referring Entity based on the outcome of the referral.)

For additional information, please visit the National Council Resource Center for Primary Care and Behavioral Health Collaboration at www.thenationalcouncil.org/resourcecenter.

www.TheNationalCouncil.org

PROVISION REGARDING INSURANCE
Does the agreement state that the Referral Provider will ensure that it and its employees providing services pursuant to the referral are covered by a professional liability insurance policy (malpractice, errors, and omissions) providing sufficient coverage against professional liabilities which may occur as a result of the services that the Referral Provider and its employees furnish to the referred patients? *Note that if the FQHC is the Referral Provider and is deemed eligible under the Federal Torts Claims Act (FTCA), the agreement may also state that in lieu of the professional liability insurance coverage specified above, the FQHC Referral Provider, at its option, may provide written assurance to the Referring CMHC that it and its health care personnel employed by (or individually contracted with) the FQHC Referral Provider have FTCA coverage for professional liability actions, claims, or proceedings arising out of acts or omissions committed during provision of services pursuant to the referral agreement.*
PROVISIONS REGARDING AUTONOMY AND COMPLIANCE WITH STATE AND FEDERAL LAW
Does the agreement contain a provision stating that each party maintains the right to enter into arrangements with other providers, whether for the same or for similar services, if such party deems it necessary?
Does the agreement contain a provision stating that neither party is under obligation to refer patients or business to the other party as a result of the agreement?
Does the agreement contain a provision stating that the health care professionals of each party retain the ability to refer patients based on professional judgment, and patients retain the freedom to see whomever they choose?
Does the agreement contain a provision stating each party agrees to comply with any federal or state law governing the privacy and confidentiality of the individually identifiable health information of patients originating with either party, including patient names and other medical information, maintained in electronic, oral or written form ("Protected Health Information" or "PHI") for the purposes of treatment, payment and health care operations, as such terms are defined in HIPAA and its implementing regulations? *Note that many states have additional restrictions on the disclosure of medical records and psychotherapy notes that address mental health and substance abuse issues.*
ADDITIONAL CONSIDERATIONS
Is the agreement written in clear and unambiguous language?
Do the CMHC and FQHC want to include a provision in the agreement addressing dispute resolution? (This provision is recommended, but not required.)

CO-LOCATION AGREEMENT

What is a co-location arrangement?

Similar to the referral model, a co-location arrangement is a partnership under which a provider agrees to treat patients who are referred to it by another provider, maintains its own practice and control over the provision of the referral services, and is legally and financially responsible for the referral services.

However, unlike the referral model, the provider furnishing the referral services is physically located at the referring entity's site.

For additional information, please visit the National Council Resource Center for Primary Care and Behavioral Health Collaboration at www.thenationalcouncil.org/resourcecenter.

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Because the co-location arrangement is a form of referral, it is critical that CMHCs and FQHCs seeking to implement a co-location arrangement satisfy the referral checklist on pages 1 through 5, as well as the co-location checklist below.

What are co-location arrangement options for CMHCs and FQHCs?

>> CMHC is physically located in and provides behavioral health services to FQHC patients at an FQHC's existing site(s); and/or

>> FQHC is physically located in and provides primary and preventive health services to CMHC patients at the CMHC's existing site(s).

Checklist of Considerations for Co-Location Agreements between CMHCs and FQHCs (To be Reviewed in Tandem with the Referral Agreement Checklist)

For purposes of this checklist, the CMHC or FQHC referring the patient is the "Referring Entity," and the CMHC or FQHC providing the referral services is the "Referral Provider."

Note that CMHCs and FQHCs seeking to implement a Co-Location Agreement must also satisfy the Referral Agreement checklist.

PRELIMINARY CONSIDERATIONS

If the FQHC is co-locating to the CMHC site, is the CMHC site currently within the FQHC's approved scope of project? If not, the FQHC must receive prior approval from HRSA to add the site to its scope of project.[2]

SCHEDULING

Does the agreement provide a schedule describing the days/hours that the Referral Provider will be providing services at the Referral Entity's site(s)?

SPACE, EQUIPMENT, SUPPLIES, ETC.

Does the agreement state that the Referring Entity agrees to provide certain space/utilities (and, as applicable, equipment, supplies, and clerical staff support) to assist the Referral Provider, which should be leased by the Referral Provider based on a fair market, arm's length negotiated rate?

- If the FQHC is co-locating to the CMHC site, it may obtain the space, equipment, supplies, utilities, and support and clerical staff at a reduced cost or free of charge if the arrangement is structured to comply with the Anti-Kickback Statute Federally-Funded FQHC Safe Harbor, or any other applicable appropriate federal and state Anti-Kickback Statute safe harbors.[3]
- If the CMHC is co-locating to the FQHC site, it may obtain the space, equipment, supplies, utilities, and support and clerical staff at a reduced cost or free of charge if the arrangement is structured to comply with appropriate federal and state Anti-Kickback Statute safe harbors?

OVERSIGHT OF REFERRAL PROVIDER

Does the agreement state that the Referring Entity may remove a Referral Provider's employee(s)/contractor(s) from its site(s) if he or she has a reasonable belief that the Referral Provider's employee(s)/contractor(s) could jeopardize the health, safety and welfare of patients if he or she continues to provide treatment? (This provision is recommended, but not required.)

2. *For additional information, review PIN # 2008-01, Defining Scope of Project and Policy for Requesting Changes, which provides comprehensive guidance regarding the process for obtaining approval for a change in scope of project.*
3. *42 CFR 1001.952(w).*

For additional information, please visit the National Council Resource Center for Primary Care and Behavioral Health Collaboration at www.thenationalcouncil.org/resourcecenter.

SIGNAGE / SEPARATE ENTITIES
Does the agreement state that the Referral Provider's employees/contractors providing services at the Referring Entity's site(s) will be clearly identified as employees/contractors of the Referral Provider and not of the Referring Entity, and that the services provided by Referral Provider's employees/contractors will be clearly identified as services provided by the Referral Provider and not services provided by the Referring Entity?
LIABILITY
Does the agreement note that the Referral Provider will be solely liable for services provided by it and its employees/contractors and the Referring Entity will not be liable for any damages arising from any acts or omissions in connection with the services provided under the referral arrangement by the Referral Provider?

PURCHASE OF SERVICES AGREEMENT

What is a purchase of services arrangement?

Under the purchase of services arrangement, one provider (i.e., the purchaser) contracts with another provider (i.e., the vendor) to furnish services to the purchaser's patients, on behalf of the purchaser, who will be served at either the purchaser's facility or the vendor's facility.

What are purchase of service arrangement options for CMHCs and FQHCs?

>> FQHC purchases behavioral health services/capacity from CMHC; and/or

>> CMHC purchases primary and preventive care services/capacity from the FQHC.

Checklist of Considerations for Purchase of Services between CMHCs and FQHCs

For purposes of this checklist, the CMHC or FQHC purchasing the other entity's services is the "Purchaser," and the CMHC or FQHC providing the purchased services is the "Vendor."

PRELIMINARY CONSIDERATIONS
Has the Purchaser conducted an appropriate procurement process, in a manner to provide, to the maximum extent practicable, open and free competition? If not, has the Purchaser provided sufficient justification for utilizing sole source contracting procedure?
If the FQHC is purchasing behavioral health services from the CMHC, are the behavioral health services currently within the FQHC's approved scope of project? If not, the FQHC must receive prior approval from HRSA to add the service(s) to its scope of project.[4]
Is the FQHC purchasing behavioral health services that will be provided to the FQHC patients at the CMHC facility or at a new facility? If so, the FQHC must receive prior approval from HRSA to add the site(s) to its scope of project.[5]

4. *For additional information, review PIN # 2008-01, Defining Scope of Project and Policy for Requesting Changes, which provides comprehensive guidance regarding the process for obtaining approval for a change in scope of project.*
5. *For additional information, review PIN # 2008-01, Defining Scope of Project and Policy for Requesting Changes, which provides comprehensive guidance regarding the process for obtaining approval for a change in scope of project.*

PRELIMINARY CONSIDERATIONS continued
If the FQHC is the Vendor (i.e., services are provided on behalf of CMHC and CMHC bills for FQHC's contracted primary care services), then the contracted services are provided as an other line of business, outside of the FQHC's approved scope of project. Accordingly, the FQHC should consider that it cannot use Section 330 grant funds, program income pledged to the Section 330 project, or grant-supported resources to support the direct or indirect expenses of providing the purchased services. In addition, the revenue generated from the contract to provide the CMHC with primary care services should be sufficient to support direct costs of the activity plus a reasonable share of overhead to ensure that Section 330 funds and other grant-related income are not used inappropriately to support costs outside the approved scope of project.

PROVISIONS RELATED TO SERVICES
Does the agreement identify the term of the agreement and, if so, is the term a minimum of one year?
Does the agreement specify all of the purchased services?
If the FQHC is the Purchaser, does the agreement require that the purchased services will be available to all of the Purchaser's patients regardless of ability to pay?
Does the agreement provide that all patients receiving services under the agreement are considered patients of the Purchaser and, as such, the Purchaser (and not the Vendor) would bill appropriate third party payors and, as applicable, collect fees from patients?
Does the agreement provide terms and mechanisms for billing and payment?
Does the agreement specify in advance the compensation for these services (or a fixed methodology by which the compensation will be established)?
Is the compensation commercially reasonable, consistent with fair market value, or does it otherwise comply with appropriate federal and state anti-kickback safe harbors?
Does the agreement state that the compensation does not vary based on the volume or value of referrals or business generated (directly or indirectly) between the CMHC and FQHC?
If the services are provided on a periodic, sporadic or part-time basis, does the agreement set forth a schedule according to which services will be provided and specify a compensation method that corresponds to the periodic, sporadic or part-time services?
Does the agreement contain a provision stating that each party maintains the right to enter into arrangements with other providers, whether for the same or for similar services, if such party deems it necessary?
Does the agreement contain a provision stating that neither party is under obligation to refer patients or business to the other party as a result of this agreement?
Does the agreement state that the health care professionals of each party retain the ability to refer to any provider based on professional judgment, and that the patients retain the freedom to see whomever they choose?

PROVISIONS RELATED TO MONITORING AND OVERSIGHT OF CONTRACTED SERVICES [6]
If the FQHC is the Purchaser, does the agreement contain affirmative safeguards that preserve the authority of the FQHC's Board of Directors to establish all policies and procedures relating to the operation of the FQHC as required under Section 330 of the Public Health Service Act ("Section 330")?
If the Vendor is providing services to the Purchaser's patients on behalf of the Purchaser, does the agreement obligate the Vendor to provide the intended services in accordance with: • relevant state and federal laws, regulations, and policies (including Section 330-related requirements, if the FQHC is the Purchaser)? • generally accepted principles and practices? (This provision is recommended, but not required.) • requirements of the Purchaser's grant and special terms and conditions, as applicable? • the Purchaser's applicable policies and procedures, including, but not limited to, relevant personnel and health care policies, procedures, standards, and protocols (e.g., quality assurance and performance standards; clinical protocols; Standards of Conduct; and provider complaint resolution procedures)? (This provision is recommended, but not required.)
Does the agreement obligate the Vendor to assure that its personnel performing services satisfy the Purchaser's professional qualifications including credentialing and privileging requirements, if applicable? (This provision is recommended, but not required.)
Does the agreement give the Purchaser's CEO/Executive Director general oversight authority over the performance of services by contracted personnel? (This provision is recommended, but not required.) • Does the agreement give the Purchaser's CEO/Executive Director authority to approve the contracted personnel, and determine the work schedules and scope of services provided by the contracted personnel? (This provision is recommended, but not required.)
Does the agreement give the Purchaser's CEO/Executive Director authority to evaluate the performance of the contracted personnel and to suspend performance, and request removal and replacement, of contracted personnel if: • the Purchaser's CEO/Executive Director is dissatisfied with performance? (This provision is recommended, but not required.) • the Purchaser's CEO/Executive Director in good faith determines that the actions of the contracted personnel jeopardize the health and well-being of the Purchaser's patients? (This provision is recommended, but not required.) • such personnel fail to maintain required licensure and/or insurance? • such personnel fail to remain eligible to participate in the Medicare and Medicaid programs and other federal health care programs?
Does the agreement obligate the Vendor to notify the Purchaser in the event that an action or claim has arisen which has resulted or could result in the revocation, suspension, or termination of the license or necessary certification of any of its personnel performing services under the agreement and, if so, does the agreement give the Purchaser the right to request removal / suspension of such individual until such action or claim has been resolved? (This provision is recommended, but not required.)
Does the agreement require the Vendor to furnish to the Purchaser programmatic and/or financial reports pertaining to the services provided under the agreement, as deemed necessary by the Purchaser for monitoring and oversight, as applicable?
Does the agreement require the Vendor to retain and provide access to such records and reports, in accordance with the procurement requirements set forth in 45 CFR Part 74?[7]

6. *While the majority of the considerations related to monitoring and oversight are not specifically required by statute or regulation, given the FQHC's and CMHC's duty to maintain accountability for expenditures of all grant funds and related income, the authors strongly urge including the recommended provisions (or similar provisions) in all CMHC/FQHC purchase of services contracts.*

7. *The Code of Federal Regulations (CFR) is available at http://www.gpoaccess.gov/cfr/index.html.*

For additional information, please visit the National Council Resource Center for Primary Care and Behavioral Health Collaboration at www.thenationalcouncil.org/resourcecenter.

www.TheNationalCouncil.org

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OTHER PROVISIONS

Does the agreement contain a confidentiality provision that prohibits disclosure of any business, financial or other proprietary information, which is directly or indirectly related to the Purchaser and obtained as a result of services performed under the agreement, unless the Purchaser gives prior written authorization for the disclosure or the disclosure is required by law (consistent with all applicable state and federal laws and regulations, as well as the Purchaser's policies, regarding the use and disclosure of confidential and proprietary information)? (This provision is recommended, but not required.)

Does the agreement contain a confidentiality provision prohibiting unauthorized use or disclosure of patient information consistent with all applicable state and federal laws, including the requirements of the Health Insurance Portability and Accountability Act, as well as the CMHC's and FQHC's policies regarding the confidentiality and privacy of patient information?

Does the agreement give the Purchaser the right to terminate in the event that the Vendor

- materially breaches any of the agreement's terms and conditions? (This provision is recommended, but not required.)
- loses its license or other certifications necessary to perform services under the agreement? (This provision is required for FQHCs)
- fails to maintain insurance? (This provision is recommended, but not required.)
- fails to remain eligible to participate in the Medicare and Medicaid programs or other federal health care programs?

If the FQHC is the Purchaser, does the agreement permit termination in the event that the Department of Health and Human Services terminates, suspends or materially reduces the FQHC's Section 330 grant award or fails to approve the agreed-upon arrangement for services? (This provision is recommended, but not required. If the CMHC is the purchaser, it may consider implementing a similar provision that refers to its applicable SAMSHA and/or state grant.)

Does the agreement identify the independent contractor relationship of the CMHC and FQHC?

Does the agreement appropriately allocate the CMHC's and FQHC's obligations with respect to insurance and indemnification?

Note that FTCA is only available for (1) the deemed FQHC; (2) FQHC employees who provide services to FQHC patients on behalf of the FQHC; (3) individually contracted providers furnishing services to FQHC patients who practice in the fields of general internal medicine, family practice, general pediatrics and OB/GYN, regardless of hours worked; and (4) individually contracted providers furnishing services to FQHC patients who practice in other fields, so long as they provide such services for an annual average of 32 ½ hours a week.

- FTCA does not cover FQHC providers that provide purchased services to the CMHC's patients on behalf of the CMHC (i.e., FQHC functions as the Vendor).
- FTCA does not cover the CMHC's providers that provide purchased services to the FQHC's patients on behalf of the FQHC unless the CMHC providers are individually contracted and provide such behavioral health services to the FQHC patients for an annual average of 32 ½ hours per week.
- FTCA does not cover indemnification of third parties.

Does the agreement contain a provision that identifies the federal laws with which the other party must comply, such as applicable civil rights laws prohibiting discrimination, in accordance with, among other things, 45 CFR Part 74 Appendix A?[8]

Does the agreement contain a "governing law" provision that identifies the applicable state and federal laws governing the FQHC?

8. *The Code of Federal Regulations (CFR) is available at http://www.gpoaccess.gov/cfr/index.html.*

SAMPLE AGREEMENTS

SAMPLE AGREEMENT BETWEEN PRIMARY CARE AND MENTAL HEALTH • Page 1
(courtesy of the Center for Integrated Health Solutions, National Council for Community Behavioral Healthcare)

MEMO OF UNDERSTANDING BETWEEN
AGENCY 1 AND AGENCY 2

The AGENCY 2 and Agency 1 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

Agency 2: The Community Mental Health Services Provider, a program operated under contract with the (Insert State Name) 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 Agency 1 patients and who might be appropriate to use Agency 1 as their "medical home".
2. Improve the overall health of consumers involved in the project.
3. Enhance Agency 1 service capacity by having on-site substance abuse and mental health screening and regular ongoing therapy services located at the primary clinic.
4. Enhance Agency 1 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:

- AGENCY 2, providing funding and project oversight;
- Agency 1, a primary healthcare provider for vulnerable citizens.

IV. TARGET POPULATION

The target population will be public mental health consumers who are already patients at Agency 1, as well as other vulnerable patients with mental health or substance abuse issues served by Agency 1 who are not currently consumers of public mental health services.

The number of public mental health consumers served at Agency 1 is expected to be at least _____.

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V. EXPECTED OUTCOMES, MEASURES, AND BENEFITS

1. Demonstration of an effective public-private 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 Agency 1;
   - Expansion of Agency 1 on-site services for vulnerable populations.

2. A blueprint for integrated treatment in (insert State Name).

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 Agency 1 could become their medical home. This presumes that the staffing provided by AGENCY 2 would remain in place.

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

VI. FINANCING PLAN

Funding: AGENCY 2 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 Agency 1 shall be CMHC employees

Billing: CMHC will bill and collect for mental health services provided by the CMHC employees located at Agency 1. Billable services and capitation offsets will apply towards AGENCY 2 costs.

Annual Report: AGENCY 2 will prepare an annual report, which will be shared with Agency 1. It is the hope and expectation that results will support a continuing partnership.

VII. POLICIES AND PROCEDURES

Agency 1 agrees to follow those polices, procedures, and administrative directives or other documents as specified by the AGENCY 2. During the term of this Agreement, AGENCY 2 shall advise Agency 1 of any applicable modifications to the Mental Health Code or any changes in the AGENCY 2 Policies and Procedures or the MDCH Administrative Rules promulgated according to the (Insert State Name)

which have a bearing on this Agreement or Agency 1. Agency 1 shall expressly acknowledge receipt of any such changes.

VIII. HIPAA COMPLIANCE AND CONFIDENTIALITY

HIPAA Compliance: Agency 1 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.

Agency 1 Requirements. Agency 1, as a business associate of AGENCY 2, must agree to appropriately safeguard any protected health information received from, or created or received by the Agency 1 on behalf of AGENCY 2 in accordance with AGENCY 2 policies and applicable state and federal laws.

A. Appropriate Uses and Disclosures of PHI. Agency 1 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 AGENCY 2 ("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 AGENCY 2 policies or required by law.

Agency 1 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. Agency 1 will ensure that any agents, including any subcontractors, to whom it provides protected health information received from, or created or received by Agency 1 on behalf of AGENCY 2 agrees to the same restrictions and conditions that apply to Agency 1 with respect to such information.

C. Consumer Requests to Review Record. Since AGENCY 2 is the holder of the mental health record for public mental health consumers, AGENCY 2 will respond to any consumer request to review such records. Agency 1 should notify AGENCY 2 immediately of the receipt of any such request.

D. Cooperation with the Secretary of Health and Human Services. Agency 1 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 Agency 1 on behalf of AGENCY 2 available to the Secretary of Health and Human Services, or its designee, for the purpose of determining AGENCY 2's compliance with the Health Insurance Portability and Accountability Act of 1996.

E. Agreement Termination. At termination of this Agreement, Agency 1 will return all protected health information received from, or created or received by Agency 1 on behalf of AGENCY 2 that Agency 1 still maintains in any form, and will retain no copies of such information. If such return is not feasible,

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Agency 1 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 Agency 1 becomes aware of a material breach or any violation of its obligation to protect the confidentiality and security of consumers' protected health information, Agency 1 must immediately take reasonable steps to cure the breach or end the violation, and must report the breach or violation to the AGENCY 2 Privacy Officer. The alleged breach or violation will be investigated and an appropriate sanction issued. AGENCY 2 reserves the right to terminate this Agreement if it determines that the Agency 1 has violated a material term of the Agreement.

G. Additional Confidentiality Requirements: Agency 1 acknowledges that consumers of public mental health services are entitled to additional confidentiality protections awarded under the (Insert State Name) Mental Health Code, which may supercede 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 supercede the confidentiality protections provided by HIPAA. When serving public mental health consumers or when providing substance abuse treatment services at its site, Agency 1 will comply with the confidentiality requirements of these and any other applicable state or federal laws, rules, or regulations.

IX. STAFF SUPERVISION

Agency 1 will participate in the oversight and supervision of CMHC staff working on site at Agency 1.

X. NOTICE

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

AGENCY 2: Executive Director
Insert Address

CLINIC: Executive Director
Insert 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 AGENCY 2 and/or any representative of AGENCY 2 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.

Agency 2		AGENCY 1	
_____		_____	
Executive Director	Date	Executive Director	Date

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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**, 20**xx**, 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 960**XX**.

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.

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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

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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

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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: **xxxx xxxxxx**, Director
xxxxxxxxxx
xxxxxxxxxx
xxxxxxxxxx
Tel: (530) **xxx xxxx**, Fax: (530) **xxx xxxx**

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.

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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

EXHIBIT A

SCOPE OF WORK

Activities	Time Line	Responsible Party/FTE	Performance Measure and/or Deliverables

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EXHIBIT B

BUDGET DETAIL WORKSHEET

Grantee:		Clinic Site:	
Check One: FY 2007/08 ☐ FY 2008/09 ☐ FY 2009/10 ☐ 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)	$

Memorandum of Agreement Between
CommuniCare Health Centers and Yolo County Alcohol Drug and Mental Health

This agreement is made between CommuniCare Health Centers (CCHC) and Yolo County Alcohol, Drug and Mental Health Department (ADMH). This Agreement is to describe and confirm the agreement and relationship between Communicare Health Centers (CCHC) Primary Care and Behavioral Health Services and Yolo County Alcohol, Drug, and Mental Health (ADMH) Department.

Agreements and Responsibilities

CCHC Agrees to:

- Accept referrals for primary medical care, mental health and medications management of ADMH stabilized mental health consumers and/or those not meeting medical necessity for services within ADMH. (See appropriate referrals below)
- Handle complicated or unstable medical conditions of ADMH .assigned to CCHC.
- Provide medical consultation upon request within *60* minutes of receiving a call from one of our ADMH providers.
  - Every effort will be made to have the Primary Care Physician of record provide consultation
  - If this provider is unavailable, either the Medical Director for CommuniCare or the MD on call will respond to the call for medical consultation
- Agrees to the joint care of consumers as appropriate
- Provide coordination/collaboration with ADMH for those patients pending SSI for psychiatric disability

Appropriate Referrals to CCHC: Consumers are considered appropriate for services under the following conditions:

- ***Foremost:***
  - They are already CCHC primary care patients
    Or
  - Partnership Health Plan patients who are willing to switch their primary care provider to CCHC if currently assigned elsewhere

  In addition:
  - Their mental health diagnosis is considered mild to moderate
    Or
  - Those with serious and persistent mental illness (SMI) who have been stabilized for at least six months, as defined by no hospitalizations in prior 6 months and psychotic symptoms are controlled

CCHC Limitations/Restrictions

Eligibility for CommuniCare Services: We reserve the right to refuse services to consumers experiencing active psychosis, consumers with severe mental illness that are not stabilized, consumers who are not amenable to treatment, or who act aggressively toward staff and/or interns/volunteers due to their mental illness/emotional disturbance. Under this MOU, such patients/consumers would remain the clinical management responsibility of ADMH.

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ADMH Agrees to:

- Provide psychiatric consultation upon request within *60* minutes of receiving a call from CCHC
  - Every effort will be made to have the Psychiatrist of record provide consultation
  - If this provider is unavailable, either the Medical Director for ADMH or the Psychiatrist on call will respond to the call for psychiatric consultation
  - Urgent consultation, call (530) 666-8630.
  - For W&I Code 5150 acute crisis evaluation
    - Call the police department for 5150 transport to closest Emergency Room.
- Re-evaluate consumers who decompensate during the course of their treatment with CCHC.
- Provide joint care of those consumers with a history of hospitalizations and decompensation.
- Supply CCHC with the reasoning for prescribing practice if consumers are on medications that are not on the formulary for Partnership Health Plan or YCHIP.
- Ensure stabilization of clients upon discharge from psychiatric hospitalization prior to referring back to CCHC for ongoing mental health treatment. See above description of stabilization.
- Provide coordination/collaboration of those patients pending SSI for a psychiatric disability.
- Facilitate trainings for CCHC providers as follows:
  - W&I Code 5150 criteria and procedures
  - Decision tree for different diagnoses and/or issues
  - Types of consumers to be referred
    - Types of medications most commonly prescribed
    - Common side effects of the medications mentioned above
    - Common signs of decompensation and “red flags” for referral back to ADMH

Appropriate Referrals to ADMH: Consumers are considered appropriate for services under the following conditions:

- Meet ADMH target population: Seriously Mentally Ill (SMI) adults and Seriously Emotionally Disturbed (SED) children and youth.

Provide the following information when referring to CCHC:

- Referral form – including current diagnoses, treatment plan and relevant treatment history
- Medication form – indicating medications and dosage, history of medications prescribed, any side effects, and/or adjustments made
- Release of information form

**All of the above paperwork will be sent to CCHC within 72 hours of referral*

ADMH Limitation/Restrictions

We do not treat Drug detoxification for Benzodiazepines, Opiates or Alcohol, nor do we provide pain management treatment or evaluations for bariatric surgery. We do not provide Attention Deficit Hyperactivity Disorder (ADHD) evaluations for adults, or provide court assessments, DMV renewal of license or for Social Security or State disability. The privately insured are not a part of our target population and must seek treatment via their insurance provider.

Problem Resolution

For cases where there is a disagreement regarding appropriateness of transferring care due to scope of practice issues, a meeting will be scheduled between the two medical directors and the Director of Behavioral Health Services and ADMH Director.

Confidentiality

Sharing of patient information will occur with patient consent, adhering to federal laws and HIPPA regulations to ensure continuity of care.

Terms

This memorandum of understanding/agreement will remain in effect from July 1, 2010 until June 30, 2011, unless terminated by at least 30 days written notice from either party specifying the date of termination and written notification to the other agency, or extended 2 subsequent years as per agreement between both agencies.

Executed this _____day of _____, 2010.

_____	_____
Director Yolo County Alcohol Drug and Mental Health.	Chief Executive Officer CommuniCare Health Centers
_____	_____
Medical Director Yolo County Alcohol Drug and Mental Health	Medical Director CommuniCare Health Centers

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TEMPLATE: MEMORANDUM OF UNDERSTANDING FOR PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES • page 1

(courtesy of Horizon House, Philadelphia)

This MEMORANDUM OF UNDERSTANDING is made by and between XXXX and YYYY on _____, 201X with the goal of enhancing the quality of health care services for medically underserved populations. Specifically, this joint effort seeks to provide integrated primary and behavioral health care for adults with developmental disabilities, mental health and/or substance abuse disorders and/or impacted by homelessness and their families in the _____ community. This MEMORANDUM OF UNDERSTANDING will confirm our preliminary discussions, which are nonbinding except as specially stated to be otherwise, between YYYY and XXXX regarding the following proposed transaction (the "Transaction"):

XXXX is a non-profit, community-based, 501 (c) (3) organization located in _____ and. XXXX is a Federally Qualified Health Center Organization, which provides preventive and comprehensive primary health care services regardless of race, ethnicity, age, gender, or insurance status.

XXXX agrees to the following:

1. Add the YYYY site as a service site within the XXXX scope of services.
2. Develop with YYYY a highly coordinated provision of Primary and Behavioral Health Care with the goal of integrating the XXXX medical services within YYYY's service delivery model at _____.
3. Provide a Mid Level Provider that is supervised by an MD/DO at the satellite office.
4. Provide supporting staff at the satellite office.
5. Provide hours of operations that are flexible and meet the demand of the YYYY population.
6. Provide all referred adults with a physical evaluation and lab tests as deemed appropriate by XXXX's physician and record findings/results in the patient's medical record.
7. Provide all referred adults with ongoing treatment for health problems within the scope of XXXX's providers.
8. Provide access to XXXX's provider "on call" services during hours when the health facility is not open and on weekends for all patients who have received physical evaluations or are under XXXX care.
9. Provide YYYY with copies of all licenses and professional/general liability insurances.
10. Provide YYYY with yearly health outcomes of referred patients. The outcomes will be based on XXXX Medical Protocols, and any additional protocols agreed to by both parties.
11. Provide YYYY with payment of leased facility within the YYYY site.

XXXX will provide these services at the YYYY facility at _____. For those patients without insurance and/or income, a fee will be charged based on XXXX's sliding fee scale, which is updated each year in accordance with the annual guidelines issued by the Federal Government.

YYYY is a private, non-profit corporation that provides a continuum of community- based treatment, rehabilitation, and support services to adults with psychiatric or developmental disabilities, drug and alcohol addictions and/or impacted by homelessness in _____ _____

YYYY:

YYYY will enter into discussion with XXXX to:

1. Develop with XXXX a highly coordinated provision of Primary and Behavioral Health Care with the goal of integrating the XXXX medical services within the YYYY service delivery model.
2. To develop in concert with XXXX disease management programs that target chronic illnesses (e.g., diabetes, cardiovascular disease, chronic obstructive pulmonary disease, etc.) and that help individuals acquire the skills they need to more effectively manage these health conditions.
3. Promote a focus on physical health as a key component of recovery.
4. As appropriate and based on client choice, refer program participants with or without insurance coverage to XXXX for medical services.
5. Complete a medical assistance application on all eligible participants.
6. Encourage all YYYY participants to keep medical appointments.
7. Collaborate with XXXX for marketing and promoting of services.
8. Lease appropriate facility space to XXXX for the performance of its functions.

The memorandum of understanding is intended to be effective for one hundred and twenty (120) days and may be extended upon the mutual agreement of the Parties, in writing. However, in no event shall this memorandum of understanding be extended beyond one hundred and twenty (120) days from the date hereof. Thereafter, this memorandum of understanding and negotiations shall end and terminate or the Parties shall enter into a definitive agreement with respect to the proposed transaction.

This letter sets forth the terms of our preliminary discussions but it is not intended to be a binding or enforceable agreement. The parties contemplate that they will become legally bound only if, as and when a definitive legal agreement is executed and delivered by the parties relating to the Transaction.

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CONTACTS
The following persons will serve as designated coordinators for the program:

XXXX YYYY

HIPAA

In accordance with the Health Insurance Portability and Accountability Act of 1996, P. L. 104-191 ("HIPAA") and the rules and regulations implemented thereunder, the parties are acting as "Covered Entities" contracting for the provision of patient care services. Accordingly the parties agree to comply with all federal, state and local laws and regulations, including without limitation HIPAA, regarding the confidentiality of patient or protected health information ("PHI"). Without limitation to other rights and remedies under this Agreement or afforded by law, either party may immediately terminate this Agreement in the event that it has determined that there is a material breach with this provision. The parties further agree to execute additional mutually agreed upon documents as required under HIPAA rules and regulations to assure the safeguarding of PHI. In the event such documentation is not agreed upon and executed, either party may terminate this Agreement with fifteen (15) days written notice.

IN WITNESS WHEREOF, this Agreement has been executed by each party's duly authorized representative in multiple originals.

YYYY By: _____

XXXX By: _____

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).

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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 polices, 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.

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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: **xxxxxxxxxx**
xxxxxxxxxx
xxxxxxxxxx

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 Date	* Date
Executive Director	Title:

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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 **XXXXXXXXX**

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 (*PHYSICIAN RESPONSE NOW*)

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 **XXXXXXXX.** 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

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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

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(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 XXXXXXXXXX. 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.

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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.

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.

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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 (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 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.

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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. <u>Data Collection, Records and Reports</u>

9.1. <u>Monthly Client Count Report</u>

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.

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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.

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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 contact 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.

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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:

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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 11/1/07or 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.

NOTE: Much of the rest of this agreement uses the same language as the Agreement for Adults on the preceeding pages, so has not been replicated here.

COOPERATIVE AGREEMENT

This Cooperative Agreement (the "Agreement") is made _____, 201_, (the "Effective Date") by and between **DELAWARE VALLEY COMMUNITY HEALTH, INC.**, ("DVCH"), a Pennsylvania non-profit corporation and **HORIZON HOUSE, INC.,** ("Horizon House"), a Pennsylvania non-profit corporation. DVCH and Horizon House are referred to herein individually as a "Party" and collectively as the "Parties".

WITNESSETH:

WHEREAS, DVCH is enrolled in Medicare as a Federally Qualified Health Center ("FQHC") as that term is defined §1861(aa) of the Social Security Act; and

WHEREAS, DVCH provides primary health care services, including preventative health care services (the "Services"), as required by Section 330 of the Public Health Services Act ("PHSA"), 42 U.S.C. § 254b, to the underserved, underinsured, uninsured, and Medicare and Medicaid populations in Philadelphia and other Philadelphia suburban counties; and

WHEREAS, Horizon House is a Pennsylvania licensed mental health treatment provider that provides a continuum of community- based behavioral health treatment, rehabilitation, and support services to adults with psychiatric or developmental disabilities, drug and alcohol addictions and/or persons impacted by homelessness who reside in Philadelphia; and

WHEREAS, Horizon House's primary offices are located at 120 South 30th Street, Philadelphia 19104 (the "Premises"); and

WHEREAS, DVCH and Horizon House recognize the need for and desire to provide integrated preventive, primary and behavioral health services to adults with psychiatric or developmental disabilities, drug and alcohol addictions and/or persons impacted by homelessness who reside in Philadelphia and currently receive services from Horizon House; and

WHEREAS, DVCH and Horizon House collectively share the goal of enhancing the quality of health care services for medically underserved populations who, as research demonstrates, experience significant morbidity and mortality disparities. DVCH and Horizon House believe that through their collective and collaborative efforts they can provide integrated primary and behavioral health care services to behavioral health consumers and thereby help to effectively reduce these disparities and achieve enhanced patient/consumer outcomes. Specifically, Horizon House and DVCH believe this goal can best be achieved by establishing a medical home with DVCH at the Premises for Horizon House patients/consumers; and

WHEREAS, DVCH also agrees to provide preventative and primary health care services to employees of Horizon House at the Premises, as well as to former Horizon House

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patients/consumers who enroll in DVCH's services but subsequently terminate Horizon House services.

NOW, THEREFORE, in consideration of the mutual promises and agreements contained herein, the Parties hereto, intending to be legally bound hereby, agree as follows:

1. Coordination of Care and Service Delivery. DVCH and Horizon House agree to work cooperatively to mutually develop a coordinated health care delivery service, including a process for consumer intake, screening and referral between the Parties, with the goal of integrating both primary care and behavioral health care services for Horizon House's patients/consumers at the Premises. The Parties further agree to mutually develop disease management programs and protocols that target chronic mental, substance use and physical diseases, including (without limitation) diabetes, cardiovascular disease and chronic obstructive pulmonary disease, to more effectively manage chronic health conditions. Said programs and protocols will be consistent with nationally accepted and recognized standards as required for the Parties to maintain their respective licensure, Medicare and Medicaid provider participation, accreditation standards and any applicable federal or state laws, rules or regulations.

a. Obligations of DVCH. Throughout the term of this Agreement and for any renewal term thereafter, DVCH agrees to:

(i) Seek and then maintain the appropriate and necessary funding and approvals as defined and required under Section 330 of the PHSA to add and maintain the Premises as an FQHC site;

(ii) Maintain its Medicare certification as a FQHC and adhere to all Medicare Conditions of Coverage as described 42 C.F.R. § 491 *et seq*.

(iii) Be responsible for the overall clinical direction and evaluation of the professional Services provided on the Premises. DVCH shall ensure that all Services are provided in accordance with applicable standards of care and in accordance with all applicable federal and state laws and regulations. DVCH shall be solely liable for all Services rendered under this Agreement.

(iv) Provide qualified professionals duly licensed or certified under Pennsylvania law and appropriately credentialed to render preventive, initial and ongoing comprehensive primary health care services, including physical evaluations, diagnostic services, management of chronic diseases, referrals for specialty care, health advocacy and health education and other like services to meet the needs of any patient/consumer referred by Horizon House. The Parties anticipate that initially said professional shall be a mid-level practitioner employee or independent contractor of DVCH who shall function under the supervision or through collaboration with a medical physician or doctor of osteopathy duly licensed under Pennsylvania law and in accordance with Pennsylvania State Board of Medicine or State Board of Osteopathy requirements. This supervising or collaborating physician shall be an employee or independent contractor of DVCH and have entered into a written collaborative agreement or supervising agreement with the DVCH mid-level practitioner thereby allowing the mid-level

practitioner to prescribe and dispense drugs in accordance with applicable Pennsylvania law. Notwithstanding anything to the contrary, the prescription of psychotropic medications for any Horizon House patient/consumer shall be considered to be outside the scope of the Services to be provided by any DVCH professional and no DVCH professional shall prescribe psychotropic medications for any Horizon House patient/consumer.

(v) Provide such staff (medical assistants or clerical staff) as is reasonably necessary for DVCH's timely and efficient provision of Services to patients/consumers who present for treatment at the Premises.

(vi) Make services available in the approved Scope of Project equally available to all patients regardless of ability to pay. For those patients without insurance and/or income, a fee will be charged based on DVCH's sliding fee scale, which is updated each year in accordance with the annual poverty level guidelines issued by the Federal Government.

(vi) Provide access to the full complement of services in DVCH's approved Scope of Project either directly or through formal, established arrangements.

(viii) Refer Horizon House patients/consumers, as appropriate, to its Fairmont Primary Care Center for OB/GYN, dental and podiatry services.

(ix) Provide DVCH staff on the Premises as described above on a schedule mutually agreed upon by the Parties and consistent with Horizon House's hours of operations. In addition, DVCH shall provide "on call" Services for patients during such times as the Premises is closed.

(x) Through its Board of Directors and management, establish and maintain operational and clinical policies related to the provision of preventive and primary care Services; maintain all necessary administrative functions, including, but not limited to, scheduling and registration of patients receiving preventive and primary care and patient records.

(xi) Be responsible for the billing and collection of the fees for all professional services performed by the DVCH and DVCH shall adhere to all applicable Medicare, Medicaid or other third party billing requirements. Horizon House shall at no time charge or bill any party for the Services rendered by DVCH.

(xii) During the term of this Agreement and for any renewal term thereafter, enter into and maintain a lease agreement for the Premises with Horizon House on such terms as mutually agreed upon by the Parties. For the purposes of the lease, the leased Premises (Leased Premises) shall be located at 120 South 30th Street, 2nd floor, Philadelphia 19104. A space plan for the Leased Premises is attached hereto.

(xiii) Provide orientation and training to DVCH staff on any issues reasonably considered relevant to this Agreement.

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(xiv) As reasonably requested by Horizon House, provide physical health consultation to Horizon House staff regarding mutual patients/consumers.

(xv) Engage in joint planning with Horizon House to establish mutually agreed upon strategic priorities and to continually improve access to care, quality of care, and relationships between DVCH and Horizon House staff.

(xvi) On an annual basis, provide Horizon House with a report that summarizes the yearly health outcomes of the patients served by DVCH at the Premises based on DVCH Medical Protocols, and any additional protocols agreed to by both Parties.

(xvii) Collaborate with Horizon House on research regarding service quality and outcomes.

(xviii) Engage in joint fund raising with Horizon House to further mutually agreed upon goals supporting the integration of physical and behavioral healthcare services.

b. Obligations of Horizon House. Throughout the term of this Agreement and any renewal term thereafter, Horizon House agrees to:

(i) Develop appropriate protocols to identify patients/consumers who would benefit from referral to DVCH for Services as a component of their recovery and to promote their physical health and well being, and refer those patients/consumers, subject to their full and informed choice and consent, to DVCH.

(ii) Be responsible for the overall clinical direction and evaluation of behavioral health services provided by Horizon House. Horizon House shall ensure that all behavioral health services are provided in accordance with applicable standards of care and in accordance with all applicable federal and state laws and regulations. Horizon House shall be solely liable for all behavioral health services rendered by Horizon House under this Agreement.

(iii) Provide qualified professionals duly licensed under Pennsylvania law and appropriately credentialed to render behavioral health care, substance use services and social services to Horizon House patients/consumers.

(iv) Maintain all applicable licenses, certifications and Medicare or Medicaid enrollment necessary to provide behavioral health care, substance abuse services and social services to Horizon House patients/consumers.

(v) Complete a Medical Assistance application for all eligible Horizon House patients/consumers.

(vi) Be responsible for the billing and collection of the fees for all professional services performed by Horizon House and Horizon House shall adhere to all applicable Medicare, Medicaid or other third party billing requirements. Horizon House shall at no time charge or bill any party for the Services rendered by DVCH.

(vii) Through its Board of Directors and management, establish and maintain operational and clinical policies related to the provision of behavioral health services provided by Horizon House; maintain all necessary administrative functions, including, but not limited to, scheduling and registration of patients receiving services from Horizon House and patient records.

(viii) Provide education and orientation to Horizon House staff relevant to the purposes and goals of the collaboration with DVCH as well as relevant policies, procedures and documentation mutually developed by the Parties in support of Horizon House patient/consumer access to DVCH Services.

(ix) Provide education and training to DVCH staff as reasonably requested by DVCH relevant to this Agreement.

(x) During the term of this Agreement and for any renewal term thereafter, enter into and maintain a lease agreement for the Premises with DVCH on such terms as mutually agreed upon by the Parties.

(xi) Collaborate with DVCH on community programs and education regarding the integrated physical and behavioral health delivery approach to recovery.

(xii) Collaborate with DVCH to market and promote the Services.

(xiii) As reasonably requested by DVCH, provide behavioral health consultation to DVCH staff regarding mutual patients/consumers.

2. DVCH Staff Placement. DVCH acknowledges that Horizon House has a duty to take due steps to protect its patients/consumers, visitors, and employees from sexual harassment and other types of disruptive, abusive, or unlawful conduct. If an allegation is made that a DVCH employee or contractor has engaged in sexual harassment, patient abuse, or other disruptive, abusive, or unlawful conduct which, in the reasonable opinion of Horizon House, has injured or places a patient/consumer, visitor or employee at risk of imminent jeopardy of their health, safety or welfare, Horizon House may request of DVCH that said employee or contractor be removed from the Premises and a suitable alternative replacement be provided.

3. Compliance.

a. Sanctioned Person. Each Party represents to the other that neither it nor any of its agents, employees, or contractors, has ever been excluded, debarred, suspended or otherwise ineligible to participate in any state or federal program (including Medicare or Medicaid); has not been convicted of any criminal offense related to the delivery of health care services under any state or federal program; and a Sanctioned Person. As used herein a "Sanctioned Person" means a person or entity who: (A) has been convicted of: (1) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal and Child Health Services Program or the Block Grants to States for Social Services Program),

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respectively; (2) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service; (3) fraud, theft, embezzlement, or other financial misconduct in connection with the delivery of a health care item or service; (4) obstructing an investigation of any crime referred to in subsections (b)(A) (1) through (3) above; or (5) unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or (B) has been required to pay any civil monetary penalty under Section 1128A of the Social Security Act, regarding false, fraudulent, or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or federal health care program, or is currently the subject of any proceeding which may result in such payment; or (C) has been excluded from participation in the Medicare, Medicaid, or Maternal and Child Health Services (Title V) Program, or any program funded under the Block Grants to States for Social Services (Title XX) Program. Each Party agrees to promptly notify the other of the occurrence of any of the foregoing events.

b. Anti-Kickback Statute. The Anti-Kickback Statute makes it a felony for an individual or entity to knowingly and willfully offer or pay or to solicit or receive remuneration in order to induce business reimbursed by a federal health care program. (42 U.S.C. §1320a-7b (b)(1) and (2)). The Parties intend that this Agreement and the lease agreement for the Premises comply with the "Health Center" Safe Harbor (42 C.F.R. §1001.952(w)) under the federal Anti-Kickback Statute as is currently in effect or as it may be modified during the term of this Agreement or any renewal term hereunder.

c. Non-Exclusivity; No Compensation for Referrals. Neither Party is under any obligation to refer patients/consumers to the other for services under this Agreement. Nothing in this Agreement is to be construed to create an exclusive arrangement between the Parties and neither Party is restricted from entering into other agreements for similar services as described in this Agreement unless such arrangement conflicts with the terms of this Agreement or substantially interferes with the Party's obligations hereunder. It is not the purpose, nor is it a requirement of this Agreement or of any other agreement between the Parties to offer or receive any remuneration or inducement to encourage the referral of any patient. Any payment or other form of consideration exchanged between the Parties herein will be for identifiable services that have intrinsic value and are legitimately needed and intended to be fully utilized, payment for which will be consistent with the fair market value of the services provided, and not determined in a manner that takes into account the volume or value of any referrals between the Parties or business otherwise generated between the Parties for which payment may be made under any government payor program. The services covered by this Agreement in aggregation with any other services purchased between the Parties during the same time period will not exceed the total of services legitimately needed by each from the other in the absence of any referrals of healthcare business between them.

d. Consumer/Patient Freedom of Choice**.** The Parties acknowledge and recognize as paramount to this Agreement, that all patients/consumers eligible for Services under this Agreement are entitled to obtain health services from any institution, agency, or person of their choice other than Horizon House and DVCH and nothing contained herein is intended to interfere with a consumer/patients freedom of choice in the selection of a provider.

4. Health Care Information and Medical Records.

a. Ownership of Medical Records. All medical and financial records created by DVCH which pertain to patients treated by DVCH as of the Effective Date, including but not limited to charts, x-rays, medical reports, fees, records of billings and payment of fees, shall remain and be at all times the property of DVCH. All medical and financial records created by Horizon House which pertain to patients treated by Horizon House as of the Effective Date, including but not limited to charts, x-rays, medical reports, fees, records of billings and payment of fees, shall remain and be at all times the property of Horizon House.

b. HIPAA. Each Party shall maintain medical records to document the services performed in such a form, containing such information and meeting all record-keeping requirements established by applicable law, licensing, reimbursement programs and accrediting agencies. Each Party agrees that each patient's medical records will be treated in accordance with all state and federal laws, rules, and regulations regarding their confidentiality, and with due regard to ethical considerations. Without limiting the generality of the foregoing, each Party acknowledges that it separately functions as a Covered Entity as that term is defined pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and set forth at 45 C.F.R. Parts 160 and 164, and its implementing regulations ("HIPAA Privacy Standards" and "HIPAA Security Standards") as amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") and its implementing regulations and acknowledges the duty to ensure that their respective medical record systems and/or computer information system and related internal policies and procedures must be compliant with all applicable security and privacy requirements under final regulations promulgated pursuant to the Administrative Simplification provisions of HIPAA and similar federal or state standard transaction, privacy and security requirements, such that billing, record keeping, and other patient data requirements function accurately, without interruption and in full compliance with applicable federal and state law. Each Party represents and warrants that all necessary and appropriate measures have been undertaken or will be taken to insure HIPAA compliance. The Parties agree to provide satisfactory assurances of compliance with HIPAA including the provisions governing the use of, access to and release of protected health information ("PHI") in accordance with HIPAA.

c. Report of Breach. The Parties acknowledge that as separate and distinct HIPAA Covered Entities, each retains certain PHI and data breach reporting obligations to patients/consumers and the Department of Health and Human Services as more fully described under the HITECH Act. The Parties agree to use their best efforts to work cooperatively with each other in complying with the HITECH Act and any applicable law currently in effect or which becomes effective during the term of this Agreement which governs breach notification to those individuals who require notice under applicable law.

d. Pennsylvania Mental Health and Substance Abuse Confidentiality Requirements. The records of Horizon House are separately protected as confidential under federal and Pennsylvania state laws governing Mental Health Services and Substance Abuse

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Services pursuant to 42 C.F.R. Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records); 55 Pa. Code § 5100.31-39 (Confidentiality of mental health records) 55 Pa. Code §5100.37 (Records relating to drug and alcohol abuse or dependence). The Parties agree to comply with the requirements of these federal and state laws and to develop, as necessary, such policies and procedures for the coordination of care and the provision of services under this Agreement.

5. Term and Termination; Term. This Agreement shall be for 1 year commencing on the Effective Date, unless earlier terminated in accordance with the provisions of this Section. Thereafter, this Agreement shall automatically renew for subsequent one-year periods.

a. Termination by Agreement. In the event the Parties shall mutually agree in writing, this Agreement may be terminated on the terms and dates stipulated therein.

b. Termination Without Cause. Either Party may terminate this Agreement upon ninety (90) days prior written notice to the other.

c. Termination for Cause. Either Party may terminate this Agreement immediately, under any of the following circumstances:

(i) Breach of the terms of this Agreement, which breach is material and not corrected to the satisfaction of the non-breaching Party within thirty (30) days after written notice thereof;

(ii) If a Party becomes a "Sanctioned Provider," as described herein;

(iii) Either Party's insolvency/bankruptcy;

(iv) Failure to enter into or renew the lease for the Premises;

(v) Loss by a Party of its Medicare, Medicaid participation or license to operate and provide services in the Commonwealth of Pennsylvania;

(vi) Failure to obtain and maintain professional liability insurance coverage.

d. Termination for Breach. Upon material breach by either Party of its obligations or representations under this Agreement, the non-breaching Party may terminate the Agreement if the breach remains uncured to the reasonable satisfaction of the non-breaching Party for more than thirty (30) days after the non-breaching Party gives written notice of such breach.

e. Termination for Regulatory Compliance. In the event that this Agreement or any part of this Agreement is deemed to be contrary to local, state or federal law by counsel for either Party or, in the opinion of such counsel, presents substantial legal risk to either party, the Parties agree to use their best efforts to make changes to this Agreement to the minimum

extent necessary to make this Agreement consistent with applicable laws, and to try to retain as closely as possible the original terms reflected in this Agreement. If this Agreement cannot be modified or amended in a way that is mutually agreeable to the Parties and to comply with applicable law after the Parties have used their best efforts, then either party may terminate this Agreement upon written notice to the other party.

6. Insurance; Indemnification.

a. The Parties shall each obtain and maintain, at their own cost and expense: (i) professional liability insurance coverage in a form and amounts sufficient to meet the requirements of Pennsylvania law in effect from time to time, and (ii) general liability insurance and such other insurance, including but not limited to workers' compensation insurance, in a form and amounts as are reasonable and appropriate. Horizon House shall obtain and maintain, at its own cost and expense premises liability insurance, in a form and amounts as are reasonable and appropriate. Upon request, the Parties shall provide each other with evidence of such insurance coverage and shall notify each other immediately of receipt of notice of any change in or cancellation of such coverage.

b. DVCH shall indemnify and hold harmless Horizon House, including but not limited to, its parent companies, appointed boards, officers, employees, agents and subagents, against all liability and costs, including reasonable attorney's fees, arising out of the negligent acts or omissions of DVCH or their agents with respect to the provision of its services pursuant to this Agreement.

c. Horizon House shall indemnify and hold harmless DVCH, including, but not limited to, its parent companies, appointed boards, officers, employees, agents and subagents, against all liability and costs, including reasonable attorney's fees, arising out of the negligent acts or omissions of Horizon House or their agents with respect to the provision of its services pursuant to this Agreement.

7. Confidential Information. In the course of performance of this Agreement, the Parties may acquire valuable proprietary data and other confidential information with respect to the other's activities, including but not limited to: business and financial methods and practices, pricing and marketing techniques, file or database materials, computer programs, lists of patients, patient record cards, patient files, data on suppliers, and similar information relating to current or future affiliates (collectively, "Confidential Information"). The Parties agree to keep confidential and not use or disclose to others except as expressly agreed in writing or as required by law, any Confidential Information the use or disclosure of which might reasonably be construed to be contrary to the best interests of the Parties. Each Party agrees that irreparable injury will result to the other from the violation or breach of this Section of this Agreement and it would be difficult to measure the damage to the non-breaching party from any disclosure of any Confidential Information described in this Section would be impossible to calculate, and that money damages would therefore be an inadequate remedy for any such breach. Accordingly, the Parties agree that in the event of a breach or act in a manner contrary to this Section 7 the Parties shall be entitled, in addition to all other remedies it may have at law or in equity, to injunctions or other

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appropriate orders to restrain any such breach without showing or proving any actual damage. For purposes of this Section 7 only, the Parties consent to the jurisdiction of the Court of Common Pleas for Philadelphia County, Pennsylvania and the United States District Court for the Eastern District of Pennsylvania.

8. Dispute Resolution. In the event any legal controversy, dispute, disagreement or claim of any kind between the Parties arising out of or relating to this Agreement, other than as described in Section 7 above, the Parties agree to exercise their best efforts to resolve the dispute as soon as possible. The Parties shall, without delay, continue to perform their respective obligations under this Agreement that are not affected by the dispute. In the event that the Parties cannot amicably resolve a dispute, disagreement, or legal controversy, the Parties consent to settlement of the legal controversy, dispute or disagreement through binding arbitration. Any arbitration shall be conducted in accordance with the American Health Lawyers Association ("AHLA") Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The award rendered by the arbitrator(s) shall be final judgment of the award and shall be entered in accordance with a court of competent jurisdiction. The issue of whether a party's claim shall be subject to arbitration under this Section shall be decided through the AHLA arbitration process. The Parties agree to divide the arbitration expenses equally.

9. No Discrimination. Each Party agrees that, in the performance of this Agreement, services will be provided without discrimination toward any patients, employees, or other persons regardless of their race, creed, color or ethnic background. DVCH shall provide Services to patients/consumers of Horizon House regardless of their ability to pay. Both Parties are equal opportunity employers. Both Parties shall comply with all requirements and provisions of the Civil Rights Act of 1964, 42 U.S.C.A. 2000 et seq. and of the Pennsylvania Human Relations Act.

10. Independent Contractor Status. It is expressly acknowledged by the Parties that the relationship created between the Parties by this Agreement is that of independent contractors and nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship, a joint venture relationship, a partnership, or similar relationship between the Parties.

11. Authority to Bind. The Parties shall not be permitted or authorized to make any disbursements, to make any purchases or to incur any liabilities on behalf of each other or to otherwise obligate the other party in any manner whatsoever, except as permitted in this Agreement.

12. General Provisions.

a. Assignment. The Parties shall not assign, sell or transfer this Agreement, its obligations hereunder or any interest herein without the prior written consent of the other.

b. Governing Law. This Agreement shall be interpreted and construed according to, and governed by, the laws of the Commonwealth of Pennsylvania.

c. Severability. If any term or provision of this Agreement or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Agreement or the application of such term or provision to persons or circumstances other than those which are held invalid or unenforceable shall not be affected thereby.

d. Captions. Captions contained in this Agreement are inserted only as a matter of convenience and in no way define, limit or extend the scope or intent of this Agreement or any provision hereof.

e. Gender. Any noun or pronoun used in this Agreement shall be construed in masculine, feminine or neuter as its sense and use may require.

f. Waivers and Amendments. No waiver of any term, provision or condition of this Agreement, whether by conduct or otherwise, in any one or more instances, shall be deemed to be or construed as a further and continuing waiver of any such term, provision or condition of this Agreement. No amendment to any provision of this Agreement shall be effective unless in writing and signed by each Party.

g. Notices. Except as otherwise provided in Section 8.3.2, all notices, requests, demands or other communications authorized or required to be given by any party pursuant to this Agreement shall be given in writing and either (a) delivered personally; (b) sent by overnight express delivery (for which written confirmation of delivery can be obtained from the carrier); or (c) sent by registered or certified U.S. mail, return receipt requested to the following addresses:

If to DVCH:

If to Horizon House:

The Parties shall be responsible for notifying each other promptly in writing of any changes of address.

h. Access to Books and Records. To the extent required by Section 1861(v)(1)(I) of the Social Security Act and until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, PARTIES shall make available upon written request of the Secretary of Health and Human Services or the United States Comptroller General or any of their duly authorized representatives, this Agreement, and any books, documents and records of PARTIES that are necessary to certify the nature and extent of costs incurred by the Parties under this Agreement.

i. Binding Agreement. All of the terms and provisions of this Agreement shall be binding upon, inure to the benefit of and be enforceable by each of the Parties hereto, their respective legal representatives and their permitted successors and assigns.

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j. Further Assurances. The Parties agree to execute such other documents as may be required to implement the terms and provisions and fulfill the intent of this Agreement.

k. Integrated Agreement. This Agreement constitutes the entire understanding and agreement between the Parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the Parties concerning the subject matter hereof.

l. Severability. If any term or provision of this Agreement or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Agreement or the application of such term or provision to persons or circumstances other than those to which it is held invalid or unenforceable shall not be affected thereby, and each term and provision of the Agreement shall be valid and enforceable to the fullest extent permitted by law

m. Section Headings. The section headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

n. Further Assurances. The Parties agree to execute such other documents as may be required to implement the terms and provisions and fulfill the intent of this Agreement.

IN WITNESS WHEREOF, and intending to be legally bound hereby, the Parties hereto have executed this Agreement on the date first written above.

Delaware Valley Community Health, Inc.

By: _____

Title: President and CEO

Horizon House, Inc.

By: _____

Title: President and CEO

EXHIBIT "A"
SCHEDULE OF SERVICES
SIERRA FAMILY MEDICAL CLINIC, INC.

This Agreement is entered into by and between the County of Nevada, Behavioral Health Department, herein referred to as "County", and Sierra Family Medical Clinic, Inc., herein referred to as "Contractor" for 1) the provision of case management and outreach and engagement services, and 2) to provide the services of a Licensed Clinical Social Worker to residents of the North San Juan Ridge Area as a component of the County's MHSA Community Supports and Services (CSS) Plan.

Project Overview:

Sierra Family Medical Clinic (SFMC) provides medical and psychological services to individuals living in the North San Juan Ridge Region. Within the County's MHSA CSS Plan, the North San Juan Ridge was identified as an area that due to its geographic location, distance from other service providers, and high poverty level as being underserved. The Mental Health Services Act seeks to expand and enhance services to address a broad continuum of prevention, early intervention, innovative treatment services that will improve outcomes and access to services for individuals that are dealing with mental health issues. A primary objective of services under this Agreement is to provide case management services, expand outreach and engagement; and to include one day per week of services by a Licensed Clinical Social Worker to increase access to healthcare-behavioral/mental health services for low income patients. At present, the County does not have a specialized mental health service site in the North San Juan Ridge Area and partners with Sierra Family Medical Clinic to increase mental health services for reaching this un-served, under-served segment of the County's population.

The Contractor's responsibilities shall include:

Case management and Outreach/Engagement

- Providing a qualified individual an average of four (4) hours per week of services that will encompass case management and outreach and engagement activities.
- Contractor shall provide services either by phone or as available by face-to-face contact.
- Contractor will facilitate linkage to formal and informal supports and connection to appropriate providers to address clients' mental health needs and various life needs such as:
    - Housing: assist clients in locating and maintaining appropriate housing, identify and pursue resources related to housing opportunities that are available,
    - Domestic violence,
    - Disability Process,

Contractor approves this page

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- Employment: assists with locating employment resources in the community through linkage and partnerships. Assists clients with appropriate referrals needed for developing job skills for the careers they choose to explore,
- Counseling: assist in locating appropriate and securing therapeutic counseling services such as individual or group counseling to address mental health needs,
- Education: identifying and locating local resources that can provide education on a broad range of mental health issues,
- Contractor shall foster positive relationships with community partners and county agencies to promote increasing access to services and identifying and serving unmet needs of community members. Contractor shall seek to engage clients to participate and link to appropriate treatment options, or rehabilitative services that are available within the County that can help persons achieve their individual goals.

Licensed Clinical Social Worker Services:

- Program shall continue to add one (1) clinical day per week of services by a Licensed Clinical Social Worker in order to increase access to behavioral/mental health services. Contractor currently has and funds a LCSW available for four (4) days a week. With funds available under this Agreement, a Licensed Clinical Social Worker shall be available five (5) days per week.
- The target population to be served is low income residents of the North San Juan Ridge. This population will receive care regardless of age, gender, race/ethnicity, and language.
- The Contractor shall perform universal screening for mental health disorders with every patient screened at least once yearly for depression, anxiety, substance use, bipolar disorder and/or ADHD as appropriate.
- Contractor shall provide fully integrated behavioral health services through referrals to onsite therapists; and provide access to a consulting psychiatrist through telemedicine (through a pilot program made available to SFMC from the University of California, Davis).
- Contractor shall utilize a "warm handoff" process. The patient shall be introduced to appropriate care providers for further care.

Anticipated Goals and Objectives:

- With a troubled economy there is an increase in the number of behavioral health patients requiring care. The cost of services at private practitioners has become prohibitive, and there is a lack of professionals who accept government insurance programs. This program will increase availability and access for mental health services for 60 low income individuals..

- Performance of universal screening for mental health disorders at least once a year, will increase identification of mental health issues and in turn improve access for appropriate services.
- Provision of fully integrated behavioral health services
- Decreased wait time for patients
- Continue to offer sliding scale fees as well as full access for Medi-Cal, Medicare, and CMSP patients.
- Decrease the load at the Nevada County Behavioral Health Department and Sierra Nevada Memorial Hospital Emergency Room by reducing the need for emergency services by those with mental illness.

Measurable Outcomes:

- Outcomes are measured through statistical analysis of records maintained and documented by SFMC.
- Improved overall health of the served population by expanding the behavioral health component of treatment available with focus on early intervention, which is crucial to maintaining mental health stability and mitigating other conditions that may result in poor patient outcomes.
- Reduced anxiety levels for patients by decreasing the "stigma" of mental health issues by having this care provided in a "primary care" medical setting.
- Decreased reliance on emergency services by Nevada County Behavioral Health Crisis Staff and at Sierra Nevada Memorial Hospital Emergency Room by increased stabilization of patients with mental illness and a decrease in the incidence of drug overdose.

Additionally, Contractor shall be responsible for providing:

1. Quarterly Progress Reports within 30 days of the end of each quarter;
2. An Annual Progress Report within 30 days of the end of the fiscal year;
3. Any MHSA Progress or Evaluation Report that is required, and as may be requested by the County. The Contractor shall cooperate with the County for compilation of any data or information for services rendered under this Agreement as may be necessary for the County to conform to MHSA CSS reporting guidelines.

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Alameda County Integrated Behavioral Health Program Primary Care Pay for Performance Criteria - Draft • Page 1

(courtesy of Lifelong Medical Center, Alameda County)

Overview

Central to the Advancing Integrated Mental Health Solutions (AIMS) model of effective behavioral health interventions in primary care are: an integrated team approach, use of appropriately sized behavioral health patient registry "careloads"[1] to support and guide ongoing care management, and attention to changes in patient assessment scores as guides to whether interventions are working or need to be modified. Since the registries, in the AIMS model, are for the purpose of intensive care management process and outcome tracking, they are comprised of an active careload limited to about 65 patients per behavioral health professional. The behavioral health professional actively follows and provides evidenced-based treatment interventions for this active careload group. The model assumes that, in addition to this careload, the behavioral health professionals are available for brief consultations with patients referred by their primary care physicians. In addition to the behavioral health professional, the team approach requires support from other key staff members that includes management of tasks such as keeping registry data updated, managing appointments, follow-up phone calls, and other integrated care tasks. The recommended ratio of 1.0 FTE behavioral health professional for every 65 active patients does not necessarily apply to the staffing levels needed for these other support tasks which can be divided among clinic staff in a variety of ways.

Category 1 payments (behavioral health staffing funds) are based upon a commitment from the clinics to accomplish multiple specified tasks in the future that are foundational to the establishment and use of patient registries for care management. Payments are made monthly and generally remain the same assuming each clinic is making reasonable progress with the tasks.

Categories 2 – 6 Pay for Performance (P4P) payments are based upon measurable achievements of specific tasks in the previous quarter per behavioral health patient careload. Each careload must be linked with a specific behavioral health professional responsible for coordinating implementation of integrated care tasks for that particular group of patients. Consequently, a clinic with multiple such careloads may earn payments at different levels within the same quarter, and may find their payments for each of these careloads changing up or down in subsequent quarters according to their performance. Category #6 payments are based in part on achievement of specific types of measurable patient outcomes.

The performance criteria for Categories #2 – #6 are as follows:

Category #2 - $ X payment per behavioral health patient careload quarterly

- Attend the 8-hour AIMS training on primary care team integration of behavioral health services. At least one representative of every type of key clinic staff from each participating clinic site should attend. Key clinic staff members include a primary care provider, behavioral health professional, a consulting psychiatrist, and key administrative and support staff. One individual from this team will need to be identified as the team facilitator that will be responsible for completing the integrated care tasks plan for the given clinic in collaboration with other key team members Those primary care physicians and consulting psychiatrists unable to attend should participate in appropriate 1-2 hour webinarson this topic.
- Identify the behavioral health professional who will be primarily responsible for managing the particular careload of patients with behavioral health conditions for ongoing care management. This identified professional must be one of the types of professionals identified as a HealthPAC primary care behavioral health provider.

  Identify the behavioral health careload target population and the behavioral health conditions and assessment tools that will be utilized in the care management approach. BHCS expects clinic organizations to at least utilize the PHQ-9 assessment tool for depression symptoms, and they may add other tools for other specific symptom clusters such as the GAD-7 for anxiety symptoms as desired.
- Complete a behavioral health patient careload plan for a given clinic that identifies the clinic staff members responsible for certain integrated behavioral health care management tasks and the data/tracking tools

1 The term "careloads" is used here to replace the term "caseloads" in order to remove reference to people as "cases."

that will be utilized to manage the careload of patients with pre-specified types of behavioral health conditions.

- Install and begin implementation of behavioral health-specific patient careload registries for ongoing care management. Demonstrate the implementation by including in the last monthly invoice for a given quarter the following information for at least 10 target population patients who have been enrolled in the panel: Client Name/SS#/DOB or other comparable patient identification information that can be utilized to match with BHCS client data, Baseline Assessment Tool Score(s) and # and types of contacts/services the client received in the most recent quarter.

Category #3 - $XX payment per behavioral health patient registry quarterly

- Meet the Category #2 Criteria for at least 30 patients per behavioral health patient registry careload for ongoing care management and
- Administer the Assessment Tool at least once subsequent to the baseline administration per quarter for at least 20 of the patients and
- Include the scores for all administrations of the Assessment Tool per patient with their associated dates
- Lead behavioral health professionals complete one or more evidenced-based clinical trainings of at least 8 hours duration relevant to the ongoing care management of the integrated behavioral health target population.

Category #4 - $XXX payment per behavioral health patient registry quarterly

- Meet the Category #3 Criteria for care management of at least 45 patients per behavioral health patient registry careload and for the same patients indicate that at least 50%:
  - Received two or more contacts per month (phone, group, or individual)
  - Received a psychiatric consultation as documented by a brief note (this does not need to involve a face-to-face visit with a psychiatrist but a documented consultative review of the client's situation is required)
  - Had a documented note in their registry regarding the status of their use of psychotropic medications (i.e. whether or not they are taking any medications, the dose, frequency, and whether the client is following the prescribed regimen.)

Category #5 - $XXXX payment per behavioral health patient registry quarterly

- Meet the Category #4 Criteria for ongoing care management of at least 65 patients per behavioral health patient registry careload.

Category #6 - $XXXXX payment per behavioral health patient registry quarterly

- Meet Category #5 Pay for Performance Criteria for at least 65 patients per behavioral health patient registry careload and also indicate that:
  - At least 35% of those enrolled in the registry careload for at least 10 weeks that had both a baseline and follow-up assessment score, had their assessment score drop by at least five points
  - At least 75% of the clients in the registry careload have a documented note in their record regarding the status of their use of psychotropic medications (i.e., whether or not they are taking any medications, the dose, frequency, and whether the client is following the prescribed regimen).

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MEMORANDUM OF UNDERSTANDING
Between BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH and
NORTHERN VALLEY INDIAN HEALTH 2012/2013

This Memorandum of Understanding (MOU) is entered into by and between the County of Butte (County), a political subdivision of the State of California, through its Butte County Department of Behavioral Health (DBH), and Northern Valley Indian Health (NORTHERN VALLEY INDIAN HEALTH). This MOU shall set forth the types and terms of collaborative services between DBH and NORTHERN VALLEY INDIAN HEALTH in relation to mutual clients served by DBH and NORTHERN VALLEY INDIAN HEALTH.

I. PURPOSE:
DBH and NORTHERN VALLEY INDIAN HEALTH enter this MOU for the following purposes:

A. Promote, enhance and increase communication and collaboration between DBH and NORTHERN VALLEY INDIAN HEALTH
B. Create a timely, efficient fast track for needed services between mutually served clients of DBH and NORTHERN VALLEY INDIAN HEALTH
C. Promote and enhance engagement of clients by streamlining intake processes
D. Provide more timely and efficient access to screenings/assessments of clients in need
E. Make available to both DBH and NORTHERN VALLEY INDIAN HEALTH important client information obtained through the referral and assessment process
F. Provide timely and convenient access to a DBH eligibility worker at Children's Health Center for uninsured NORTHERN VALLEY INDIAN HEALTH clients

II. TARGET POPULATION: The primary target population will be youth clients of NORTHERN VALLEY INDIAN HEALTH in need of mental health services.

III. SERVICES TO BE PROVIDED:

A. DUTIES AND RESPONSIBILITIES OF DBH:

1. DBH will co-locate a DBH staff at Children's Health Center, 277 Cohasset Road, Chico, for eight (8) hours per month. The primary function of this staff person will be to provide mental health screenings/assessments to any/all NORTHERN VALLEY INDIAN HEALTH clients identified as Medi-Cal clients living in the Chico area. DBH staff will arrange for additional specialty mental health services by DBH as indicated and/or needed, including referrals to community resources; and will facilitate return of clients who are stable following specialty mental health services to primary care.

2. The co-located DBH staff will serve as liaison between NORTHERN VALLEY INDIAN HEALTH and county operated specialty mental health programs of Chico Counseling Center. The goal of liaison work is to facilitate timely and efficient referrals between the two agencies.

3. Clients who call the DBH ACCESS line and are living in the Chico area will be asked if they have a primary care provider.

a. If their primary care provider is NORTHERN VALLEY INDIAN HEALTH, they will be referred to Children's Health Center for a behavioral health screening with DBH.
b. If they do not have a primary care provider, they will be provided the option of a screening appointment at a DBH facility.

B. DUTIES AND RESPONSIBILITIES OF NVIH

1. NORTHERN VALLEY INDIAN HEALTH shall provide a room one day per month for the DBH staff.

2. Both parties agree to cooperate in providing information and documents required by regulatory agencies either party may be accountable for in a timely manner.

IV. TERM: The term of this MOU shall become effective upon date of execution and terminate no later than June 30, 2013.

V. COMPENSATION:

This MOU is non-financial in nature and binds no party to financial obligations to any other.

VI. CONFIDENTIALITY:

A. NORTHERN VALLEY INDIAN HEALTH shall maintain the confidentiality of all County records and information, including, but not limited to, claims, County records, patient/client records and information, and I/S records to the extent required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 (Public Law 111-5, Title XIII); Welfare and Institutions (W&I) Code Sections 5328 through 5330, inclusive; W&I Code Section 14100.2; Title 42 CFR Section 431.300 et seq; and 42 CFR Part 2, including any subsequent amendments thereto, and all other applicable County, State, and Federal laws, ordinances, rules, regulations, manuals, guidelines, and directives, relating to privacy/security, whichever is most restrictive. NORTHERN VALLEY INDIAN HEALTH shall require all its officers, employees, and agents providing services hereunder to acknowledge, in writing, understanding of, and agreement to fully comply with, all such confidentiality provisions.

Notification of Breach: During the term of the MOU, NORTHERN VALLEY INDIAN HEALTH shall notify DBH within two (2) business days of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of DBH data in violation of any applicable federal or state laws or regulations. NORTHERN VALLEY INDIAN HEALTH shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

B. DBH shall maintain the confidentiality of all NORTHERN VALLEY INDIAN HEALTH records and information, including, but not limited to, claims, records, patient/client records and information, and I/S records to the extent required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 (Public Law 111-5, Title XIII); Welfare and Institutions (W&I) Code Sections 5328 through 5330, inclusive; W&I Code Section 14100.2; Title 42 CFR Section 431.300 et seq; and 42 CFR Part 2,

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including any subsequent amendments thereto, and all other applicable County, State, and Federal laws, ordinances, rules, regulations, manuals, guidelines, and directives, relating to privacy/security, whichever is most restrictive. DBH shall require all its officers, employees, and agents providing services hereunder to acknowledge, in writing, understanding of, and agreement to fully comply with, all such confidentiality provisions.

Notification of Breach: During the term of the MOU, DBH shall notify NORTHERN VALLEY INDIAN HEALTH within two (2) business days of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of NORTHERN VALLEY INDIAN HEALTH data in violation of any applicable federal or state laws or regulations. DBH shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

VII. MUTUAL HOLD HARMLESS: It is agreed that NORTHERN VALLEY INDIAN HEALTH shall defend, save harmless and indemnify County, its officers and employees from any and all claims for injuries or damage to persons and/or property which arise out of the terms and conditions of this MOU and which result from the negligent acts or omissions of NORTHERN VALLEY INDIAN HEALTH , its officers and/or employees.

It is further agreed that County shall defend, save harmless and indemnify NORTHERN VALLEY INDIAN HEALTH, its officers and employees from any and all claims for injuries or damage to persons and/or property which arise out of the terms and conditions of this MOU and which result from the negligent acts or omissions of County, its officers and/or employees.

In the event of concurrent negligence of NORTHERN VALLEY INDIAN HEALTH, its officers and/or employees, and County, its officers and/or employees then the liability for any and all claims for injuries or damages to persons and/or property which arise out of the terms and conditions of this MOU shall be apportioned under principles of comparative negligence as established presently by California law, or as may be hereafter modified.

VIII. INSURANCE:

A. Without limiting NORTHERN VALLEY INDIAN HEALTH indemnification, NORTHERN VALLEY INDIAN HEALTH shall procure and maintain for the duration of this MOU, insurance against claims for injuries to persons or damages to property that may arise from, or be in connection with the performance of the work hereunder by NORTHERN VALLEY INDIAN HEALTH , and NORTHERN VALLEY INDIAN HEALTH agents, representatives, employees, and subcontractors. At the very least, NORTHERN VALLEY INDIAN HEALTH shall maintain the insurance coverage, limits of coverage and other insurance requirements as described in Attachment I, which by reference is made part of this MOU. Certificates evidencing the maintenance of NORTHERN VALLEY INDIAN HEALTH'S insurance coverage shall be filed with DBH.

B. The County of Butte self-insures third party liability claims alleging bodily injury, personal injury, property damage, or public officials' errors and omissions. The County self insures losses up to $100,000 per occurrence. Losses exceeding $100,000 are covered by an excess insurance purchased through the County Supervisors Association of California-Excess Insurance Author-

ity (CSAC-EIA). The excess policy provides coverage for losses up to 20 million dollars, which the County is legally required to pay because of liability imposed by law or assumed by contract. A recent actuarial evaluation performed by Bickmore Risk Services found the County's self-insurance reserves to be adequately funded.

IX. ALTERATION OF TERMS: The body of this MOU fully expresses all understandings of the parties concerning all matters covered and shall constitute the total MOU. No addition to, or alteration of, the terms of this MOU whether by written or verbal understanding of the parties, their officers, agents or employees shall be valid unless made in the form of a written amendment to this MOU which is formally approved and executed by all parties.

X. NOTICES:

All notices, claims, correspondence, reports and/or statements authorized or required by this MOU shall be addressed as follows:

DBH **xxxxxxxxxx**
Assistant Director, Clinical Services

NORTHERN VALLEY INDIAN HEALTH
xxxxxxxxxx
Medical Director, Northern Valley Indian Health

XI. DISPUTE RESOLUTION:

Any disagreements that may occur shall be resolved at the lowest possible level within the two agencies and with a cooperative spirit. DBH and NORTHERN VALLEY INDIAN HEALTH will designate individuals who are responsible to resolve issues in a timely fashion regarding this MOU. Should agreement not be reached between the agencies after working through the process already prescribed, then the matter should go for discussion and consideration between the Directors of each agency.

XII. APPLICABLE LAW AND FORUM: This MOU shall be construed and interpreted according to California law and any action to enforce the terms of this MOU for the breach thereof shall be brought and tried in the County of Butte.

XIII. TERMINATION:

DBH and NORTHERN VALLEY INDIAN HEALTH each reserve the right to immediately terminate this MOU, notifying each other likewise.

XIV. This MOU with Attachment I represents the entire undertaking between the parties.

IN WITNESS WHEREOF, the parties hereto have executed this MOU as of the day and year first above written.

(signatures, dates and titles)

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MEMORANDUM OF UNDERSTANDING BETWEEN LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH SUBSTANCE ABUSE PREVENTION AND CONTROL AND LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

INTERDEPARTMENTAL AGREEMENT

PURPOSE

The purpose of this MOU is to formalize clinical, programmatic, and fiscal agreements between the County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control (SAPC) and the Department of Mental Health (DMH) in order to best support high quality, integrated treatment for County residents with co-occurring mental health and substance abuse disorders.

DEFINITIONS

1. COD Clients: Clients with co-occurring substance abuse and mental health disorders.
2. COD (MH) Mental Health Clients: COD clients who receive service support from DMH.
3. COD (SA) Addiction Disorder/Substance Abuse Clients: COD clients who receive service support from SAPC.
4. COD (MH, SA) Clients: COD clients who receive service support from both SAPC and DMH.
5. SAPC site: Program operated by SAPC.
6. MH site: Program operated by DMH.
7. SAPC/MH site: Program jointly funded by SAPC and DMH.

SCOPE

This MOU pertains to adults and youth with co-occurring mental illness and substance abuse problems (COD) who have been appropriately determined to require services (See programmatic agreements: Identification of COD service recipients in DMH funded programs (COD[MH]), in SAPC funded programs (COD[SA]), or in programs funded by both agencies (COD[MH, SA]).

GUIDING PRINCIPLES

Co-morbidity is an expectation, not an exception (for both systems).

Both mental illness and substance dependence are examples of primary illnesses that can be understood using a disease and recovery model, with parallel phases of recovery, each requiring phase-specific treatment.

When mental health and substance abuse problems co-exist, each can be considered primary, and coordinated/integrated dual primary treatment should be recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.

The term "coordinated/integrated" services should refer to the approach for persons with co-occurring problems as "one team with one plan for one person for recovery" involving "all necessary services and support delivered by a single service team that has all the needed skill sets to develop and follow one client-directed plan that focuses on recovery and the individual's goals and strengths."

Program planning for coordinated and integrated services should be conducted using consumer data from both systems, particularly for those persons served by both systems.

Services should be age-specific and culturally and linguistically appropriate. Services should consider educational level/comprehension, emotional/physical development and social skills/style. The role of family/caregivers in service delivery should also be considered.

CLINICAL AGREEMENTS

1. SAPC and DMH shall jointly develop clinical practices parameters for integrated COD treatment to which all clinical programs in both agencies shall adhere.

2. Clinical leadership from both agencies shall meet on a regular basis to review clinical issues and to update COD parameters, best practices, and competencies, and other associated clinical policies and training needs.

PROGRAMMATIC AGREEMENTS

Evaluation of individuals with COD:

1. COD (SA) clients who are referred to DMH with specified documentation will be evaluated for mental health problems that would change their status to COD (MH) or COD (MH, SA).

2. COD (MH) clients who are referred to SAPC with specified documentation will be evaluated for substance abuse problems that would change their status to COD (SA) or COD (MH, SA).

Identification of COD service recipients:

1. COD (MH) clients with active cases are identified solely by DMH.
2. COD (SA) clients with active cases are identified solely by SAPC.
3. COD (MH, SA) clients with active cases are identified jointly by DMH and SAPC.

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Determination of treatment site(s) for clients with COD (MH, SA):

1. COD (MH, SA) clients with either severe mental illness (SMI) (as defined in statute) or who are Medi-Cal beneficiaries and meet mental health Medi-Cal medical necessity criteria should be treated in MH sites or SAPC /MH sites.

2. COD (MH, SA) clients with severe SA (requires substance abuse treatment services not routinely available in MH sites) should be treated in ADPA sites or ADPA/MH sites.

3. COD (MH, SA) clients who require residential treatment should be treated in sites that best manage the problem responsible for the need for a residential treatment setting.

Determination of treatment necessity and treatment services for clients with COD (MH, SA):

1. Determination of necessity and type of mental health treatment delivery on-site at SAPC programs for COD (MH, SA) clients is made solely by DMH on the bases of clearly defined criteria related to treatment needs.

2. Determination of necessity and type of substance abuse treatment delivery on-site at DMH programs for COD (MH, SA) clients is made solely by SAPC on the bases of clearly defined criteria related to treatment needs.

FISCAL AGREEMENTS

Funding of services at integrated treatment sites:

1. COD (MH, SA) clients who are determined to need MH treatment at integrated sites are funded by DMH within clearly defined programmatic and fiscal parameters that compose a specified benefits package.

2. COD (MH, SA) clients who are determined to need SA treatment at integrated sites are funded by SAPC within clearly defined programmatic and fiscal parameters that compose a specified benefits package.

3. A specified benefits package includes descriptions of service intensity, duration, limits, formulary, and monitoring requirements.

4. Availability of specified benefit packages to SAPC/DMH programs requires program adherence to DMH and ADPA standards and requirements.

5. Medication costs should be born by the program that reimburses the prescribing services.

ADDITIONAL AGREEMENTS

1. Each agency will notify the other agency whenever it admits or discharges a COD (MH, SA) client.

2. Each agency will share individual clinical information with providers from the other agency delivering field services to COD (MH, SA) clients at its programs.

3. Receipt of DMH services shall not in and of itself be reason for refusal of SA services at SAPC programs.

4. Receipt of SAPC services shall not in and of itself be reason for refusal of DMH services at DMH programs.

5. SAPC programs shall not refuse admission to DMH clients or discharge DMH clients from treatment solely on the basis of use of DMH prescribed medications.

6. System-wide clinical information sharing, for the purposes of service provision, program planning and fiscal control, should be facilitated by both agencies to the greatest extent permissible by current statutes and technology.

7. This agreement will be effective from February 2, 2010. The agreement will be jointly reviewed on an annual basis and adjusted as needed to reflect programmatic changes that may occur over time.

IN WITNESS HEREOF, the parties hereto have executed this Agreement as of this 2nd day of February, 2010.

Los Angeles County Department of Mental Health

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Memorandum of Understanding

This agreement is entered into by and between _____, (hereafter referred to as _____) and the _____, a federally qualified health center (hereafter referred to as FQHC), and is executed pursuant to the terms and conditions set forth herein. In consideration of those mutual undertakings and covenants, the parties agree as follows:

I. PURPOSE

This Memorandum of Understanding ("MOU") is entered into by _____ and the FQHC in order that, the _____ may provide increased substance abuse services to certain individuals who reside in _____ county, are designated as a medically underserved population, and are in need of the services provided by our joint agencies. The parties agree to the division of responsibilities as outlined in Sections IV, V, VI, and VII.

II. AUTHORITY

The _____ enters into this MOU pursuant to the authority found in _____ bylaws and articles of incorporation. The FQHC enters into this MOU pursuant to the authority found in FQHC bylaws and articles of incorporation.

III. TERM OF AGREEMENT

This MOU shall become effective [date] and shall remain in effect through [date].

IV. RESPONSIBILITIES OF THE_____

The _____ shall have the following responsibilities:

a) The _____ shall provide substance abuse recovery ("services") to the following target populations:
   - Individuals re-entering the community from state and county correctional facilities.
   - Veterans and their family members.
   - Prescription drug abusers.
   - Homeless.
   - Individuals with co-occurring substance use and mental disorders.
   - Medically underserved populations

b) The service shall be paid for through _____ and provided by the _____ (service provider).

c) The services available through vouchers shall be the following:

- Screening / Assessment
- Intervention
- Treatment
- Treatment Planning
- Substance Abuse Education – Group
- Substance Abuse Education – Individual & Family
- Outpatient Treatment-Group
- Outpatient Treatment– Individual
- Intensive Outpatient Treatment
- Day/Night Treatment
- Family/Marriage Counseling
- Methadone and Maintenance Treatment
- Co-Occurring Treatment Services
- Co-Occurring Medication Evaluation
- Parenting/Child Development – Group
- Parenting/Child Development – Individual/Family
- Case Management
- Family Support/Parenting
- Continuing Care
- Alcohol/Drug Screening
- Recovery Coaching
- Transportation
- Transitional Care/ Residential Treatment Level 4
- Transitional Living Facility
- Supportive Housing / Living Services
- Support Groups
- Support Counseling
- Employment Coaching
- TASC
- Day Care
- Incidental Expenses
- Recovery Support Services Coordination
- E-Counseling
- Detoxification – Outpatient
- Life Skills Training
- Medication Assisted Treatment – Vivitrol

d) The _____ shall ensure that all services provided are culturally sensitive services to the greatest extent possible.

e) The _____ shall be responsible for training all FQHC staff in the policies and procedures of the Florida Substance Abuse program with special emphasis on each of the following:
   - Client eligibility
   - Client choice
   - Referral procedure
   - Intake procedure
   - Outcome measures
   - Non-supplantation policy

f) The _____ shall be responsible for providing any report or information required by State SAMH program office/SAMHSA/CSAT concerning Services Provided.

V. RESPONSIBILITIES OF THE FQHC:

The FQHC shall have the following referral policies:

a) Scope of work
   1. The FQHC shall refer medically underserved individuals to _____ who are in need of the above services provided by _____.
   2. Services shall be provided for medically underserved individuals who reside in one of the following counties: _____
   3. FQHC shall allow _____ assessors and care coordinators to co-locate in a satellite office in order to facilitate referral to _____.

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4. Referred medically underserved individuals shall meet all of the following qualifications:
   1) reside in _____.
   2) have a history of substance abuse.
   3) have voluntarily expressed a willingness to participate in services.

b) Administrative and funding terms, requirements and limitations

1. The FQHC acknowledges and agrees that no funds will be paid to the FQHC for the purpose of performing the work related to this agreement as outlined in the preceding scope of work.

VI. MUTUAL RESPONSIBILITIES

Each party shall cooperate with the other party and meet with the other party as necessary to further the objectives of this memorandum.

Each party agrees to meet regularly and to provide any information or documentation necessary to fulfill the responsibilities of _____ or FQHC under this memorandum.

VII. SECURITY AND PRIVACY OF HEALTH INFORMATION

Through this MOU the parties wish to acknowledge their mutual obligations arising under laws and regulations of the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy Regulations effective April 14, 2003, and Security Regulations effective on April 20, 2005; and (2) Confidentiality of Alcohol and Drug Abuse Patient Records (CADAPR). 45 CFR 164. 42 CFR 2.

The _____ agrees to comply with all requirements of HIPAA and CADAPR in all activities related to the MOU, to maintain compliance throughout the life of the MOU, to operate any systems used to fulfill the requirements of this MOU in full compliance with HIPAA and CADAPR and to take no action which adversely affects FQHC's compliance with either Federal statute.

To the extent required by the provisions of HIPAA and regulations promulgated hereunder, the _____ assures that it will appropriately safeguard Protected Health Information (PHI), as defined by the regulations, which is made available to or obtained by the _____ in the course of its work under the MOU. For the purposes of this MOU the term PHI shall include the protections under both 45 CFR 164 and 42 CFR 2. The _____ agrees to comply with all applicable requirements of law relating to PHI with respect to any task or other activity it performs under this MOU, including the following:

- Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that the _____ receives, maintains, or transmits on behalf of the FQHC;
- Not using or further disclosing PHI other than as permitted or required by this MOU or by applicable law;

- Using appropriate safeguards to prevent use or disclosure of PHI other than as provided by this MOU or by applicable law;
- Mitigating, to the extent practicable, any harmful effect that is known to the _____;
- Ensuring that any sub-contractors or agents to whom the _____ provides PHI received from the FQHC agree to the same restrictions, conditions, and obligations applicable to such party regarding PHI and agrees to implement reasonable and appropriate safeguards to protect it;
- Making available the information required to provide an accounting of disclosures pursuant to applicable law;
- At the termination of the MOU the protections in this agreement shall continue to be extended to any PHI maintained by the _____ for as long as it is maintained.

The parties agree that all terms in this section of the MOU not otherwise defined shall be defined by reference to the same terms in the HIPAA in its implementing regulations.

VIII. MODIFICATION

This memorandum may be modified at any time by a written modification, upon mutual agreement by both agencies.

IX. EFFECTIVE DATE

This memorandum of understanding is effective on the date that both signatories have executed this document.

The parties, having read and understood the terms of this memorandum do, by their respective signatures below, hereby agree to the terms and conditions thereof.

X. NON-COLLUSION AND ACCEPTANCE

The undersigned attests, subject to the penalties for perjury, that he/she is the agreeing party, or that he/she is the representative, agent, member or officer of the agreeing party, that he/she has not, nor has any other member, employee, representative, agent or officer of the division, firm, company, corporation or partnership representative by him/her, directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid, any sum of money or other consideration for the execution of this agreement other than that which appears upon the face of the agreement.

XI. SIGNATURES

In Witness Whereof, _____ and _____ FQHC have, through dually authorized representatives entered into this agreement. The parties having read and understand the foregoing terms of the Agreement do by their respective signatures dated below hereby agree to the terms thereof.

_____ FQHC, Inc. _____ _____
Chief Executive Officer Date

Agency Name _____

Director_____ Date:_____

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Draft Memorandum of Understanding

I. Purpose:

The purpose of the WV SBIRT is to reduce the statewide substance misuse by expanding and enhancing the existing continuum of substance abuse delivery system in West Virginia through the integration of screening, brief intervention, brief treatment and referrals into the primary care and other healthcare settings.

II. Screening Process:

To this end, agrees to partner with _____to incorporate alcohol/ drug screening for all patients using prescreening questions supplied by the SBIRT Project. If a patient screens positive, the patient will be referred to the SBIRT staff, preferably before the patient leaves the medical facility. The SBIRT staff will administer the "Alcohol, Smoking, and Substance Involvement Screening Test" (ASSIST) which will be utilized to determine the level of care needed by the patient. With proper consent, the patient will receive the appropriate level of care, i.e. brief intervention or brief treatment; or a referral for behavioral health care will be made.

III. SBIRT Project Commitment (Bureau of Behavioral Health and Health Facilities):

A. The State of West Virginia is the applicant organization for the WV SBIRT project and assumes fiscal and managerial responsibility for the funding.

B. Project leadership will be accomplished by the Bureau for Behavioral Health and Health Facilities, employing the Clinical Project Director, who works as a team member with key representatives from Behavioral Health who will partner with Primary Care and other medical entities.

III. Behavioral Healthcare Administration agrees to the following:

A. Will recruit and hire staff to perform brief interventions and brief treatment for those who screen positive for substance abuse involvement. A "positive" screen will be followed by the administration of the ASSIST instrument and a recommendation for a level of intervention will be made.

B. The Behavioral Healthcare staff will communicate back to the Primary Care Center the nature of the patient's substance involvement and will document accordingly in the medical record of such. The Behavioral Healthcare staff will maintain all confidentiality pertaining to all medical Information received while engaged with the primary care clinic. This confidentiality will extend after engagement with the medical facility is ended.

C. The BHC staff will notify the medical facility of any patients who are a danger to themselves or others and how may need to be evaluated for emergency evaluation under state law.

D. The Behavioral Healthcare staff will participate in any staff meeting or trainings that the PCC feel are necessary for effective involvement with patients of the medical facility.

E. The Behavioral Healthcare staff will be under supervision of a competent, qualified supervisor while seeing patients at the medical facility.

F. The Behavioral Health Care Provider will provide consultation and training as needed to the participating partner (s) regarding conducting screenings, how to motivate patients to engage in the process and other clinical "best practices".

G. The Administration and representatives of the Primary Care Center will be held harmless of any Liability insurance at BHC level.

IV. The Administration and staff of the medical facility agrees to the following:

A. Screenings will be administered in a private, confidential location.

B. All positive screenings will be reviewed by the attending physician who will impress on the patient,
the importance of follow-up with SBIRT staff.

C. The medical/office staff at the medical facility will assure that all patients receive a screening.
D. The medical facility will assure that the SBIRT Staff have a space in which to conduct brief interventions or brief treatment.

E. Office Staff of medical facility will monitor that all patients are screened.

F. A system for avoiding duplicate screenings will be developed conjointly.

_____	_____
Behavioral Health Center Administrator	Date
_____	_____
SBIRT Clinical Director	Date
_____	_____
Primary Care CEO	Date

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MEMORANDUM OF UNDERSTANDING BETWEEN LONE STAR CIRCLE OF CARE AND BLUEBONNET TRAILS COMMUNITY MHMR CENTER

This Memorandum of Understanding ("MOU") for the provision of psychiatric and behavioral health services is made and entered into effective (_____date) by and between Lone Star Circle of Care ("LSCC") and Bluebonnet Trails Community MHMR Center d/b/a/ Bluebonnet Trails Community Services ("Bluebonnet"). Each of LSCC and Bluebonnet are referred to herein as a "Party" and, collectively, the "Parties".

Recitals

WHEREAS, LSCC is committed to the energetic and steadfast pursuit of quality, accessible and sustainable primary healthcare for central Texas residents, focusing on the uninsured and underserved;

WHEREAS, Bluebonnet strives to ensure the provision of accessible, efficient and effective services supporting the dignity and independence of those they serve; and

WHEREAS, the Parties endeavor to increase access to quality behavioral health and medical care in Williamson County, Texas'

NOW THEREFORE, in consideration of the mutual covenants, representations, warranties and agreements contained herein, the receipt and sufficiency of which is hereby acknowledged, LSCC and Bluebonnet agree as follows:

1. Obligations of LSCC. LSCC agrees to:

   a. Provide behavioral health and medical heathcare services to children and adolescent clients transitioning out of Blue Bonnet's care. Specifically, LSCC shall:

      ii. Provide an initial evaluation of the behavioral health needs of the children and adolescents referred from Bluebonnet; and

      iii. Attain appropriate authorizations for treatment from the client's payor source.

   b. Provide on-going behavioral health and medical care, where appropriate, and provide treatment for children and adolescents referred from Bluebonnet consistent with the policies and procedures set forth by LSCC.

   c. Complete and maintain patient medical records and other documentation required by the client's payor as well as LSCC policies and procedures.

   d. Bill Medicaid and other payors for routine medical and behavioral health services provided to Medicaid-eligible and other third party payor-eligible children and adolescents. In the event a client's payor denies the claim, LSCC will have no financial recourse against Bluebonnet to recover such expenses.

e. Provide any and all insurance or other liability coverage necessary to protect LSCC from all applicable risks and hold Bluebonnet harmless from and against any and all claims arising out of LSCC's provision of medical or psychiatric services under this MOU.

2. Obligations of Bluebonnet. Bluebonnet agrees to:

   a. Initiate referrals to LSCC for children and adolescents ready to leave Bluebonnet care.

   b. Initiate referrals to LSCC for children and adolescents currently receiving rehabilitative services and case management services through Bluebonnet for whom psychiatric or counseling services are medically necessary.

   c. Provide any and all requested clinical, demographic, and payor information to LSCC to assure the client's smooth transition into LSCC care.

   d. Consider the uncompensated to Medicaid ratio when allocating child and adolescent referrals, understanding that LSCC's resources are overly burdened if the uncompensated to Medicaid ration is higher than 1:3.

   e. Provide any and all insurance coverage necessary to protect Bluebonnet from all applicable risks and hold LSCC harmless from and against any and all claims arising out of Bluebonnet's provision of services.

3. Obligations of LSCC and Bluebonnet. Both Parties agree to:

   a. Adhere to the Business Associate Agreement and incorporated by reference herein.

   b. Comply fully with the terms of the Anti-Kickback statute [42 U.S.C. 1320a-7b(b)]. The Parties acknowledge that their officers and directors are familiar with the terms of the Anti-Kickback statute and intend that the terms and conditions of this MOU comply fully with the terms of the Anti-Kickback statute. To the extent any term or condition of this MOU is deemed by legal counsel for either Party to not comply with the Anti-Kickback statute, then the remainder of this MOU shall be unaffected thereby and in lieu of such term or condition there shall be added as a party of this MOU a term or condition similar to such non-compliant term or condition as similar to such non-compliant term or provision as may be possible and be compliant with the Anti-Kickback statutes.

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MEMORANDUM OF UNDERSTANDING – THE CENTER FOR COMMUNITY HEALTH

This Memorandum of Understanding ("MOU") details an agreement by and between the following parties:

DEPARTMENT OF HEALTH SERVICES
(hereafter referred to as "DHS");

and

DEPARTMENT OF MENTAL HEALTH SERVICES
(hereafter referred to as "DMH");

and

DEPARTMENT OF PUBLIC HEALTH
(hereafter referred to as "DPH");

and

JWCH INSTITUTE, INC.
(hereafter referred to as "JWCH").

I. PURPOSE

This MOU will create a public-private partnership of critically needed health and mental health services in the Skid Row area of Los Angeles. The MOU seeks to better integrate services by providing improved services at the remodeled Leavey Center Building located at 512 – 522 South San Pedro Street, Los Angeles, California 90013. The building will house both private agencies and County departments (i.e., those parties as listed hereinabove) to operate and conduct a clinic known as the Center for Community Health ("Center"). The Center will operate as an Organized Health Care Arrangement ("OHCA") and provide an integrated service delivery model to effectively serve the medical and behavioral, including mental health, needs of homeless and other indigent patients. The integrated service approach will help to eliminate service duplication, maximize resources, and expand current services.

The OHCA will be comprised of various multidisciplinary teams to provide a "medical home" for each client that will be responsible for coordinating the client's care and navigation through the health care system. Services offered at the Center include primary care, mental health services, substance abuse assessment services, dental services, HIV services, tuberculosis ("TB") screening and treatment, Sexually Transmitted Disease ("STD") diagnostic services and treatment, Hepatitis "C" diagnostic services and treatment, podiatry

care, optometry services, case management, and benefits establishment assistance. Referrals will be made for other services on an as-needed basis.

Center's Service Protocol

As part of the design of the Center, the primary care physician shall have the responsibility to provide medical care and to make referrals for ancillary care and services as needed. The Center has established protocols to refer patients to ancillary services at the Center, such as mental health/psychiatry, substance abuse assessment, TB, EIC HIV, clinical, pharmacy, podiatry, chronic condition case manager, dental and others.

The Center's protocols also address access to additional specialty services not provided at the Center such as medical detoxification, emergency/9-1-1 procedurals, and inpatient hospitalization (including mental health). Consistent processes will be implemented for accessing ancillary services such as dispensary, laboratory, and radiology at the Center.

Center's Policies and Procedures

The Center Policies and Procedures consist of six (6) categories as follows: Administrative Reception; Administrative Discharge; Clinical Administrative Processes; Clinical Processes; Human Resources; and, Organizational/Facility Management. The Policies and Procedures will serve to govern day-to-day processes and operations of the Center and its collaborative partners and their staff. In addition, as an OHCA, the Center has Polices and Procedures specific to the operation of the OHCA. A Service Oversight Group for integrated management of the facility and patient issues (clinical and administrative) has been established; the Oversight Group includes clearly outlined mandates for participation requirements and oversight responsibility. Training and communication plans for all staff on relevant Policies and Procedures are available to ensure understanding and compliance with the Center's Policies and Procedures and any OHCA Policies and Procedures.

The Center's Policies and Procedures and any OHCA Policies and Procedures are not intended to replace or modify County or County departmental policies. Center staff shall adhere to all policies and procedures that are applicable to their position.

Center's Outcome Measurement Process

Each of the participating parties to this MOU will cooperate with, and participate in, evaluation activities that gauge such factors as: the status of integration, patient management and outcomes, quality improvement; and patient satisfaction. Collective performance goals and measures of the OHCA are anticipated to ensure that the results of the integrated model can be documented and findings can be acted upon to ensure quality of care, efficiency and

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effectiveness of the Center and its partner organizations. JWCH will take the lead and coordinate these evaluation activities.

II. GENERAL RESPONSIBILITIES OF THE PARTIES

1. **JWCH: Is a licensed Federally Qualified Health Center ("FQHC") in accordance with Section 330 of the Public Services Act (42 USCS § 2546) and is the lead organization on site at the Center and will provide the following services:**

   A. Manage the day-to-day operations and implementation of the OHCA integrated services delivery model. To this end, JWCH will coordinate with County Departments to implement the integrated services protocols, organize orientation and training on integrated services systems, and measure and evaluate outcomes.

   B. Intake, assessment, eligibility screening, primary care services, clinic nursing services, dental services, radiology, electrocardiograms ("EKG"), family planning and other reproductive health services, cancer screening, male wellness, HIV testing, HIV prevention and support services.

   C. Manage the on-site laboratory and on-site dispensary/pharmacy.

   D. General case management services.

   E. Case management for persons living with HIV/AIDS.

   F. Coordinate with area community providers including social service and housing providers for the referral of patients.

   G. On-going facility maintenance and any immediate facility related need, including scheduling of the clinic space usage.

   H. The parties agree that JWCH is not authorized to incur any costs on behalf of the County without prior written approval.

2. **DHS: Is a County department that will provide the following services:**

   A. HIV/AIDS confirmatory testing, HIV/AIDS outpatient medical care, referral to sub-specialty services at Los Angeles County + University of Southern California ("LAC+USC") healthcare Network to treat and manage opportunistic infection, referral to DMH for mental health services, and medical case management.

B. As part of the continuing efforts to improve adherence to specialty care appointments, DHS will seek to expedite access to appointment slots for urgent and semi - urgent referral requests (as defined in the Leavey Center Integrated Services Protocols) for chronically homeless Leavey clients. This will be accomplished by providing appointment dates to the requested specialty care clinic within one week from receipt of the request whenever possible. Due to high demand for DHS specialty care services, available appointment slots are prioritized for the highest acuity patients.

3. **DMH: Is a County department that will provide the following services:**

A. Co-occurring mental health screening, assessment, treatment, and medication support.

B. Case management services, and substance abuse screening in coordination with physical healthcare staff as part of an integrated physical and behavioral health team approach to consumer care.

C. Benefit establishment assistance, emergency shelter and permanent housing assistance, and linkage to other supportive services as indicated (including more intensive mental health services such as Full Service Partnerships, or clinic-based outpatient services, and professionally operated or Client Run Wellness Center programming).

4. **DPH: Is a County department that will provide through its Community Health Services ("CHS"), the following services:**

A. Two (2) TB medical clinic sessions on site per week from 8:00 a.m. through 11:30 a.m. (Monday and Thursday). Two (2) sessions per week will be maintained for access purposes. However, DPH reserves the option to reduce the clinic sessions to once per week based on patient need.

B. Radiology services and direct observed therapy (a.k.a., "DOT") for TB medications at Center and/or in the field. This is a daily or bi-weekly service, depending on the clinically determined DOT.

The schedule of services described above under Subparagraph "A" and "B", hereinabove, will be sustained as written pending any changes in communicable disease morbidity in the Center's service area. A further decrease in demand for TB services will result in the reduction of TB clinic sessions to one (1) per week.

DPH, through its Alcohol and Drug Program Administration ("ADPA"), will provide the following services:

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C. Assessment and referral services to be provided by one staff from an ADPA-contracted provider, Homeless Health Care Los Angeles (HHCLA). HHCLA services will include substance abuse assessment, intake, and referral; linkages with public and private social and health service providers; referrals to substance abuse residential or non-residential treatment services or other ancillary services, such as domestic violence and anger management resources.

III. GENERAL TERMS

1. This MOU shall be effective upon the signature date below through June 30, 2010, and shall be thereafter automatically renewed annually without further action by the parties for one (1) year periods. In any event, either party can terminate this MOU and their responsibilities under this MOU, without cause, within thirty (30) calendar days notice to the other parties.

2. The parties agree that there will be no remuneration between any of the parties for any services provided by any party under this MOU.

3. The parties agree that this MOU may be modified or amended upon all parties' written consent.

4. The parties agree to use their best efforts to resolve any conflicts that may arise related to this MOU. Should unresolved conflict occur between the staff regarding case activity, recommendations or outcome, the situation should then be discussed and addressed by the designated Program Managers and/or referred to the level of the designated District/Division Chiefs of each County Department. If there is no resolution at this level, then all parties will follow each Department's chain of command.

5. This MOU is intended to define the working relationships among the Center participants. It is not intended to modify, alter, or replace any separate agreements among the parties, including but not limited to JWCH Institute's Public Private Partnership Agreement with County or JWCH's space use agreement.

6. Each party will appoint a person to serve as the official contact to individually coordinate the responsibilities of their respective party under this MOU. The following persons, identified by position title, have been designated as the responsible parties for all communications related to this MOU:

PARTNERSHIP AGREEMENT BETWEEN
AGENCY 1 AND AGENCY 2

This agreement is made and entered into as of the _____day of _____, 2___ by and between Agency 1 (AGENCY 1) and Agency 2 (AGENCY 2).

WHEREAS, AGENCY 1 and AGENCY 2 intend by this agreement to set forth the terms and conditions of engaging in a process of merging both organizations into a single organization; and

WHEREAS, the both Boards of Directors have voted to merge; and

WHEREAS, the two organizations will be sharing the same health care facility as of _____; and

WHEREAS, patients of _____ will benefit from merging of the organizations;

NOW, THEREFORE, in consideration of the covenants, conditions and stipulations expressed in this document and in consideration of the mutual benefits to be derived for the consumers, patients and community, the parties agree as follows:

Article 1: Mutual Goals and Objectives

While the full integration of the two organizations may take 18-24 months the parties have agreed that Phase 1 will include Governance and Administrative Integration and Phase 2 will include Clinical and Service Integration. Clinical/Service Integration Initiatives that could result in immediate improvements, cost savings and/or reimbursement increases will be implemented in Phase 1. Specific action steps for these goals and objectives are included in the Administrative and Governance work plans.

1. By (Insert Date) (Phase 1 – Administrative/Governance Integration) AGENCY 1 and AGENCY 2 will have completed the necessary steps to create a single organization, to be known as _____. Specific objectives for (Insert Date) include, but are not limited to, the;

    - Creation of a new governance structure that is acceptable to the creating entities, meets State of _____ non-profit organization laws and meets the requirements of the Bureau of Primary Health Care/FQHC guidelines;
    - Creation of a new Corporation _____ Creation of new/revised bylaws for the new corporation;
    - Creation of consistent Human Resources policies and procedures for the merging of staff into one organization;
    - Completion of all due diligence steps

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- Notify all funding partners of the changes and insure continued funding from BPHC and (Insert State Name) Health Department
- Determine who the Executive Director
- Align the administrative/support staff (HR, IT Finance, etc)
- Prescriber billing processes
- Building reception

4. By (Insert Date) (Phase 2 – Clinical Service Integration) AGENCY 1 and AGENCY 2 will have completed a plan (benefit design) for the integration of all direct service delivery that has the potential to create a "value added" benefit for consumers. This process will include, but not be limited to:
    - An evaluation of the specialty mental health services to be provided to the priority populations under the (Insert State Name) Department of Health by the new corporation, in accordance with known evidence based practice and consumer and family demand'
    - An evaluation of the degree and amount of behavioral health services to be provided to non-priority behavioral health patients of the new corporation.
    - A process for insuring that all patients have access to a range of medical and behavioral health services that meet their needs.

ARTICLE 2: TARGET POPULATION

By law, AGENCY 2 must serve anyone who requests medical services from the Health Center. By law, AGENCY 1 must provide specialty mental health services to priority populations. In some situations, these populations will overlap and this overlap provides the basis for this merger. In addition, the parties share a common mission to provide a full array of health services to all individuals using the new corporation's services. . The parties commit to recognizing and honoring the priority populations that require service under law. The parties also agree to use efficiencies gained, increase reimbursements and/or or grants to expand and deliver integrated health services to all individuals using the new corporation's service.

ARTICLE 3: EXPECTED OUTCOMES, MEASURES AND BENEFITS

1. Demonstration of an effective partnership between AGENCY 1 and AGENCY 2 will include:

    - Improved health status for mutual consumers/patients as a result of one team communicating regularly about patient care
    - Enhanced health care for priority populations, Medicaid and indigent consumers
    - Expansion of health and behavioral health services for consumers.

2. Reduction in the morbidity and mortality of individuals with serious mental illness by the early identification and treatment of medical conditions

3. Reduction of the degree of disability or mental health conditions by early identification and treatment in the primary care setting.

4. Increase in patient visits at the health clinic site, including primary care and behavioral health visits.

ARTICLE 4: FINANCING PLAN

During the transition phases of this merger, the parties agree to inform each other of major purchases and expenditures; however, the parties will maintain separate financing structures until the merger is complete.

ARTICLE 5: POLICIES AND PROCEDURES

During the transition phases of implementation the parties agree to follow those policies, procedures and administrative directives or other documents as specified by the (Insert State Name) State Health and Human Services and Medicaid program. During the term of this agreement AGENCY 1 shall be responsible for advising AGENCY 2 of any applicable modifications to these documents.

Both parties also agree to follow those policies, procedures and administrative directives or other documents as specified by the Bureau of Primary Care and HRSA. During the term of this agreement AGENCY 2 shall be responsible for advising AGENCY 1 of any applicable modifications of rules, regulations or procedures created by these bodies.

HIPAA COMPLIANCE: The parties agree that all aspects of this partnership shall be in compliance with all of the aspects of the Health Insurance Portability and Accountability Act of 1996 and the Administrative Simplification section, Title II, Subtitle F, regarding standards for privacy and security of Protected Health Information (PHI) as outlined in the Act. For the purpose of this partnership, it is recommended that the two systems declare themselves an "Organized Healthcare Delivery System under HIPAA.

A. APPROPRIATE USES AND DISCLOSURES OF PHI: Any joint clinics described in this project may use or disclose information for:

- the proper management and administration of its business;
- purposes of treatment, payment (if allowed by law) or healthcare operations;
- providing data aggregation services relating to the health care operations of the joint clinics (data aggregation means combining protected health information related or received by the providers to permit data analyses that relate to the health care operations of the covered entity); or purposes set forth in policies required by law.

Any joint clinics 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

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health information must be made pursuant to a properly executed Release of Information.

Both agrees to insure that any agents, including any subcontractors, to whom it provides protected health information received from, or created or received by the clinic on behalf of either party, agrees to the same restrictions and conditions that apply to the parties with respect to such information.

B. CONSUMER REQUESTS TO REVIEW RECORD: The holder of the record will respond to any consumer request to review their record. The holder of the joint record will be determined in the business model selected for the clinic.

C. COOPERATION WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES: The clinics will make their internal practices, books and records relating to the use and disclosures of protected health information received from, or created or received by the clinics available to the Secretary of Health and Human Services, or its designee, for the purpose of determining compliance with the Health Insurance Portability and Accountability Act of 1996.

D. AGREEMENT TERMINATION: At the termination of this agreement, protected health information received from, or created or received by one party on behalf of the other party shall be returned and shall not be maintained in any form and the other party shall not retain copies of such information. II such return is not feasible, all parties must extend the protections of the Agreement to the information and limit further uses an disclosures to those purposes that make the return or destruction of the information feasible.

E. BREACHES OF CONFIDENTIALITY: If any party becomes aware of a material breach or any violation of its obligation to protect the confidentiality and security of consumers' protected health information, the party must immediately take reasonable steps to cure the breach or end the violation, and must report, the breach or violation to its respective privacy officer. The alleged breach or violation will be investigated and an appropriate action issued.

ARTICLE 6: TERMS OF AGREEMENT

The agreement shall be in effect for the period of _____ through _____. The agreement may be modified, in writing, with the mutual consent of both parties.

IN WITNESS THEREOF, the parties have this executed this agreement as signified by the signing below.

BY:_____ BY: _____
CEO Date CEO Date
Agency 1 Agency 2

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.

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(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

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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.

How Do You Know if It's Working?

NOTE: Many of the screening tools included in the "Screening Instruments" section can be periodically readministered to assess both individual clinical progress and overall treatment effectiveness. Partially written and partially compiled by Barbara Demming Lurie.

POSSIBLE MEASURES TO EVALUATE THE INTEGRATION OF PRIMARY CARE, MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS

PROCESS MEASURES	Have It?	Consider It?
• Percentage of clients approached to participate in collaborative care • Percentage of clients approached to participate in collaborative care who agree to it (*number of clients who consented divided by total approached*)		
• Percent of clients asked to sign a release of information consent allowing for exchange of information between agencies		
• Percent of clients who sign releases of information allowing for information exchange between agencies		
• Percent of clients asked if they have received primary care services in the past year		
• Frequency of contacting clients' other treatment providers to coordinate care		
• Percent of mental health clients whose screening indicated need for further health intervention who were referred to primary health clinic		
• Length of time between primary care referral and behavioral health appointment within primary care clinic for clients		
• Length of time between primary care referral from mental health clinic and first appointment for clients		
• Reason why clients screening positive were not seen by primary care clinic (client's choice; referral not made; clinic not able to accommodate client; other)		
• Percent of referrals resulting in appropriate behavioral feedback to referral source		
• Percent of primary care clients who were referred for mental health services within the primary clinic		
• Percent of primary care clients who were referred for mental health services outside the primary clinic		
• Percent of mental health clients screening positive for substance abuse referred to substance abuse services		
• Percent of substance abuse clients screening positive for mental/physical health problems referred out for treatment		

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• Frequency of referred client keeping first appointment		
• Percent of clients completing the recommended course of treatment		
• Frequency of clients referred from mental health clinic to primary care keeping first appointment		
• Rate of kept/missed appointments in referral agency, not counting first visit		
• Type and frequency of physical wellness-oriented programs/training conducted		
• Average number of clinic visits by clients per quarter		
• Percent of clients with established integrated treatment plan		
• Percent of smokers participating in smoking cessation activities		
• Percent of clients with positive BMI and/or waist girth scores participating in nutrition/exercise programs and/or education		
• Percent of clients evidencing physical problems receiving follow-up measurements at least once every eight weeks to assess progress		
• Percent of clients who drop out of program (fail to appear for scheduled visits (over a three month period)		
• Percent of clients newly prescribed psychotropic medication		
• Type and duration of treatment (mental health, substance abuse and primary care) by diagnosis		
• Average length of treatment session by diagnosis		
• Individualized cost of mental health services in mental health clinics		
• Individualized cost of mental health services in primary care		
• Individualized cost of substance abuse services in mental health and primary care setting		
• Individualized cost of medical services		
• Percent of clients enrolled in physical wellness programs (diet, exercise, etc.)		
• Availability of written material to meet the linguistic needs of the population being served.		
• Frequency of cross-discipline training of mental and physical and substance use health service providers; number and level of staff attending		
• Availability of service personnel who speak the same language as the population being served.		
• Level and effectiveness of care management		
• Frequency of progress assessments		
• Frequency of treatment changes/referrals made when indicated by assessment results		
• Number and qualifications of mental health professionals affiliated with primary care program		

• Level of fidelity to collaborative agreements		
• Percent of clients whose physical health risk factors are assessed at_____(specify time intervals)		
• Percent of clients whose mental health status is assessed at _____ • (specify time intervals)		
• Percent of clients receiving active care management		
• Percent of clients whose health medication is assessed at _____ • (specify time intervals)		
• Percent of clients whose psychiatric medication is assessed at_____ • (specify time intervals)		
• Physical proximity of mental health services to participating primary care clinic		
• Ave. amount of total staff time devoted to meeting clients' mental health needs		
• Average amount of staff time devoted to meeting clients' physical health needs		
• Accuracy of outcome data collected and reported by facility (as ascertained by an independent review)		
• Timeliness of data submission by clinic		
• Client to primary care provider ratio		
• Percent of clients completing prescribed course of treatment		
• Frequency of case conferencing between mental health and primary care professional staff		
• Quality of services as assessed by random chart review		
• Level of stigma and/or hesitancy (or alternatively, level of comfort) clients experience in accessing mental health care as measured by their self-report		
• Client adherence to mental health treatment plans and medication		
• Client adherence to medical treatment plans and medication compliance		
• Establishment of agreements, memorandum of understandings, etc between the primary care and mental health systems		
• Establishment of agreed-upon referral guidelines, policies and procedures		

PHYSICAL HEALTH SCREENING MEASURES	Have It?	Consider It?
• Percent of total clients screened for BMI • Percentage of clients screening positive for BMI (e.g., less than 18.5 or more than 24.9)		
• Percent of total clients screened for smoking • Percentage of clients screening positive for smoking		
• Percent of total clients screened for nonprescription substance abuse • Percentage of clients screening positive for nonprescription substance abuse		
• Percent of total clients screened for co-occurring prescription substance abuse not including alcohol • Percentage of clients screening positive for co-occurring prescription substance abuse not including alcohol		
• Percent of total clients screened for co-occurring alcohol dependence • Percent of clients screening positive for co-occurring alcohol dependence		
• Percent of total clients screened for waist girth • Percentage of clients screening positive for waist girth (e.g., greater than 39.5 inches for men and 35.5 inches for women)		
• Percent of total clients screened for psychotropic medications • Percentage of clients currently on psychotropic medications		
• Percent of clients on psychotropic medications screened for A1C levels • Percent of clients on psychotropic medications with positive A1C levels (e.g., greater than 6.5)		
• Percent of total clients screened for blood pressure • Percentage of clients screening positive for blood pressure (e.g., 140 and above systolic and/or greater than 90 diastolic)		
• Percent of clients screened for cardiovascular disease via lipids profile (HDL, LDL, triglycerides) • Percent of clients screening positive for HDL, LDL and/or triglyceride levels		
• Percent of clients who completed a verbal or written medical history intake, including personal and family history • Percent of clients whose personal or family medical history indicated physical risk factors for diabetes, COPD or heart disease		

Many of the physical health measures contained on this page were proposed by the Small County Care Integration (SCCI) Collaborative, sponsored by the California Institute of Mental Health.

OUTCOME MEASURES	Have It?	Consider It?
• Level of client satisfaction with accessibility of mental health services		
• Level of client satisfaction with accessibility of physical health services		
• Level of client satisfaction with effectiveness of mental health services		
• Level of client satisfaction with effectiveness of physical health services		
• Provider satisfaction with promptness, level and effectiveness of services provided by partnering agencies		
• Client self-assessment of functioning and of quality of life		
• Mental health functioning as self-assessed by client (emphasis on targeted problems)		
• Mental health functioning as assessed by provider (initial screening measures can be reapplied periodically to assess change; emphasis on targeted problems))		
• Physical health status as assessed by client (emphasis on targeted problems)		
• Physical health status as assessed by provider (emphasis on targeted problems)		
• Physical health indicators (if targeted):		
• body mass index		
• waist girth		
• weight		
• blood pressure		
• glucose levels		
• lipid levels		
• smoking rate (where applicable)		
• exercise habits		
• nutritional habits		
• substance abuse frequency (where applicable)		
• alcohol use (where applicable)		
• degree of pain experienced		

For clients with co-occurring mental disorders and chronic obstructive pulmonary disease:		
• Oxygenation		
• Pulmonary function		
• Exercise capacity		
For clients with co-occurring mental disorders and heart disease:		
• incidence of death		

• incidence of heart attacks		
• incidence of strokes		
• blood pressure		
• heart-sensitive C-reactive protein level		
• HDL/LDL levels		
For clients with co-occurring mental health disorders and diabetes (in addition to weight/BMI and waist girth):		
• Hemoglobin A1C levels		
• Progression of microvascular disease of the eyes		
• Abnormalities of the kidney		
• Foot exam		
• Frequency of alcohol/substance use before and after treatment (for those treated for these issues)		
• Pre and post smoking frequency by clients participating in smoking cessation activities		
• Other targeted behavioral changes specifically addressed by the program (e.g., improved diet, exercise; medication compliance, etc.)		
• Client adherence to treatment plan and medication compliance		
• Number and severity of relapses		
• Cost-effectiveness of services, including cost of services and cost off-sets/savings		
• Frequency of psychiatric hospital admissions		
• Frequency of medical admissions		
• Frequency of ER visits by clients		
• Knowledge level of primary care medical staff in mental health areas, including identification of and approaches to psychiatric problems (as measured pre and post project)		
• Knowledge level of mental health staff of physical conditions associated with mental health problems (as measured pre and post collaboration)		
• Level of familiarity of staff with national and local resources for persons with mental and/or physical disorders (as measured pre and post collaboration)		
• Primary care provider comfort level in dealing with persons with mental disorders (as measured pre and post collaboration)		
• Primary care rate of prescribing psychotropic medications (as measured pre and post collaboration)		
Other:		

DEMOGRAPHIC DATA FOR CLIENTS
• Client age, gender, race/ethnicity • Client personal/family health history, including diabetes, hypertension and cardiovascular disease • Personal/family history of and current substance abuse • Personal/family history of and current tobacco use • Client social supports • Presenting behavioral health problems and diagnosis • Presenting physical health problems and diagnosis • Presenting co-occurring substance abuse disorders • History of previous psychiatric treatment/hospitalization • Medications prescribed • Current housing situation (including whether clients have or are lacking a fixed, regular, and adequate nighttime residence)

Performance Measures Chart

The Stanislaus Behavioral Health and Recovery Services evaluated the first year of their integrated behavioral health project, implemented through contracts with two primary care providers in their county. A major goal was to increase access to quality behavioral health services for underserved ethnic and geographic populations in the county. The chart below shows their performance measures, based on a Results Based Accountability (RBA) framework.

RBA Category		Performance Measure	Data Source	Methodology and Frequency
How much did We do?	1	Number of unduplicated patients receiving behavioral health services through the funding provided	Contractor patient Database	Patients served by contractor by account number, name, gender and date of birth quarterly
	2	Number of behavioral health visits/encounters provided through the funding provided	Contractor patient database	Services provided by contractor by patient account number quarterly
How well did We do it?	1	Staff Satisfaction with Integrated Behavioral Heath	Staff Satisfaction Questionnaire	questionnaire administered to staff of both contractors using Survey Monkey annually
	2	Number and percentage of patients with no current or previous BHRS service experience	BHRS patient database and contractor unduplicated clients served	Comparison of contractor unduplicated patients served by matching with BHRS patients using name, gender and date of birth Quarterly and annually
	3	Percentage of patients who are Hispanic	Contractor patient database	Reported by contractor for each unduplicated patient served quarterly
	4	Percentage of patients whose preferred language is Spanish	Contractor patient database	Reported by contractor for each unduplicated patient served quarterly
	5	Patient satisfaction with outcome of care	Patient Satisfaction questionnaire	Questionnaire administered to patients receiving behavioral health services during one week period. Annually

Performance Measures Chart, Cont.

	6	Retention of Hispanic patients beyond the initial visit compared with other cultural/ethnic groups	Contactor patient database	Unduplicated patients served with at least two subsequent visits by reported ethnicity Annually
Is anyone better off?	1	Improvement in depression	Patient Health Questionnaire (PHQ-9)	PHQ-9 Questionnaire completed on each visit by persons scoring 4 or higher on their initial screening. Comparison of scores for subsequent visits. Annually

DECIDING ON WHAT TO MEASURE – THE BASICS

(courtesy of Multnomah Mental Health and Addiction Services Division, Cascades Community Oregon; Joan Rice, joan.m.rice@multco.us; edited)

Goals for Measurement and Evaluation

The Institute for Healthcare Improvement believes that new designs can and must be developed to simultaneously accomplish three critical objectives, or what they call the "Triple Aim:"

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

Questions to Answer

Questions relevant to the Triple Aim and to information needs at the system, population, care team, panel, and individual patient levels:

- Is integrated care (behavioral health in primary care/primary care in behavioral health) of value to payors, providers and patients?
- Are the interventions clinically effective?
- Are there opportunities for Quality Improvement in organizational processes of delivering integrated care?
- Can the data be used to shape delivery of care, for specific patients, for a patient population, for the community?

The Potential Audience

It is envisioned that the data collected, analyzed and reported will provide information for a variety of audiences:

- Federal policy makers (e.g., HRSA)
- State policy makers (e.g., elected officials, Health Authority, Quality Institute)
- Payors (e.g., impact on system costs)
- Organizational Boards of Directors (e.g., FQHCs and MH/SU agencies)
- Partners in delivering services (e.g., ease of implementation, quality improvement)
- Providers (e.g., satisfaction, skill development and comfort)
- Care Teams (e.g., clinical operations)
- Patients (e.g., clinical outcomes, experience/satisfaction)
- Researchers
- Professional organizations

Prioritization of Potential Measures

The group reviewed multiple sources of potential measures, identified an initial listing for each of the five typologies, and used the following criteria to narrow to the recommended measurement sets in the tables that follow.

- Information provides value to policy makers
- Information provides actionable data at the provider/clinical level
- Information crosswalks across presenting conditions and across primary care and MH/SU
- Information tracks patient engagement/empowerment
- Information can be used to correlate delivery system variables with health outcomes
- Information relates to structure, process and outcomes
- Information can be gathered with ease, at relatively low cost

SAMPLE CLIENT SATISFACTION QUESTIONS

	Strongly Agree	Somewhat Agree	Neither Agree or Disagree	Somewhat Disagree	Strongly Disagree	This Doesn't Apply
The location of the **medical services** was convenient for me to get to.						
It was easy to get **mental health** services I needed.						
It was easy to get the **medical services** I needed.						
I didn't have to wait long to get an appointment for **mental health** services.						
I didn't have to wait long to get an appointment for **medical** services.						
Once at the **mental health** clinic, I didn't have to wait long to be seen.						
Once at the **medical clinic**, I didn't have to wait long to be seen.						
The staff gave me a satisfactory amount of time during my **mental health** visits						
The staff gave me a satisfactory amount of time during my **medical** visits.						
The **mental health** staff took my preferences into account in deciding what my treatment would be.						
The **medica**l staff took my preferences into account in deciding what my treatment would be.						
When I left, I clearly understood the purpose and risks of each medication I was prescribed						
I was given a good explanation of the things I needed to do to manage my **mental health**.						
I was given a good explanation of the things I needed to do to manage my **physical** health.						
I was satisfied with how my						

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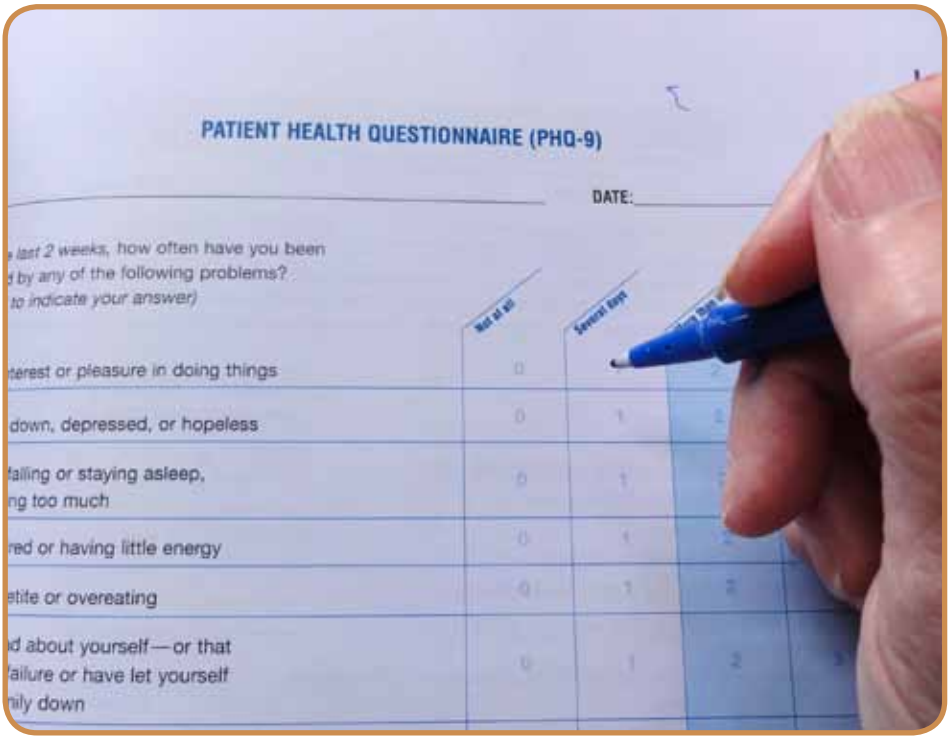
mental health needs were addressed						
I was satisfied with how my physical health needs were addressed						
The staff was sensitive and accommodating to my cultural/ethnic background						
Treatment information was given in a way that I could easily understand.						
I felt respected an well- treated by staff at the **mental health** clinic						
I felt respected and well-treated by staff at the **medical** clinic.						
I'm satisfied with how My substance use issues were addressed.						
I'm comfortable going to the **mental health** clinic for services						
I'm comfortable going to the **medical clinic** for services.						
The clinic helped me get the services I needed in the community.						
My **mental health** clinician kept me informed about my treatment and progress						
My **medical** clinician kept me informed about my treatment and progress.						
My clinicians kept each other informed about my treatment and progress**.**						
My clinicians worked well together to coordinate my care						
I knew which clinician to turn to when I had a problem.						
As a result of treatment, I can now manage my **mental health** problems better.						
As a result of treatment, I can now manage my **physical** condition better.						

SAMPLE PROVIDER SATISFACTION QUESTIONS

Questions posed to providers could include:

- How satisfied are you with the ease of referral to mental health services/primary care/substance use services?
- How much, if at all, did ease of referral to mental health/primary care/substance use services increase as a result of this project?
- How satisfied are you with the feedback you received about your clients' status and care after you referred clients to mental health/primary care/substance use services?
- How much time did it take, on average for your referred client to get an appointment with mental health/primary care/substance abuse services?
- How knowledgeable did you find the mental health/substance abuse/primary care providers in your own area?
- How knowledgeable did you find the mental health/substance abuse/primary care providers in their own area?
- How satisfied are you with the level of communication between your services and mental health/substance abuse/primary care services?
- How much, if at all, did the level of communication between your services and mental health/substance abuse/primary care services increase as a result of this project?
- How effective did you find the primary care/mental health/substance abuse services were in addressing the needs of your clients?
- How much, if at all, did access to consultation from primary care/mental health/substance abuse increase as a result of this pilot?
- In the last month, approximately how many times did you have contact with a mental health/primary care/substance abuse provider outside your own clinic regarding a client in the pilot project?
- How easy was it for you to access client treatment information, laboratory results, or medical records for the clients you were treating?
- What, if anything, is working well in the collaboration between primary care, mental health and substance abuse services?
- How much, if at all, did your comfort level in treating persons with mental disorders increase as a result of this project?
- How much, if at all, did your knowledge base increase regarding treating persons with mental disorders as a result of this project *(for primary care personnel)?*
- How much, if at all, did your knowledge base increase regarding cardiovascular diseases and diabetes (*for mental health personnel)*
- How would you rate communication between primary care and mental health in this project?
- What, if anything, is not working well in the collaboration between primary care, mental health and substance abuse services?
- What suggestions can you make to improve the collaboration between mental health, primary care and substance abuse services?

SAMPLE
Screening and Evaluation Instruments



NOTE: *There are a myriad of screening instruments in circulation. Those contained within these Tool Kit pages were selected becase of popularity, validity, or relevance, but inclusion does not imply endorsement of these 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 _____

IBHP Integrated Behavioral Health Project

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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.)

	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.

PHYSICAL HEALTH SCORE

Item	Raw Score*
8 =	_____
9 =	_____
10 =	_____
11 =	_____
12 =	_____
Sum =	_____ x 10 =

MENTAL HEALTH SCORE

Item	Raw Score*
1 =	_____
4 =	_____
5 =	_____
13 =	_____
14 =	_____
Sum =	_____ x 10 =

SOCIAL HEALTH SCORE

Item	Raw Score*
2 =	_____
6 =	_____
7 =	_____
15 =	_____
16 =	_____
Sum =	_____ x 10 =

GENERAL HEALTH SCORE

Physical Health score = _____
Mental Health score = _____
Social Health score = _____
Sum = _____ ÷ 3 =

PERCEIVED HEALTH SCORE

Item	Raw Score*
3 =	_____ x 50 =

SELF-ESTEEM SCORE

Item	Raw Score*
1 =	_____
2 =	_____
4 =	_____
6 =	_____
7 =	_____
Sum =	_____ x 10 =

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.

ANXIETY SCORE

Item	Raw Score*	Revised
2 =	_____	_____
5 =	_____	_____
7 =	_____	_____
10 =	_____	_____
12 =	_____	_____
14 =	_____	_____
Sum =		_____ x 8.333 =

DEPRESSION SCORE

Item	Raw Score*	Revised
4 =	_____	_____
5 =	_____	_____
10 =	_____	_____
12 =	_____	_____
13 =	_____	_____
Sum =		_____ x 10 =

ANXIETY-DEPRESSION (DUKE-AD) SCORE

Item	Raw Score*	Revised
4 =	_____	_____
5 =	_____	_____
7 =	_____	_____
10 =	_____	_____
12 =	_____	_____
13 =	_____	_____
14 =	_____	_____
Sum =		_____ x 7.143 =

PAIN SCORE

Item	Raw Score*	Revised
11 =	_____	_____ x 50 =

DISABILITY SCORE

Item	Raw Score*	Revised
17 =	_____	_____ x 50 =

* 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.

MINI Patient Health Survey

(courtesy of 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.

		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.

		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 of 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 attach 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: _____

LOCUS ASSESSMENT

(Version 2000)

(courtesy of State of Nevada, Division of Mental Health and Developmental Services)

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_____

II. Functional Status

1 Minimal Impairment
2 Mild Impairment
3 Moderate Impairment
4 Serious Impairment
5 Severe Impairment
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_____

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_____

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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_____

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:
_____
_____
_____

GAD-7 (GENERALIZED ANXIETY DISORDER)

(*developed by Robert L. Spitzer, MD et al. Archives of Internal Medicine, 2006*)

How often during the past two weeks have you felt bothered by:

1. Feeling nervous, anxious, or on edge?
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly everyday

2. Not being able to stop or control worrying?
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly everyday

3. Worrying too much about different things?
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly everyday

4. Trouble relaxing?
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly everyday

5. Being so restless that it is hard to sit still?
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly everyday

6. Becoming easily annoyed or irritable?
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly everyday

7. Feeling afraid as if something awful might happen?
   0 = not at all
   1 = several days
   2 = more than half the days
   3 = nearly everyday

Scoring:
Each question has a number value (0-3). Add the numbers. Scores of 5, 10 and 15 represent mild, moderate and severe anxiety respectively significant anxiety is present. Researchers found that people diagnosed with GAD have an average score of 14.4 while people without GAD average 4.9.

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PTSD CHECKLIST (PCL)

Patient Name: _____ **Date:** _____

If an event listed on the Life Events Checklist **happened to you** or you **witnessed it,** please complete the items below. If more than one event happened, please choose the one that is **most troublesome to you now.**

The event you experienced was _____ on _____ .
(EVENT) (DATE)

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then **circle** one of the numbers to the right to indicate how much you have been **bothered** by the problem **in the past month.**

BOTHERED BY	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Repeated disturbing memories, thoughts, or images of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they remind you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being “super alert” or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

Mono County Behavioral Health

INTAKE

AOD ☐ MH ☐ Service Code: 610 Phone Walk-In

Date_____ Completed By_____

Please Check Off:

- ☐ Informed about Confidentiality and Mandated Limits
- ☐ Informed about Cost of Services and Payment
- ☐ Meds Run Attached
- ☐ Copy of Insurance Card Attached
- ☐ Consumer entered in ShareCare
- ☐ Admission Entered in ShareCare
- ☐ Electronic Intake Log Completed

1. Identifying Information

Name_____ Referred by_____

Caller_____ Relationship to Client_____

Language: ☐English ☐Spanish ☐Other Needs interpreter? ☐Y ☐N Gender_____

Age_____ DOB_____ SSN#_____

Relationship Status: ☐Single ☐Married ☐Domestic Partnership ☐Widowed ☐Divorced

Address: Mailing_____ Physical_____ City_____

Phone: Home_____Work_____ Cell_____

Best time to call?_____ Okay to leave message? ☐Y ☐N

Employer_____ ☐ full time ☐ part time

Source of income: ☐employment ☐public assistance ☐unemployment ☐disability

☐other (explain)_____ ☐none

Health Insurance: ☐medi-cal ☐cmsp ☐private ☐peapod ☐EAP ☐none ☐self-pay

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_____

2. Psychosocial Information

Length of time at current address_____

Length of time in Mono County_____

Who lives in your home with you:

Name:_____ Relationship: _____Age:_____

Name:_____ Relationship: _____Age:_____

Name:_____ Relationship: _____Age:_____

Name:_____ Relationship: _____ Age:_____

Are there children or other significant family members who do not live with you? If so, who?_____

Current support system. Check all that apply:

☐ Immediate Family members ☐extended family members ☐friends locally ☐friends in other areas ☐ coworkers ☐pets ☐religious or spiritual affiliates ☐12-step community ☐other ☐none
Details/Explain?_____
_____

Do you have adequate housing? ☐Y ☐N

What are your means of transportation? ☐working vehicle ☐nonworking vehicle ☐rides with friends or family ☐public transport ☐bicycle ☐walking ☐hitchhiking ☐other

_____

3. Presenting Problem/Chief Complaint/What does client want help with?

_____
_____
_____
_____
_____
_____
_____

Client's assessment of current stressors rated on 1 – 10 scale (1 = not a problem, 10 = highest stress)

Primary support group___ social environment___ educational problems___ occupational problems___ housing problems___ economic problems___ problems with access to health care___ problems related to legal system___ other psychosocial or environmental problems___ acculturation_____ child care ___ language ___

Current Coping Strategies

_____

_____

_____

Client's perception of what goes well in his/her life:

_____

_____

_____

Psychological symptom areas—use assessment from tx plan

_____

4. Risk Assessment

Suicidal thoughts ☐Y ☐N ☐past If yes, give frequency and intensity of thoughts._____

suicide plans ☐Y ☐N ☐past If yes, specify_____

attempts ☐Y ☐N ☐past If yes, specify when & how_____

Is there a current safety plan in place to prevent suicide? Yes no. if yes, specify_____

Self-injury behaviors ☐Y ☐N ☐past If yes, specify_____

Excessive risk-taking ☐Y ☐N ☐past If yes, specify_____

Thoughts of harming others ☐Y ☐N ☐past If yes, specify about whom_____

Current plan to harm another ☐Y ☐N ☐unwilling to say ☐N/A

Tarassof warning required? ☐Y ☐N ☐n/a

Family violence/Partner violence: Yes No past.

If yes, is client victim? ☐Y ☐N If yes, is there an adequate safety plan? ☐Y ☐N

Wild Iris referral provided? ☐Y ☐N ☐n/a

Assault/Harassment: ☐Y ☐N

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If yes, is client a victim? ☐Y ☐N Is client currently safe? ☐Y ☐N

If client is a child, has he/she experienced child abuse? ☐Y ☐N If yes, explain

5. Substance Use History

SUBSTANCE	Age 1st Used	Progression of use at age?	Tolerance Increase	Current Frequency of Use	Current Amount used	Binge Use Patterns	Ever have Withdrawal Symptoms	Date Last Used
Alcohol			☐Y ☐N				☐Y ☐N	
Marijuana			☐Y ☐N				☐Y ☐N	
Inhalants			☐Y ☐N				☐Y ☐N	
Cocaine			☐Y ☐N				☐Y ☐N	
Nicotine			☐Y ☐N				☐Y ☐N	
Caffeine			☐Y ☐N				☐Y ☐N	
Over the counter			☐Y ☐N				☐Y ☐N	
Prescription drugs			☐Y ☐N				☐Y ☐N	
Heroin			☐Y ☐N				☐Y ☐N	
Methamphetamine			☐Y ☐N				☐Y ☐N	
Other drugs:			☐Y ☐N				☐Y ☐N	
Observations:								

DRUG OF CHOICE:

Ever use more than intended?: ☐Y ☐N Blackouts?: ☐Y ☐N

Attempts to control use?: ☐Y ☐N

Have you experienced or are you experiencing any of the following withdrawal symptoms?:

Tremors ☐Y ☐N Nausea/Vomiting ☐Y ☐N Diarrhea ☐Y ☐N Hallucinations ☐Y ☐N

Insomnia ☐Y ☐N Seizures ☐Y ☐N Agitation ☐Y ☐N DT's ☐Y ☐N

Depression ☐Y ☐N Lablle Mood Swings ☐Y ☐N

TOBACCO USE CURRENTLY:
PARENTAL/OTHER BLOOD-RELATIVE SUBSTANCE DEPENDENCE (GENERATIONAL / BIOLOGICAL) EXISTS/EXISTED:

---

6. Legal History

Current legal status: ☐none ☐informal probation ☐formal probation ☐parole

Current Court case involvement or pending: ☐Y ☐N If yes, what type? (CPS, child custody, divorce, criminal)

Incarcerated within past 12 months? ☐Y ☐N if yes, when, where, for how long and for what___

Past History of incarceration ☐Y ☐N If yes, when, where, for how long, for what_____

Victim of a crime? ☐Y ☐N If yes, when, what crime_____

Police Involvement in the last 12 months? ☐Y ☐N If yes, explain_____

---

7. Current Involvement with Other Agencies

Check all that apply:

☐CPS ☐probation ☐wild iris ☐IMACA ☐public health ☐school ☐first 5 ☐peapod
☐Social Services ☐APS ☐Child Support ☐SARB

Releases obtained for agencies checked above? ☐Y ☐N ☐n/a

If client is in school, is there an IEP? ☐Y ☐N ☐N/A

---

8. Medical History

Primary Care Physician_____ **Last Physical Date**_____
Last: Doctor Visit_____ **Dental Visit**_____ **Vision/Hearing Visit**_____
Releases Obtained? ☐Y ☐N

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Do you experience, or have you experienced, any of the following? If so explain/give dates.

Allergies_____ Chronic Pain_____
Seizures_____ Appetite/Weight Change_____
Head Injury_____ Illness/Surgery_____
Hypo/Hyperthyroid_____ Tobacco Use_____
Loss of Consciousness_____ Pregnancy_____
High blood pressure_____ Substance Use_____
Migranes/Headaches_____ Diabetes_____
Sleep Issues_____
Medical Marijuana? ☐Y ☐N explain_____
Alternative Medical Practices? ☐N ☐N explain_____
Hospitalization in last 12 months? ☐Y ☐N explain_____

_____

9. Previous Psychological services

Outpatient psychotherapy ☐Y ☐N If yes, when/where_____
psychoeducation (i.e. anger management, parenting) ☐Y ☐N If yes, when/where_____
residential treatment (group home, rehab) ☐Y ☐N If yes, when/where_____

Psychiatric Hospitalization ☐Y ☐N If yes, when/where_____

Previous psychiatric diagnoses? ☐Y ☐N if yes, specify_____

Previous psych meds? ☐Y ☐N if yes, specify_____

List current psych meds and prescribing physician:

_____

_____

Release for Records? ☐Y ☐N ☐N/A

HRQOL-4

A four-question health and mental health survey developed by the Centers for Disease Control and Prevention (CDC) Health Related Quality of Life Surveillance Program.

1. Would you say that in general your health is excellent, very good, good, fair, or poor?

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

3. Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

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.

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

(World Health Organization)

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of **'standard drinks'**. Please ask for clarification if required.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many standard drinks do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

The first three questions form the Audit-C, a reliable indicator that can be embedded in a more general health questionnaire. Scoring: For the full Audit, a score of 8 or more in men (7 in women) indicates a strong likelihood of hazardous or harmful alcohol consumption. A score of 20 or more is suggestive of alcohol dependence. For the Audit C, a = 0 points; b = 1 point; c = 2 points; d = 3 points; and e = 4 points. In men, 4 or more points reliably identifies persons who are hazardous drinkers or who have active alcohol disorders. In women, a score of 3 or more is considered positive.

DAST-10 DRUG ABUSE SCREENING TEST

Addiction Research Center, Author: Harvey A. Skinner, PhD, Dean, Faculty of Health, York University, Toronto, Canada.1982

The Drug Abuse Screening Test (DAST) was designed to provide a brief instrument for clinical and non-clinical screening to detect drug abuse or dependence disorders. It is most useful in settings in which seeking treatment for drug use problems is not the patient's stated goal. DAST scores are highly diagnostic with respect to a DSM diagnosis of psychoactive drug dependence. The DAST is available in both 20-item and 10-item formats; an Adolescent version is also available. The 10 item scale below was selected in 2012 by a group of researchers from the National Drug Abuse Treatment Clinical Trials Network to serve as the recommended assessment tool for use in general medical settings. (University of Washington)

In the past 12 months:

Circle your response:

1. Have you used drugs other than those required for medical reasons? Yes No
2. Do you use more than one drug at a time? Yes No
3. Are you always able to stop using drugs when you want to? Yes No
4. Have you had “blackouts” or “flashbacks” as a result of drug use? Yes No
5. Do you ever feel bad or guilty about your drug use? Yes No
6. Do those close to you ever complain about your involvement with drugs? Yes No
7. Have you neglected your family because of your drug use? Yes No
8. Have you engaged in illegal activities in order to obtain drugs? Yes No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? Yes No
10. Have you had medical problems as a result o your drug use (for example, memory loss, hepatitis, convulsions, bleeding, etc.)? Yes No

Scoring: 1 point for each question answered “yes” except for question 3 in which a “no” receives 1 point.

Score	*Degree of Problems Related to Drug Abuse*	*Suggested action*
0	*no problems reported*	*none at this time*
1-2	*low Level*	*monitor; reassess at later time*
3-5	*moderate level*	*further investigation*
6-8	*substantial level*	*intensive assessment*
9-10	*severe level*	*intensive assessment*

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CO-OCCURRING SCREENING INSTRUMENT

*(courtesy of the Los Angeles County Department of Mental Health.
Developed by the Co-Occurring Joint Action Council)*

Section 1: Mental Health		
Yes	No	
☐	☐	Have you ever been worried about how you are thinking, feeling, or acting?
☐	☐	Has anyone ever expressed concerns about how you were thinking, feeling, or acting?
☐	☐	Have you ever harmed yourself or thought about harming yourself?

Section 2: Alcohol & Drug Use		
Yes	No	
☐	☐	Have you ever had any problem related to your use of alcohol or other drugs?
☐	☐	Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use or suggested cutting down?
☐	☐	Have you ever said to another person, "No, I don't have an alcohol or drug problem," when around the same time you questioned yourself and felt, *maybe I do have a problem?*

Section 3: Trauma/Domestic Violence		
Yes	No	
☐	☐	Have you ever been in a relationship where your partner has pushed or slapped you?
☐	☐	Before you were 13, was there any time when you were punched, kicked, choked, or received a more serious physical punishment from a parent or other adult?
☐	☐	Before you were 13, did anyone ever touch you in a sexual way or make you touch them when you did not want to?

MaineHealth

Adult Wellbeing

Today's Date: _____ **Name:**_____ **Date of Birth:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**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. Feeling nervous, anxious, or on edge	0	1	2	3
4. Not being able to stop or control worrying	0	1	2	3

Has there ever been a period of time when you were not your usual self and...	No	Yes
5. ... you felt so good or full of energy that other people thought you were not your normal self or it got you into trouble? (e.g., unable to sleep, over-spending, gambling)	☐	☐
6. ...you were so irritable that you shouted at people or started fights or arguments?	☐	☐

During the past year:	No	Yes
7. Have you had 4 or more drinks (women) / 5 or more drinks (men) in a day?	☐	☐
8. Have you used an illegal drug or used a prescription drug for a non-medical reason?	☐	☐

Over the last 4 weeks:	No	Yes
9. Have you had a problem with sleep more than occasionally? (This could include: trouble falling asleep, waking frequently, or sleeping too much.)	☐	☐

10. **Circle the number or description that most accurately describes your daily activities, social activities and overall health in the past 4 weeks.**

DAILY ACTIVITIES

How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?

No difficulty at all		1
A little bit of difficulty		2
Some difficulty		3
Much difficulty		4
Could not do		5

SOCIAL ACTIVITIES

Has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

OVERALL HEALTH

How would you rate your health in general?

Excellent		1
Very good		2
Good		3
Fair		4
Poor		5

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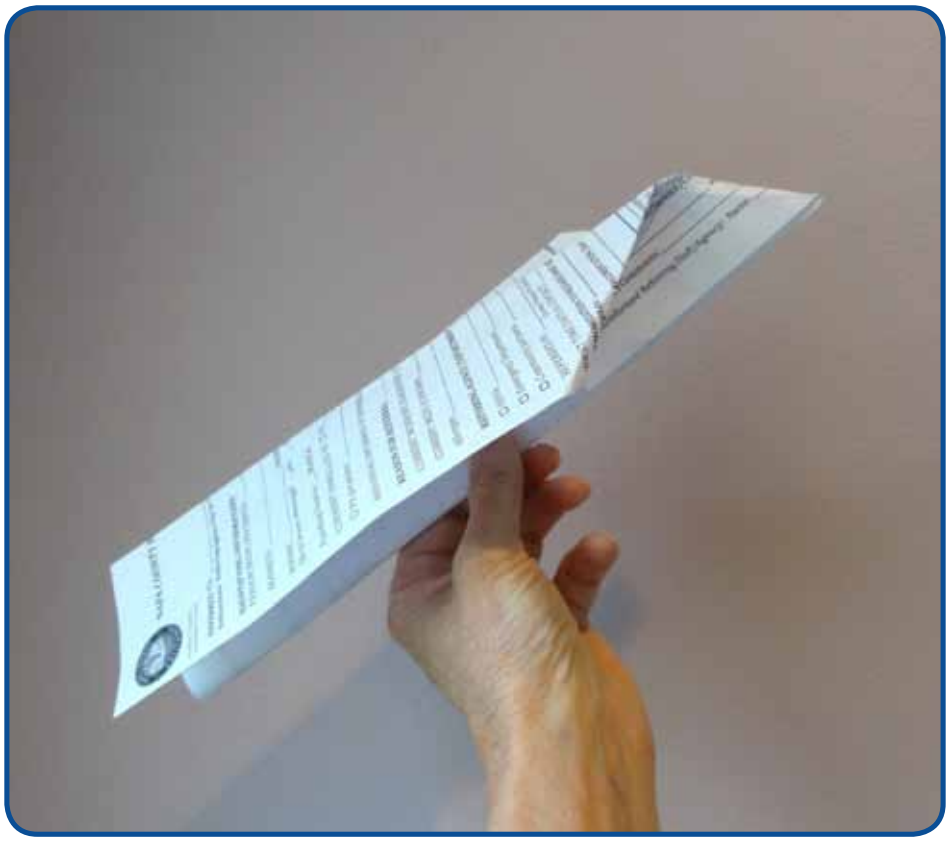
SAMPLE
FORMS



A Tradition of Stewardship
A Commitment to Service

NAPA COUNTY HEALTH CARE UNIVERSAL REFERRAL

2344 Old Sonoma Rd.
Napa, CA 94559

REFERRED TO: _____**Date:**_____
Instructions: Referring Agency Fax to Clinic Ole 254-1779, Medication Clinic 299-2165, Alcohol & Drug Services 259-8716

IDENTIFYING INFORMATION:
PERSON BEING REFERRED: _____ DOB: _____ Age:____
LAST NAME FIRST NAME
ADDRESS: _____ GENDER: ☐Male ☐ Female

PHONE: _____PRIMARY LANGUAGE: _____☐Interpreting needed/language:_____
Ok to leave message? __yes __no Physical Limitations_____

Funding Source: __MediCal __CMSP __MediCare __Sliding Scale __Commercial Ins.

CURRENT ENROLLED IN: ☐ PC: _____☐ MH: _____ ☐ ADS: _____

☐ PH program: _____ ☐ NONE: _____☐ UNKNOWN: _____Other_____

INDIVIDUAL INFORMED OF REFERRAL on (date):_____ IF NOT, special circumstances:_____

REASON FOR REFERRAL: _____

CURRENT WORKING DIAGNOSES (If Known): _____

CURRENT MEDS if KNOWN: _____

Allergies_____ Referral Urgency __High __Medium __Low

REFERRING AGENCY/DEPARTMENT:

☐ HHSA: _____ ☐ Primary Care: _____

☐ Emergency Department_____ ☐ Inpatient Facility: _____

☐ Community partners: _____ ☐ Other: _____

REFERRED BY: _____ CONTACT INFO: (fax/phone) _____
(Contact Person-PLEASE PRINT)
BEST TIME/DAYS to CONTACT: _____

AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION ATTACHED ☐ YES ☐NO
IF NO explain: _____

SUPPORTING DOCUMENTATION (list – see guidelines for recommended supporting documents for referral to different programs) _____

DISPOSITION

☐ Assessment Scheduled: _____
☐ Assessment completed-Recommendations attached: _____
☐ Additional information needed: _____
☐ Alternative referral recommended: _____
☐ Referral declined by beneficiary: _____
☐ Unable to contact referred party: _____
☐ Enrolled in treatment (Date/Service/Contact Person):

Appointment date(s): _____ with Provider/Team: _____ Contact Info: _____

☐Other /Comments:_____

☐Informed Referring Staff/Agency: Name: _____ by (phone/email/FAX): _____Date: _____

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Behavioral Health Request for Information from Primary Care

(courtesy of the Los Angeles County Department of Mental Health)

This form is used for the purpose of exchanging practitioner and beneficiary information to enhance care coordination for Medi-Cal Managed Care beneficiaries.

BENEFICIARY INFORMATION

Name: _____ **DOB:** _____ **Telephone:** _____

Address: _____ **City:** _____ **Zip:** _____

SSN: _____ ☐ **Medi-Cal #:** _____

BEHAVIORAL HEALTH PRACTITIONER – INITIATING QUERY OR COORDINATION OF CARE

Practitioner's Name: _____ **Telephone:** _____ **FAX:** _____

Email: _____ **Date of Last Visit:** _____

Behavioral Health Diagnosis(es): _____

Current Medications: _____

Reason(s) for Request:

☐ Coordination of Care ☐ Identify Current Medications ☐ Medical Evaluation Results ☐ EKG Results

☐ Neurological Assessment ☐ Laboratory/Imaging Results: _____

☐ Other _____

Practitioner's Signature: _____ **Date:** _____

After making a copy of the form for your records, give the original to the beneficiary to take to the Primary Care Practitioner (PCP) who will complete the response portion and return the form to you for filing in the client's medical record. Send additional pertinent information as you feel necessary.

PRIMARY CARE PRACTITIONER - RESPONDING TO REQUEST

The behavioral health practitioner initiating this form is requesting information about the above named person. Please complete and return this form via the beneficiary or by faxing to the behavioral health practitioner.

PCP Name: _____ **Telephone:** _____ **FAX:** _____

Diagnosis(es): _____

Date of Last Visit: _____ **Email:** _____

Current Medications: _____

Recommendations or Response to the Request (attach information if necessary): _____

Practitioner's Signature: _____ **Date:** _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Primary Health Request for Information from Behavioral Health

(courtesy of the Los Angeles County Department of Mental Health)

This form is used for the purpose of exchanging practitioner and beneficiary information to enhance care coordination for Medi-Cal Managed Care beneficiaries.

BENEFICIARY INFORMATION

Name: _____ **DOB:** _____ **Telephone:** _____

Address: _____ **City:** _____ **Zip:** _____

SSN: _____ ☐ **Medi-Cal #:** _____

PRIMARY CARE PRACTITIONER (PCP) – INITIATING QUERY OR COORDINATION OF CARE

Practitioner's Name: _____ **Telephone:** _____ **FAX:** _____

Email: _____ **Date of Last Visit:** _____

Physical Diagnosis(es): _____

Current Medications: _____

Reason(s) for Request:

- ☐ Depression or anxiety symptoms not responding to therapy
- ☐ Suspected Pediatric ADHD
- ☐ Suspected Psychosis
- ☐ Suspected Mood Disorder
- ☐ Coordination of Care
- ☐ Suspected Substance Abuse
- ☐ Other _____

Practitioner's Signature: _____ **Date:** _____

After making a copy of the form for your records, give the original to the beneficiary to take to the Behavioral Health Practitioner (BHP) who will complete the response portion and return the form to you. Send results of CBC, LFTs, TFTs, U/A, EKG, and any relevant consults, procedure results, or information with your request.

BEHAVIORAL HEALTH PRACTITIONER- RESPONDING TO REQUEST

The PCP initiating this form is requesting behavioral health information for the above named person. Please complete and return this form via the beneficiary or by faxing to the PCP.

BHP Name: _____ **Telephone:** _____ **FAX:** _____

Diagnosis(es): _____

Date of Last Visit: _____ **Email:** _____

Current Medications: _____

Recommendations or Response to the Request (attach information if necessary): _____

Practitioner's Signature: _____ **Date:** _____

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Inter-Agency Referral Form for Alcohol and Drug Services

(courtesy of Napa County Health & Human Services Agency)

REFERRAL FORM

IDENTIFYING INFORMATION:

REFERRED BY: _____ DATE REFERRED_____ PHONE: _____
LAST NAME FIRST NAME

PERSON BEING REFERRED: _____ DOB: _____
LAST NAME FIRST NAME

ADDRESS: _____ GENDER: ☐Male ☐ Female

PHONE: _____ PRIMARY LANGUAGE ☐English ☐Spanish ☐Other/ASSISTIVE DEVICES _____

PAYOR: ☐ Drug Medical ☐Medi-Cal ☐Insurance ☐Self Pay ☐Other _____

PRIMARY CARE PHYSICIAN (PCP) _____NPI#_____PHONE:_____
LAST NAME FIRST NAME

REFERRING AGENCY/DEPARTMENT:

☐ HHSA
- ☐ Child Welfare Services
- ☐ Comprehensive Services for Older Adults
- ☐ Mental Health
- ☐ Public Health
- ☐ Self-Sufficiency (Cal WORKS)
- ☐ Other: _____

☐ CRIMINAL JUSTICE/LAW ENFORCEMENT
- ☐Probation ☐ CCSC/BI LSCMI#_____
- ☐ AB109
- ☐ Courts
- ☐ Police Department
- ☐ Public Defender
- ☐ District Attorney
- ☐ Sheriff Department
- ☐ Corrections
- ☐Other: _____

☐ OTHER AGENCIES
- ☐ Partnership Health Plan
- ☐ Path2Health/CMSP
- ☐ Clinic Ole
- ☐ Queen of the Valley
- ☐ NEWS
- ☐ HOPE
- ☐ Puertas Abiertas
- ☐ Shelter
- ☐ McAlister
- ☐ Other: _____

REASON FOR REFERRAL:

☐ Information/Referral ☐ Screening ☐ Crisis ☐ Assessment ☐ Treatment

☐ Consultation ☐ Case Management ☐ Aftercare ☐Other_____

AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION ATTACHED ☐ YES ☐ NO

SECTION TO BE COMPLETED BY ALCOHOL AND DRUG SERVICES STAFF ONLY

DISPOSITION OF REFERRAL:

☐ Assessment Completed

☐ Placed in Treatment Level based on Assessment: ☐ Detoxification ☐ Residential ☐ Day Treatment

☐ Intensive Outpatient ☐Outpatient ☐Other Services _____

☐ Referred to: ☐AA ☐NA ☐Alanon ☐Contractor_____ ☐Other Agency_____

☐ Other _____

☐ Informed Referring Agency of Disposition Staff Contacted: _____ Date: _____

ADS Staff Name: _____/_____ Date: _____
(Person completing this section/disposition of referral) LAST NAME FIRST NAME/JOB TITLE

05/29/2012 4:26:50 PM

Behavioral Health Primary Physician Patient Care Communication Form

Yolo County Alcohol Drug and Mental Health Services

(courtesy of Communicare Health Centers, Yolo County, CA)

Patient Name:	Date of Birth:	Social Security:
Address:	Phone:	Guarantor:

Primary Physician Information	**Behavioral Health Clinician Information**
Name:	**Name:**
Address:	**Address**
Phone:	**Phone:**

Sent To: ☐ Primary Care Physician ☐ Behavioral Health Provider

Purpose:

☐ Consultation ☐ Continuing Care ☐ Treatment Initiation

☐ Update ☐ Change in Treatment Plan ☐ At Treatment Termination

☐ Care Coordination Alert – Tx and Appt. Compliance ☐ Request that PCP will be following patient for Mental Health medications

☐ Other (specify) _____

Instructions:

To be completed by Behavioral Health Clinician

Diagnosis and/or brief description of presenting problem:

Action Plan: (Future treatment options)

BH Clinician Signature: Date:

Current Psychotropic Medications	**Dosage**	**Start Date**

To be completed by Primary Care Physician

Other information relevant to this patient's treatment, reason for referral/consultation request. Describe behavior/symptoms (attach additional pages or forms with information relevant to patient's treatment):

Primary Physician Signature: Date:

Significant Medications	**Dosage**	**Start Date**

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Referral to Primary Care from Behavioral Health Agency

(courtesy of Sierra Family Medical Clinic)

Referring Provider: **Date of Referral :** _____

Patient's Name: _____ **Phone #:** _____

Gender: Male Female **Age:** _____

Warm Handoff Done: Yes No

REASON FOR REFERRAL

Needs adjustment or addition of medication for behavioral health problem:

Medication:_____ Current Dosage:_____

Adjustment or addition suggested: _____

Side effect problems:

With BH medication: _____

With Other medication: _____

Other Medical problem: _____

_____

Patient Referral

If not seen today visit with Medical scheduled? Yes No Date scheduled: _____

FOR MEDICAL CLINIC ONLY

Date seen at Clinic _____ Patient did not show up

Medical Provider Initials _____ Patient not seen for other reasons

Referral to Behavioral Health from Primary Care Clinic

(courtesy of Sierra Family Medical Clinic)

Referring Provider:_____ **Date of Referral :** _____

Patient's Name: _____ **Phone #:** _____

Gender: Male Female **Age:** _____

Warm Handoff Done: Yes No

REASON FOR REFERRAL

Lifestyle Management Issues ***(check all that is applicable)***

Weight Management Tobacco use Recreational/ Illicit Drug Use

Stress Management Alcohol use Insomnia

Other _____

Behavioral Management Issues ***(check all that is applicable)***

Depression and Anxiety Depression only Anxiety only

Marital Relationship Bipolar

Other _____

Comments: _____

_____

Patient Referral

If not seen today visit with BHC scheduled? Yes No Date scheduled: _____

FOR BEHAVIORAL HEALTH COUNSELOR

Date seen at BHC _____ Patient did not show up

BHC Initials _____ Patient not seen for other reasons

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Behavioral Health Consultation Referral

Patient Name: _____ DOB: _____ Date: _____

Med Rec #: _____ Referral to: ☐ PCC ☐ Psychiatrist ☐ Psychotherapy ☐ CSS / MH

Phone #: _____ Referred by *(Provider)*: _____

Please Evaluate or Follow-up with Patient for: (Check as many boxes as apply)

Depression	Anxiety	Mood/Behavior Problems	Substance Abuse *(Specify)*
☐ Problem Coping c Depression *(Specify)*	☐ Problem Managing Anxiety *(Specify)*	☐ Peer Relational Conflicts	☐ EHOH
☐ Situational Depressed Mood	☐ Panic Attacks	☐ Sleep Problems	☐ Marijuana
☐ Functional Impairment	☐ Related to Specific Situations	☐ Attention Problems	☐ Nicotine
☐ Hx of Mania (Bipolar)	☐ Generalized	☐ Impulsivity/ Hyperactivity / Restlessness	☐ Caffeine
☐ Suicidal Ideation	☐ Obsessive/Compulsive Behavior	☐ Anger Control Problems	☐ Amphetamines
☐ Issues of Loss/Bereavement	☐ Related to Trauma (i.e., PTSD)	☐ Child Abuse/Neglect	☐ Opiates
		☐ Sexual Abuse/Assault *(Specify)*	☐ Prescription Medications
		☐ Victim ☐ Perpetrator	☐ Over the Counter Medications
		☐ Irritability/Agitation	☐ Inhalants
		☐ Other	☐ Other
Psychosis	**Adjustment Problems**	**Medical-Related Issues**	**Pregnancy *(Specify)***
☐ Auditory Hallucinations	☐ Acculturation / New Arrival Issues	☐ Chronic Pain/Illness, Fibromyalgia, CFS	☐ Prevention
☐ Visual Hallucinations	☐ Problems Accessing Services	☐ Diabetes Issues	☐ Unwanted
☐ Delusions (Bizarre / Irrational Beliefs)	☐ Homelessness	☐ Medication Adherence Issues	☐ Fetal Death
☐ Disorganized Speech / Behavior	☐ Financial Problems	☐ Traumatic Brain Injury	☐ Teen
	☐ Work-Related Stress	☐ Memory Problems / Dementia	☐ Related Emotional Problems
	☐ Joblessness / Termination Issues	☐ Other	
Sexual Issues	**Relationship / Family Issues**	**Childhood**	**Eating / Control Issues**
☐ Sexual Dysfunction	☐ Parenting Issues	☐ Child Behavior Problems	☐ Eating Disorder (i.e., Bulimia)
☐ Problem c Sex Interest / Communication	☐ Relationship / Couples Problems	☐ Enuresis / Encropresis	☐ Change in Appetite
	☐ Domestic Violence	☐ Communication Issues (i.e., withdrawal)	☐ Over Eating
		☐ Developmental Learning D/O (i.e., MR)	☐ Weight Gain / Loss
		☐ Somatic Complaints	

Additional Concerns or Questions: _____

Initial Behavioral Health Consultation Note

☐ Called Pt., Left Message: (Int. _____) ☐ Called Pt., No ans./ Busy: (Int. _____) ☐ Scheduled Appt. for ___ / ___ / ___

Subjective / Objective:

Mood: ☐ Depressed ☐ Anxious ☐ Angry ☐ Elevated ☐ Irritable ☐ Normal
☐ SI/HI (specify) Plan: _____ Intent: _____ Si/Hi/At Hx: _____ ☐ Means: _____

Affect: ☐ Intact/Normal ☐ Constricted ☐ Flat ☐ Blunted ☐ Labile

Thought Process ☐ Normal ☐ Blocking ☐ Tangential ☐ Circumstantial ☐ Loose

Insight: ☐ Good ☐ Fair ☐ Poor

Living Situation: ☐ Alone ☐ Partner ☐ Children ☐ Siblings ☐ Parents ☐ Homeless ☐ Other

Social Support:

Available Resources	*Contact with Resources*			
Family Members	☐ Frequent	☐ Occasional	☐ Rare	☐ Never
Friends/Neighbors/Coworkers	☐ Frequent	☐ Occasional	☐ Rare	☐ Never
Community/Religious Supports	☐ Frequent	☐ Occasional	☐ Rare	☐ Never

Diet: (Food, Fluids, Habits) _____

Substance Use: (EtOH, Caffeine, MJ) _____ Frequency: _____

Sleep: (Amt, Quality, Routine) _____

Exercise / Stress Relief: (Type, Frequency) _____

Assessment/Intervention:

_____

Diagnosis: **Axis I** **Code** _____ **Nomenclature** _____

Code _____ **Nomenclature** _____

Axis II **Code** _____ **Nomenclature** _____

Recommendations / Referrals:

_____

BH Signature: _____ **Date:** _____ **Follow Up:** _____ **Co-Signature:** _____

Sample Forms

Request for Psychiatric Consultation

(courtesy of Yolo County Alcohol, Drug and Mental Health, CA)

Partnership Health Plan

Date sent:
Received:

Patient Name (Last, First, Middle Initial)	Date of Birth
Parent Name (if patient is a minor)	Phone ( )
Primary Language (If patient is a minor please indicate parent's primary language) ☐ **English** ☐ **Spanish** ☐ **Other (please specify):**	Phone (alternate) ( )
Address (street, apt. #, city, state, zip code)	Social Security Number --- ---
Diagnostic Impression:	

PLEASE CHECK ALL BOXES THAT PERTAIN TO SYMPTOMATIC CONCERNS		
☐ **Depression**	☐ **Suicidal ideation**	☐ **Suicidal planning/gestures**
☐ **Hallucinations**	☐ **Paranoia**	☐ **Disassociation**
☐ **Self-injurious behavior (specify):**		☐ **Agitation**
☐ **Severe insomnia**	☐ **Loss of functionality**	☐ **Danger to others**
☐ **Anger management**	☐ **Grave Disability**	☐ **Substance Abuse**
☐ **Other (specify):**		

LEVEL OF INTERVENTION REQUESTED

☐ **Psychiatric consultation (the receiving psychiatrist will review the referral and provide phone consultation or an in person appointment as per their assessment of this information)**

☐ **Therapy only (MUST HAVE MEDI-CAL ONLY COVERAGE): please have your patient call Crisis and Triage at 1-530-666-8630 to schedule their own services. THERE IS NO NEED FOR A PHYSICIAN REFERRAL. All clients making contact are screened for the appropriate level of care and referred for appropriate services.**

PSYCHIATRIC MEDS. (if currently prescribed)	MAX. DOSAGE ATTEMPTED	LENGTH OF TREATMENT	RESULT (concerns, side effects, benefits, etc. to assist the consulting psychiatrist)

PLEASE ATTACH PRINTOUT OF ALL MEDICATIONS

Specify clinic/lab evaluations, which have been completed to rule out physical health disorders:

☐ **CBC** ☐ **Chemistry Panel** ☐ **LFT** ☐ **Thyroid Panel** ☐ **Drug Screen** ☐ **None**

☐ **Other (specify):**

PLEASE ATTACH COPIES OF ALL POSITIVE LAB RESULTS

CO-OCCURING CONDITIONS		
☐ **Traumatic brain injury**	☐ **Diabetes**	☐ **Thyroid (hypo/hyper)**
☐ **Cancer**	☐ **COPD**	☐ **Chronic pain**
☐ **Dementia (i.e. medically related cognitive impairment)**		☐ **Severe weight loss**
☐ **Pregnancy**	☐ **Post-partum**	☐ **Menopause**
☐ **Other:**		

PLEASE ATTACH COPIES OF RELEVANT H&P'S, CLINICAL NOTES, CONSULTS, LABS, ETC.

Referring MD/NP name:	Office Contact:
Office Phone:	OfficeFAX:

IBHP Integrated Behavioral Health Project

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Client Questionnaire About Medical Services Received

(courtesy of Horizon House, Philadelphia, PA)

Program_____

Dear Horizon House Participant:

Horizon House is thinking about offering medical services at our 30th Street location. To help us make a decision about offering medical services, we'd like to know a little about the medical services you receive, how happy you are with your doctor, and whether you would use medical services at 30th Street if they were available.

Please answer the following questions by placing a check mark (√) next to the best choice:

1. Do you currently have a medical doctor?
   __ Yes
   __ No

2. Is this the doctor you see if you need a check-up, want advice about a health problem, get prescriptions refilled, or get sick or hurt?
   __ Yes
   __ No

3. How long have you been going to this doctor?
   __ Less than 6 months
   __ At least 6 months but less than 1 year
   __ At least 1 year but less than 3 years
   __ At least 3 years

4. How often do you see this doctor?
   __ Every 2 years
   __ Once a year
   __ Every 6 months
   __ Every 3 months
   __ Never

5. How happy are you with your medical doctor?
   __ Very Happy
   __ Happy
   __ Not too happy
   __ Unhappy

6. If medical services were available at our 30th St office, how likely is it that you would use a doctor at Horizon House for your medical care?
   __ Very likely
   __ Likely
   __ Not so likely
   __ Unlikely

Thank you for completing this survey!

Template
FQHC Change in Scope Request to Operate a Primary Care Site at an Outpatient Mental Health Center

(courtesy of the Pennsylvania Department of Health)

XXXX FQHC proposes to add a site for primary medical care at YYYYY, an outpatient mental health treatment center located at _____. YYYYY is a private, non-profit corporation that provides outpatient mental health services, fully licensed by the _____ Department of Health. This proposed program is a result of collaborative discussions with YYYY regarding the lack of access to primary medical care services for persons with serious mental illness. The target population for this project consists of clients being treated at YYYY only and not the general population in this area.

According to the National Center for Community Behavioral Health's April 2009 report on the future of the behavioral health system, behavioral healthcare operates as a system within, beside, beneath, and, at times, totally separate from the broader healthcare arena. This report refers to statistics showing that people living with serious mental illnesses are dying 25 years earlier than the rest of the population. This disparity in mortality is found to be due, in large part, to unmanaged physical health conditions caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.

The report observes that lack of access to primary care services and lack of focus on unmanaged physical health conditions in community mental health centers are two major barriers to addressing the disparity in the morbidity and mortality of persons with serious mental illness (SMI). These statistics suggest that persons with SMI may be the population with the greatest health disparity in the United States.

XXXX will provide on-site primary medical care to existing adult clients at this center, delivered by a Mid-level practitioner supervised by a MD/DO. Services will be available 5 days per week. Clients who need dental services will be referred to XXXX's Care Center. Most of YYYY's patients are insured through the State's Medicaid program and revenue from medical services will adequately cover the costs of this program. For patients without health insurance, a fee will be charged based on XXXX's sliding fee scale. No additional section 330 grant funds will be required. (See budget)

TRAINING & RESOURCES

INTEGRATED BEHAVIORAL HEALTHCARE TRAINING AND RESOURCES

Note: Since IBHP is responsible for this Tool Kit, we get to give our own website a special plug. We've created a virtual library as a resource for those contemplating, planning and operating programs that integrate behavioral and medical services. Go to: www.ibhp.org

Name of Organization	Type of Organization	Description of Integration Training Resources	Website and Contact
Addiction Technology Transfer Center Network	Federally-sponsored multidisciplinary resource for professionals in the addictions treatment and recovery services field	▪ sponsors CATES (California Addiction Training and Education Series) on a regional basis to acquaint providers about how substance use disorders treatment will figure into the Patient Protection and Affordable Care Act; ▪ offers free on-line cognitive behavioral therapy course; ▪ offers free self-paced substance abuse-related on-line courses, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) training	http://www.attcnetwork.org/regcenters/generalContent.asp?rcid=11&content=STCUSTOM1; *Website for on-line learning*: http://www.attcelearn.org/ *Contact:* ghovik@ucla.edu for CATES; *Contact:*WenPin.Lai@va.gov for cognitive behavioral therapy course;
Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care.	Federally-funded national resource and coordinating center for integrated care.	▪ provides a web-based informational hub structured around eight topics: education; policy; research; financing and sustainability; clinical and community; health information technology; resources; and collaboration; ▪ has a research section on website which allows the user to look up current research by entering title, author or key words	http://integrationacademy.ahrq.gov *Contact:* (301) 427-1104
AIMS Center, University of Washington	University	▪ offers fee-based certificate program in integrated behavioral health, consisting of three in-depth courses of 90 contact hours each over six months; ▪ provides fee-based consultation and training in integrated care; currently working with several California counties; ▪ makes on-line 12-module training on the IMPACT model of treating depression in primary care available free	http://uwaims.org/ http://impactuw.org/training/onlinetraining.html *Contact:* uwaims@uw.edu, powersd@uw.edu

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Alcohol and Other Drug Policy Institute		▪ provides free training and technical assistance to the drug treatment field ▪ assists in designing and implementing a statewide system of care	http://www.aodpolicy.org/TCTA/TCTA.htm *Contact:* vkogler@aodpolicy.org
Behavioral Health Connect	Private consultation organization formed by professionals from University of Massachusetts (geared to primary care private practice rather than FQHC's)	▪ "offers turn-key behavioral health solutions for primary care practices seeking to operate as Patient Centered Medical Homes"; ▪ makes behavioral health consultants available to primary care patients and providers, on-demand, using video conferencing technology; ▪ incorporates psychiatric consultation, self-care resources and care managers	http://bh-connect.com/pages/overview.html *Contact*: tfarris@bh-connect.com
California Institute for Mental Health (CiMH)	Statewide organization funded through charitable foundations, county, state, and federal contracts, grants, fees, and product sales to promote excellence in mental health	▪ conducts regionally and issue-oriented learning collaboratives about various aspects of integrated care; ▪ sponsors in-person and web-based integrated care training; ▪ identifies and describes integrated care programs and pilots throughout the state; ▪ develops informational material on relevant collaborative topics; ▪ makes training webinars available on-line; ▪ maps integration initiatives throughout California'	http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx http://www.cimh.org/Initiatives/Primary-Care-BH-Integration/Webinars.aspx *Contact:* nnitsch@cimh.org
California Institute of Mental Health (CiMH) Small County Integration Collaborative	Statewide organization's time-limited (one year) integrated care initiative for small county mental health agencies	▪ concentrates on improving medical outcomes in persons with serious mental health disorders in 13 rural counties by instituting and testing physical risk identification practices within the mental health system. ▪ uses an incremental step-by-step approach to help county mental health departments identify and implement actionable and measurable medical goals. ▪ develops change packages with specific goals and measurement approaches; ▪ conducts learning community training	*Contact:* jclancy@cimh.org

California Institute of Mental Health (CiMH) Care Integration Collaborative	Statewide organization's time-limited integration project involving behavioral health and primary care providers	▪ sponsors learning sessions to accelerate integrated care in California; ▪ brings together seven teams of county partners from the local mental health plan, primary care, specialty mental health, and substance use agencies to work on improving intra-county collaboration and thus client health outcomes. ▪ focuses on screening and monitoring, and coordinating stepped care among primary and specialty providers; ▪ develops change packages with specific goals and measurement approaches	http://www.cimh.org/Initiatives/Primary-Care-BH-Integration/Webinars.aspx ; http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx *Contact* gale.bataille@mac.com
CalMEND	Now concluded statewide initiative sponsored by the California Department of Health Care Services and the Department of Mental Health to improve quality and outcomes for publicly funded mental health services	▪ sponsored integration of primary care and mental health learning collaborative; conducted a pilot project (CPCA) involving six county mental health-primary care partnerships designed to improve healthcare for persons with co-occurring mental and physical illness [no longer active]	http://www.dhcs.ca.gov/provgovpart/Pages/CalMENDLandingPage.aspx
Center for Integrated Healthcare	U.S. Dept. of Veterans Affairs	▪ gives an overview of current research projects at the Center; ▪ furnishes an operations manual for co-located collaborative care and practice management tools	http://www.mentalhealth.va.gov/coe/cih-visn2/
Center for Integrated Health Solutions	Nationally-based agency run by the Nat'l Council for Community Behavioral Healthcare and funded by SAMHSA and HRSA	▪ offers training and technical assistance; ▪ provides on-demand webinars; ▪ sponsors integration-oriented learning communities in different regions of the United States; ▪ provides newsletters; discussion boards; tool kits; guidelines; fact sheets; and training curricula on all facets of integrated care practice and workforce development	http://www.integration.samhsa.gov/ *Contact:* integration@thenationalcouncil.org

Center of Excellence for Integrated Care (ICARE)	A program of the North Carolina Foundation for Advanced Health Programs	▪ Website describes practice models, practice tools, roles and responsibilities, billing codes and other practical issues germane to integrated behavioral care	http://www.icarenc.org/
Cherokee Health Systems Primary Behavioral Care Integration Training Academy	Training branch of a Tennessee-based primary care clinic nationally recognized for its pioneer work in integrated care	▪ provides technical assistance to organizations interested in integrated care implementation and solutions; ▪ offers shadowing opportunities for primary care and behavioral health providers at their facility; ▪ conducts strategic, tactical and business planning and demonstrates financial models; ▪ offers individual case consultations	http://www.cherokeetraining.com/
Collaborative Family Health Association (CFHA)	Professional organization devoted to collaborative care; fee-based membership	▪ holds annual conference focusing on integrated behavioral care; ▪ publishes *Families, Systems, & Health*' a peer-reviewed, multidisciplinary journal that publishes clinical research, training, and theoretical contributions in the areas of families and health, with particular focus on collaborative family healthcare ▪ sponsors work groups on select topics (for members); ▪ offers blogs on various collaborative care issues; ▪ posts a jobs board ▪ displays Powerpoints and distributed material from conferences (for members)	http://www.cfha.net/ *Contact:* info@CFHA.net
Community Clinics Health Network	Foundation-supported organization run by the Council of Community Clinics (CCC) of San Diego to assist CCC members with the transition of San Diego's Medi-Cal patients to	▪ implements San Diego Integration Institute to assist behavioral health, alcohol and other drugs service, and primary care providers in achieving inter-organization, bi-directional integration; ▪ provides on-demand webinars on integrated topics via their website; ▪ develops learning communities; ▪ holds San Diego-based integration summits discussing barriers and	http://www.cchealthnetwork.com/projects/integration-institute-(i2).aspx; http://www.cchealthnetwork.com/about/cchn-events-calendar/on-demand-webcasts-.aspx *Contact:* info@ccc-sd.org

	managed care.	solutions; ▪ surveys and describes integrated programs in San Diego	
Council of Community Clinics	Consortium of community health clinics in San Diego county	▪ manages the Mental Health and Primary Care Integration Project, funded by the Mental Health Services Act and San Diego County; ▪ coordinates SAMHSA-funded pilot program partnering mental health and primary care agencies; ▪ runs the Community Clinic Health Network (see separate listing)	http://www.ccc-sd.org/ http://www.cchealthnetwork.com/about/cchn-events-calendar/on-demand-webcasts-.aspx *Contact*: info@ccc-sd.org
Fairleigh-Dickinson University	University	▪ sponsors a fee-based certificate program in Integrated Primary Care that can be accessed on-line (20 weeks to complete; consists of five units, each divided into 4 week-long modules, each including a video lecture, interaction with the instructor and colleagues through chats, and additional readings)	www.integrated care.fdu.edu *Contact:* mcgrath@fdu.edu
Hogg Foundation for Mental Health	Endowed foundation to promote mental wellness in Texas	▪ provided grants to clinics to further integrated care; ▪ offered learning collaboratives to Texas clinics ▪ provides web-based seminar about financing integrated care; ▪ published a report about integrated care resources, programs, policies and barriers	http://www.hogg.utexas.edu/initiatives/integrated_health_care.html http://www.hogg.utexas.edu/uploads/documents/IHC_Resource_Guide1.pdf
HRSA Primary Care	Federal government	▪ awards grants to primary care providers ▪ provides technical assistance for development and operation of primary care programs ▪ includes tools like terminology tip sheets and templates on website ▪ with SAMHSA, co-sponsors the Center for Integrated Health Solutions (see separate listing)	http://bphc.hrsa.gov/
IMPACT	Program sponsored by the University of Washington, Dept. of Psychiatry and the Behavioral Sciences	▪ offers tools, training research findings and success stories centering on evidence-based approach to treating depression in primary care	http://impact-uw.org/

Integrated Behavioral Health Project (IBHP)	CalMHSA-sponsored organization based at the Tides Center promoting integrated care throughout California	▪ identifies and disseminates effective, culturally-relevant strategies for integration; develops and provides tools, technical assistance and information; ▪ conducts training on various facets of integrated care; ▪ maintains integration resource website that includes operational manuals, forms, tools, research findings, models, procdures, etc; ▪ publishes a Collaborative Care Tool Kit; ▪ provides technical assistance to providers interested in furthering integrated care	www.ibhp.org *Contact*: info@ibhp.org
Integrated Care Resource Center	Government-run (U.S. Dept of Health and Human Services) resource for states	▪ disseminates best practices for delivering coordinated health care to Medicaid's high-need, high-cost beneficiaries; ▪ offers information about care management, program design, consumer engagement and data management to enhance integrated care	http://www.integratedcareresourcecenter.com/Default.aspx *Contact:* integratedcareresourcecenter@cms.hhs.gov
MacArthur Initiative of Depression in Primary Care		▪ provides website that describes projects to improve primary care management of depression and details research findings; ▪ offers Tool Kit to help primary care providers recognize and manage depression	http://www.depression-primarycare.org/
Mental Health America	Nonprofit national mental health advocacy organization	▪ supports national, state, and local efforts to integrate mental and general health care Addresses public policy issues relating to integrated care; ▪ offers occasional webinars on integrated care topics; ▪ provides information on client engagement, cultural competence, wellness and self-help ▪ includes Powerpoint presentations on integrated care on its website	http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/integrated-care *Contact:* info@mentalhealthamerica.net
Mental Health America of California	Nonprofit statewide mental health advocacy organization	▪ is a partner with IBHP in its efforts to enhance integrated care; ▪ addresses integrated care policy issues via legislation and other avenues	http://www.mhac.org/ *Contact:* zkhanna@mhac.org

Milbank Memorial Fund	Endowed foundation that works to improve health	▪ sponsored a report describing evolving models of behavioral health integration in primary care settings	http://www.milbank.org/reports/10430EvolvingCare/10430EvolvingCare.html
Mountainview Consulting Group	Private consultants	▪ offers an array of technical assistance and field training about the primary behavioral health model (championed by Kirk Strosahl) ▪ assisted San Francisco County in implementing a system wide integrated behavioral health model	http://www.behavioral-health-integration.com/news.php
National Academy for State Health Policy	Independent academy of state health policymakers	▪ provides information about integrated health homes and evidence-based behavioral health practices among many other health-related topics ▪ offers webinars available on-line about integrated care in the patient-centered health home	http://www.nashp.org/webinar/power-integrated-care-implementing-health-homes-medicaid *Contact:* info@nashp.org
National Committee for Quality Assurance (NCQA)		▪ describes standards, criteria, practices and quality measurements for the patient-centered medical home	http://www.ncqa.org/Home.aspx
National Council for Community Behavioral Healthcare	National membership professional organization of behavioral health agencies	▪ runs the Center for Integrated Health Solutions (see above); ▪ holds annual conference that often includes integrated care presentations and discussions; ▪ addresses public policy issues related to integrated care ▪ oversees learning communities for Primary Care-Behavioral Health Integration (PCBHI) grant recipients.	http://www.thenationalcouncil.org/ *Contact:* Communications@thenationalcouncil.org
National Institute on Drug Abuse (NIDA)	Federal government agency	▪ provides interactive tools to guide clinicians in detecting and treating substance abuse	http://www.nida.nih.gov/nidamed/screening/
Ohio Coordinating Center for Integrating Care	Sponsored by the Ohio Department of Mental Health	▪ provides networking opportunities, training and technical assistance to providers, funders, consumers and family members; ▪ advocates for integrated care ▪ evaluates efficacy by helping providers collect, analyze and share quality improvement, program evaluation and consumer outcome data	http://www.occic.org/

Patient-Centered Primary Care Collaborative	Foundation-supported collaborative of large national employers, primary care physician associations, health benefits companies, trade associations, profession/affinity groups, academic centers, and healthcare quality improvement associations	▪ serves as a dissemination center for information on patient centered medical home pilot (PCMH) efforts around the country; ▪ assists in demonstration efforts through sharing of best practices, lessons learned, and results from existing PCMH projects	http://www.pcpcc.net/ *Contact:* (202) 417-2081
Rand Partners in Care	Nonprofit research organization	▪ consists of two programs designed to improve quality of care for depression in managed primary care practices	http://www.rand.org/health/projects/pic.html
Sierra Family Medical Clinic	Primary care clinic in Nevada City, CA	▪ created a series of free training videos demonstrating how primary care providers can introduce patients to behavioral health services and professionals through a "warm hand-off"	http://www.youtube.com/user/sierrafamilymedical?feature=results_main
Substance Abuse and Mental Health Administration (SAMHSA)	Federal government	▪ lists, describes, and awards nationwide grants for health homes and primary and behavioral health care integration; ▪ provides screening tools, models, outcomes, research and payment methods; ▪ sponsors the Center for Integrated Health Solutions (see listing)	http://www.samhsa.gov/healthReform/healthHomes/index.aspx
UC Davis Department of Psychiatry	University	▪ provides telepsychiatry services to community care facilities	*Contact:* robert.mccarron@ucdmc.ucdavis.edu; jaesu.han@ucdmc.ucdavis.edu
UC San Francisco School of Nursing	University	▪ offers training program for psychiatric mental health clinical nurse specialists and nurse practitioners to provide primary mental health care	http://nursing.ucsf.edu/ *Contact:* beth.phoenix@nursing.ucsf.eduhttp://nursing.ucsf.edu/

UCLA Integrated Substance Abuse Program (ISAP)	University	▪ coordinates substance abuse research and treatment within the Department of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine; ▪ works to develop and evaluate new approaches and moves empirically supported treatments into mainstream application; ▪ offers 1.5 hour self-paced online SBIRT course; ▪ sponsors co-occurring disorders conferences and training	http://www.uclaisap.org/index.html *Contact:* isap@ucla.edu.
University of Massachusetts Medical School, Center for Primary Care	University	▪ offers fee-based live weekly (over six months) televised integrated care training course resulting in a certificate in Primary Care Behavioral Health; ▪ includes integrated models, cost effectiveness, other resources on website; ▪ offers computer-based individual integration training for a fee	http://www.umassmed.edu / content.aspx?id=76312 *Contact:* alexander.blount@umassmemorial.org; mch@umassmed.edu
University of Michigan	University	▪ offers, for a fee, a web-based 40 hour course designed for clinical practitioners culminating in a Certificate in Integrated Behavioral Health and Primary Care	http://ssw.umich.edu/programs/ce/ibhpc/fees.html
University of Missouri School of Medicine	University	▪ offers web-based individual integration training for a fee ▪ offers on website training in SBIRT – Screening, Brief Intervention and Referral to Treatment – for use in medical settings to address substance abuse issues	https://adept.missouri.edu/
University of Vermont School of Medicine, Behavioral Health VT	University	▪ created a series of web-accessed training videos focusing on operational aspects of integrated care	http://www.youtube.com/user/BehavioralHealthVT

Chart prepared by Barbara Demming Lurie, IBHP for CalMHSA

A SAMPLING OF IN-HOUSE INTEGRATED CARE COURSES/PROGRAMS AT COLLEGES AND UNIVERSITIES		
Arizona State University, Nicholas A. Cummings Health Program	offers a Doctor of Behavioral Health, tailored to behavioral care providers in primary care	*Contact:* Ronald.odonnell@asu.edu.
Dartmouth Hitchcock Medical Center	offers fellowships in Behavioral Medicine including one in Primary Care Psychology	*Contact:* Tim Ahles, PhD, 603 650-7521.
Forest Institute of Professional Psychology	offers a Primary Care Psychology Program	*Contact:* (800) 424-7793
George Washington University Medical Center	Created a Center for Integrated Behavioral Health Policy to work with employers and public health care purchasers, health plans, providers, and government leaders to create policies and practices that integrate behavioral and physical health	*Contact:* SaraR@gwu.edu,
Loma Linda University, Marital and Family Therapy Program and the School of Public Health Department of Health Promotion and Education.	offers a certificate program in drug and alcohol counseling	http://www.llu.edu/behavioral-health/cfs/certificate.page *Contact:* bjones@llu.edu
Michigan State University, Flint Area Medical Education	**Offers two**-year post doctoral fellowships in Clinical Health Psychology with positions in Health Psychology/Physical Medicine and Rehabilitation or Health Psychology/Primary Care and Specialty Care Medicine	*Contact:* kassiff@msufame.msu.edu
Radford University, in concert with SVCHS Integrative Behavioral Health Care Services	developing a certificate program for all disciplines of psychology, clinical counseling, and clinical social work preparing future behavioral health specialist to work within primary care settings	*Contact:* bmcfeatur@radford.edu
UC Davis Department of Psychiatry	offers integrated psychiatric residencies; has six year $2.8 million grant to "further develop a replicable and integrative a med/psych curriculum that can be used at other training programs"	http://www.ucdmc.ucdavis.edu/psychiatry/residency/combfam/ *Contact:* robert.mccarron@ucdmc.ucdavis.edu; jaesu.han@ucdmc.ucdavis.edu

UCLA Collaborative Centers for Integrative Medicine	offers pre and post graduate fellowships in "Health Psychology: Biobehavioral Issues in Physical and Mental Health" focusing on the biopsychosocial bases of health and illness; includes the Norman Cousins Center for Psycho-neuroimmunology which "investigates the interactions between the brain and the body and the role of psychological well-being for health and recovery from illness"	http://ccim.med.ucla.edu/; *Contact:* mstuber@mednet.ucla.ed *Contact*: emayer@ucla.edu
University of Arkansas Department of Psychology	scheduled to begin an Integrated Behavioral Sciences Service program designed to bring behavioral health care to primary care settings	*Contact:* psycapp@uark.edu
University of California, San Diego, Family Medicine Center	takes a collaborative care approach for training medical and other graduate students at their Family Medicine Center	http://som.ucsd.edu/ *Contact*: Gkallenberg@ucsd.edu
University of California, San Francisco School of Nursing, Advanced Practice Psychiatric Nurse Program	offers training for psychiatric mental health clinical nurse specialists and psychiatric mental health nurse practitioners in primary care settings; places nursing students in integrated primary care settings	*Contact:* beth.phoenix@nursing.ucsf.edu and ames.dilley@ucsf.edu
University of Chicago-affiliated Chicago Center for Family Health and MacNeal Health Network	provides post-graduate training in family therapy and family systems-based health care in collaboration with a multidisciplinary team of specialists	*Contact:* ccfh.admin@ccfhchicago.org
University of Massachusetts Medical School, Center for Primary Care	has a two year post-doctoral fellowship in primary care psychology	http://www.umassmed.edu/Content.aspx?id=93428 *Contact*: amy.green@umassmed.edu
University of Minnesota, Dept. of Family Medicine and Community Health	offers a postdoctoral fellowship in behavioral medicine emphasizing integration of behavioral medicine in primary care	*Contact:* fmch@umn.edu
University of Mississippi Medical Center, Department of Family Medicine	offers two two-year psychology postdoctoral fellowships in primary care	*Contact:* University of Mississippi Medical Center, 2500 N. State St., Jackson, MS 39216
University of Rochester Medical School's Center for Health and Behavioral Training	offers a Primary Care Family Psychology post-doctorate fellowship	*Contact:* Carol_Podgorski@urmc.Rochester.edu
University of Southern California (USC) School of Social Work	has graduate program to train social work students as cancer depression clinical specialists	http://sowkweb.usc.edu/ *Contact:* ell@usc.edu

chart prepared by Barbara Demming Lurie, IBHP, for CalMHSA

In addition, the following universities and health organizations received HRSA grants to support graduate psychology training in integrated settings:

Alfred I. Dupont Hospital for Children/NCC-DV,	Wilmington, DE
Board of Trustees, University of Arkansas	Fayetteville, AR
Boston Medical Center Corp.	Boston, MA
Cherokee Health Systems	Knoxville, TN
Children's Hospital Los Angeles	Los Angeles, CA
Eastern Virginia Medical School	Norfolk, VA
Georgia State University Research Foundation,	Atlanta, GA
Medical College of Georgia, Research Institute, Inc.	Augusta, GA
Regents of the University of Colorado/University of Colorado	Colorado Springs, CO
The Regents of New Mexico State University	Las Cruces, NM
University of Massachusetts Medical School	Worcester, MA
University of Nebraska Medical Center	Omaha, NE
University of North Carolina at Greensboro	Greensboro, NC
University of North Dakota	Grand Forks, ND
University of Rochester Medical Center	Rochester, NY
University of Texas Austin	Austin, TX
University of Washington	Seattle, WA
Virginia Commonwealth University	Richmond, VA
Wayne State University	Detroit, MI

PRACTICAL INTEGRATED CARE HOW-TO BOOKS, TOOL KITS AND MANUALS

AUTHOR	TITLE	DESCRIPTION	INTERNET ACCESS
Christopher Hunter et al.	*Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention*	Offers framework to guide practice as well as a toolbox with sample transcripts, checklists, and patient handouts	Can be purchased ($66) at: http://www.amazon.com/Integrated-Behavioral-Health-Primary-Step/dp/143380428X
CiMH (Dale Jarvis)	*Tool Kit of Promising Practices for Financing Integrated Care in the California Safety Net*	Explores the complex mix of funding streams for mental health, physical health and substance abuse treatment and suggests successful approaches to reimbursement	http://www.ibhp.org/uploads/file/Dale%20Jarvis%20Promising%20Practice%20Tool%20Kit.pdf
CiMH Care Integration Collaborative	*Care Integration Collaborative Core Measures*	Gives suggested measures and methodology for collecting data assessing steps to increase and improve collaboration between primary care, substance abuse treatment providers and mental health agencies	http://www.ibhp.org/uploads/file/CIC_Measures_Draft_120320_B.pdf
CiMH Small County Integration Collaborative	*SCIC Core Measures*	Gives steps, suggested measures and methodology for collecting data assessing interventions to improve physical health of clients in the mental health system	http://www.ibhp.org/uploads/file/SCCI_Measures_Draft_12_03_10_E.pdf
Commonwealth Fund	*Reducing Care Fragmentation*	Offers change ideas, case studies and forms designed to bridge the care gap	http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf
Golden Valley Health Centers (Elizabeth Morrison)	*Manual for Integrated Health Services*	Provides protocol, sample scripts, forms and protocol, staffing recommendations and other useful information for behavioral health professionals working in primary care settings	http://www.ibhp.org/uploads/file/IBHSManual2008.pdf
Hogg Foundation	*Integrated Health: Connecting Body and Mind*	Summarizes various approaches to integration and what is known about their effectiveness; identifies resources; and describes integrated health care programs nationally.	http://www.hogg.utexas.edu/uploads/documents/IHC_Resource_Guide1.pdf

IBHP (Barbara Demming Lurie)	*Partners in Health: Mental Health, Primary Care & Substance Use Interagency Collaboration TOOLKIT (2013)*	Contains advice, checklists, MOU's, job descriptions, forms, model descriptions and other material to assist collaboration between primary care and mental health providers.	http://www.ibhp.org
K. Miles, Karen Linkins, et al.	*Conceptualizing and Measuring Dimensions of Integration in Service Models Delivering Mental Health Care to Primary Care Patients*	Offers a menu of process and outcome measures, level of integration indicators, client satisfaction surveys and other measurement instruments	www.ibph.org/index.php?section=pages&cid=184
Larry James and William O'Donahue	*The Primary Care Tool Kit: Practical Resources for the Integrated Primary Care Provider*	Contains chapters on how to determine need; financial models; behavioral screening; and implementing consultation services, among many	http://www.amazon.com/Primary-Care-Toolkit-Integrated-Behavioral/dp/0387789707/ref=sr_1_10?s=books&ie=UTF8&qid=1366696533&sr=1-10 (preview pages only; book has to be purchased)
Millbank Memorial Fund (Chris Collins et al.)	*Evolving Models of Behavioral Health Integration in Primary Care*	Describes various integrated models and gives incremental steps for integrating care (in tables in the second half of this paper)	http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf
Robinson, P. & Reiter, J. (2006)	*Behavioral Consultation and Primary Care: A Guide to Integrating Services*	Presents a guide for implementing the behavioral health consultation model within primary care	Can be purchased ($61) via http://www.amazon.com/Behavioral-Consultation-Primary-Care-Integrating/dp/0387329714#reader_0387329714
US Air Force	*Primary Behavioral Health Care Services Practice Manual (2002)*	Provides instructions for establishing primary care-based behavioral health programs	http://www.integratedprimarycare.com/files/primary%20care%20practice%20manual.pdf

Prepared for CalMHSA by IBHP, Barbara Demming Lurie

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 biopyschosocial model.	Grants, county funds and 3rd 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 3rd 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.

Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives
Final Report

Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
Colorado Access Integration Model Denver, Colorado and surrounding areas	Colorado Access, a managed care organization formed by Denver area safety-net providers to serve publicly insured populations	Adult Medicaid enrollees, focusing on the most costly 2-3%	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.	Grants and Medicaid managed care capitation payments	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.	Significant reduction in physical health care costs for high risk plan members, making it an economically sustainable model of integration
Community Care of North Carolina Mental Health Integration North Carolina	Community Care of North Carolina, the state's PCCM program	Adolescents and adults in the Medicaid PCCM program	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.	Medicaid and grant funding	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.	Standard measurements across the pilot sites have been created. Data collected from the PHQ-9 supports the project and the need for additional support.

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Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
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" worksites to facilitate communication among interdisciplinary staff.	3rd 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 are 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.	3rd 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.

Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives
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Name of Program/Location	Implementer	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes
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 3rd 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.

AND SOME OTHER INITIATIVES…

NATIONAL

SAMHSA (the federal Substance Abuse and Mental Health Administration) awarded more than $26.2 million to 94 community behavioral health organizations across the U.S. to enhance the integration of mental and physical care. The grant program "supports community-based behavioral health agencies' efforts to build the partnerships and infrastructure needed to initiate or expand the provision of primary healthcare services for people in treatment for serious mental illnesses" and also for those with co-occurring substance abuse disorders.

STATE EFFORTS

Minnesota's DIAMOND program was created by medical groups, health plans, the Minnesota Department of Human Services, employer groups and patients to improve health care for people with depression in primary care. The program, based on the IMPACT model for treating depression, is groundbreaking because it changes the way care is given and paid for in the primary care setting. Under the pay model, the health plans give medical groups a monthly fee that covers the bundle of DIAMOND services, including a care manager. DIAMOND was launched in March 2008 and is involved through 74 primary care clinics in Minnesota.

Cherokee Health in Tennessee, the granddaddy of integrated care, is both a community mental health center and an FQHC in rural East Tennessee. Of their 40,000 clients in 2001, 56% sought behavioral care and 44% primary care.

North Carolina and **Massachusetts** are the first states to officially run integrated pilots in the public sector. **Buncombe County, North Carolina,** has an especially active integrated program. The **North Carolina** Center for Excellence in Integrated Care is an expert resource for the support of health care providers in the integration of medical care with behavioral health care.

New York's Center for Excellence in Integrated Care was created by the New York State Health Foundation in association with NYS Offices of Mental Health and of Alcohol & Substance Abuse Services to improve outpatient services for New York State residents who are struggling with co-occurring mental health and substance use conditions. The Center's primary goal is to increase the capacity of New York's more than 1,200 addiction and mental health outpatient clinics to provide integrated clinical care for people with co-occurring conditions. The New York State Office of Mental Health has also funded demonstration programs for Integrated Physical and Behavioral Health Care for the Elderly.

The **Ohio** Coordinating Center for Integrating Care (OCCIC) was created by the Ohio Department of Mental Health to share information and resources about integrating and coordinating physical and mental health care. The Center shares information and provides networking opportunities; determines need and solutions; advocates for integrated care and evaluates efficacy.

In **Oregon,** Multnomah County published a report about its integrated care efforts, giving a conceptual framework for this initiative as well descriptions of other programs across the country and its own model. The included forms, tables, and questionnaires may be particularly useful to other local governments considering or initiating integrated behavioral healthcare.

The National Academy for State Health Policy has issued a report detailing how two states - **Missouri** and **Tennessee** - have approached integrated relationships between key safety net health systems - community health and mental health centers. The May, 2010 report, A Tale of Two Systems: A Look at State Efforts to Integrate Primary Care and Behavioral Health in Safety Net Settings, looks at strategies, challenges and lessons learned.

Ranked among the nation's top 100 integrated delivery networks, **MaineHealth** has taken a leadership role in developing programs to improve chronic illness care in Maine through its Clinical Integration programs.

Missouri has pioneered a community mental health center-based program for Medicaid beneficiaries with severe mental illness that provides care coordination and disease management to address the "whole person," including both mental illness and chronic medical conditions. Missouri's mental health home model leverages an existing mental health system, with added training for providers on chronic conditions as well as the use of data and analytic tools. In October 2011, Missouri became the first state to apply for and be awarded a Medicaid State Plan Amendment to enable Health Homes in both primary care and behavioral health. See the HEALTH HOMES section of this website for more information about this program.

With funding from the Agency for Healthcare Research and Quality, the **Pittsburgh** Regional Health Initiative is leading a three-year initiative, called Partners in Integrated Care, to disseminate and implement evidence-based depression and unhealthy substance use services in primary care settings. PIC consists of a multi-state partnership among organizations that are experienced in implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) for unhealthy alcohol and other drug use and Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) for collaborative depression care management in primary care.

As part of the "Rethinking Care" program, **Pennsylvania** is designing and testing innovative care delivery models for Medicaid with mental illness and physical co-morbidities that could be replicated statewide. "Early Lessons from Pennsylvania's SMI Innovations Project for Integrating Physical and Behavioral Health in Medicaid" (May, 2012) chronicles the progress of four state pilots implementing new strategies to improve health while containing costs for Medicaid's highest need population.

Some locales are offering primary care services in mental health settings, rather than vise versa. Thresholds Psychiatric Rehabilitation in **Chicago** linked up with the University of Chicago College of Nursing to do so. Western Psychiatric Institute in **Pittsburgh** teamed up with the University of Pittsburgh Medical Center to offer comprehensive care services. The **Massachusetts Behavioral Health Partnership** has three primary care projects embedded in psychiatric day programs in three cities. The **Excel Group** in **Arizona** has undertaken a comparable program. As mentioned above, **Missouri** has established health homes in a community-based mental health settings.

CALIFORNIA CONTACTS

Some Key California Organizations

California Department of Alcohol & Drug Programs
1700 K ST.
Sacramento, CA 95811
(916) 327-4178
Resource Center: (916) 327-3728
(Resource Center): resourcecenter@adp.ca.gov
(effective 7/1/13, will be subsumed under the Department of Health Care Services)

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
1600 9th Street, Rm. 151
Sacramento, CA 95814
(800) 896-4042; dmh.dmh@dmh.ca.gov

California Institute for Mental Health (CiMH)
2125 19th Street, 2nd Floor
Sacramento, CA 95818
(916) 556-3480; nnitsch@cimh.org

California Mental Health Directors Association (CMHDA)
2125 19th Street, 2nd Floor
Sacramento, CA 95818
Office (916) 556-3477; Fax (916) 446-4519

California Mental Health Planning Council
MS 2706; PO Box 997413
Sacramento, CA 95899-7413

California Network of Mental Health Clients
9300 Tech Center Drive, Suite 160
Sacramento, CA 95826
(916) 233-2897; Main@californiaclients.org

California Telehealth Resource Center
2001 P Street, Suite 100
Sacramento, CA 95811
(877) 590-8144

CalMHSA
George Hills Company
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA 95670-6394
(916) 859-4805

County Alchohol and Drug Program Administrators Association of CA
1415 L Street, Suite 1000
Sacramento, CA 95814
Office (916) 441-1850; Fax (916) 441-6178
slgs@slgs.org

County Medical Services Program (CMSP)
1451 River Park Drive, Suite 222
Sacramento, CA 95815
(916) 649-2631
info@cmspcounties.org

Mental Health America of California (AKA Mental Health Association in California)
1127 11th Street, Suite 925
Sacramento, CA 95814
Office: (916) 557-1167

National Alliance for the Mentally Ill (NAMI) California
1851 Heritage Lane, Ste 150
Sacramento, CA 95815
916-567-0163 nami@namicalifornia.org

Working Well Together
info@workingwelltogether.org

California 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
455 K Street
Crescent City, CA 95531
Ph: 707 464-7224

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
4441 E. Kings Canyon Rd
Fresno, CA 93702
Ph: 559 600-9190

Glenn
Glen County Behavioral Health
242 N. Villa Ave.
Willows, CA 95988
Ph: 530 934-6582

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
450 Kings County Dr, Suite 104
Hanford, CA 93230
Ph: 559 582-3211

Lake
Lake County Mental Health Department
991 Parallel 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
480 East 13th St.
Merced, CA 95341
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
4095 County Circle Drive
Riverside, CA 92503
Ph: 951 358-4500

Sacramento
Department of Health & Human Services
7001-A East Parkway
Sacramento, CA 95823
Ph: 916 875-2002

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

Primary Care Associations in California

STATEWIDE

California Primary Care Association (sponsors the Behavioral Health Network)	1231 I Street, Suite 400 Sacramento, CA 95814	(916) 440-8170	www.cpca.org
California Consortium for Urban Indian Health	1004A O'Reilly Avenue San Francisco, CA 94129	(415) 345-1205	www.ccuih.org/
California Family Health Council	3600 Wilshire Boulevard, Ste 600 Los Angeles, CA 90010-2648	(213) 386-5614	www.cfhc.org

REGIONAL

Alameda Health Consortium	101 Callan Avenue, Suite 300 San Leandro, CA 94577	(510) 297-0230	www.chcn-eb.org
Alliance for Rural Community Health (Lake and Mendocino Counties)	1165 South Dora Street, Ste A-3 Ukiah, CA 95482	(707) 462-1477	www. ruralcommunity health.org
Capitol Health Network (Sacramento region)	4825 J Street, Suite 222 Sacramento, CA 95819	(916) 447-7222	www. capitolhealth network.org
Central Coast Health Network	2000 O St., Suite 100, Sacramento, CA 95811	(916) 678-1758	http://centralcoast healthnetwork. org/
Central Valley Health Network (including Fresno, Bakersfield, Stockton, Merced, and other Central Valley sites)	2000 O Street, Suite 100 Sacramento CA 95811	(916) 552-2846	www.cvhnclinics. org
Coalition of Orange County Community Clinics	17701 Cowan Avenue, Suite 220 Irvine CA 92614-6057	(949) 486-0458	http://www.coccc. org
Community Clinic Association of Los Angeles County	1055 Wilshire Boulevard, Ste 100 Los Angeles, CA 90017	(213) 201-6500	www.ccalac.org
Community Clinic Consortium (Contra Costa and Solano County)	3720 Barrett Avenue Richmond, CA 94805-2253	(510) 233-6230	www.cliniccon sortium.org
Community Health Partnership (Santa Clara County area)	100 North Winchester Boulevard, Suite 250 Santa Clara CA 95050-6250	(408) 556-6605	www.chpscc.org
Council of Community Clinics	7535 Metropolitan Dr. San Diego CA 92108	(800) 640-1662	www.ccc-sd.org

Health Alliance of Northern California	2280 Benton Dr. Bldg C, Suite C Redding, CA 96003	(530) 247-1560	http://thehanc.org/
North Coast Clinics Network (Humboldt and nearby area)	P.O. Box 966 Eureka, CA 95502	(707) 444-6226	www.northcoastclinics.org
Redwood Community Health Coalition (Marin, Napa, Yolo and Sonoma)	P.O. Box 751090 Petaluma, CA 94975	(707) 792-7900	www.rchc.net
San Francisco Community Clinic Consortium	1550 Bryant Street, Ste 450 San Francisco, CA 94103	(415) 355-2222	www.sfccc.org

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