

Improving the Integration of Primary and Behavioral Health Care

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Overview

- National Council Goals for Collaborative Care
- Population Prevalence
- Four Quadrant Planning Model/Clinical Models
- Finance/Business Models
- Primary Care-Mental Health Collaborative Care Project

National Council Goals for Collaborative Care

- Every provider of public BH services assures assessment of health status as well as mental status and has specific protocols in place for medically monitoring all consumers receiving second generation antipsychotic medications. An integral part of their service for consumers is to assure that each person is connected to a primary care medical home, and there are specific mechanisms between the BH and primary care providers for coordination of services.
- Note that by Behavioral Health (BH), we mean both mental health and substance abuse (SA, AOD) services

National Council Goals for Collaborative Care

- The safety net population in every community served by providers of public BH services and by CHCs has seamless access to both BH and physical healthcare. There is a strong working partnership among these providers, with roles defined, referral protocols in place, and cross-placement of clinical staff.

Safety Net Population Prevalence

- Medicaid Mental Health managed care penetration targets were set at 10% in the early 90s, based on a 7% rate in the commercial population—this has influenced financing levels for the public mental health system
- Emerging data suggests much higher prevalence in the Medicaid, state General Assistance/Indigent and uninsured populations and inability of the public mental health system to serve these populations

PREVALENCE OF PSYCHIATRIC DISORDERS IN LOW-INCOME PRIMARY CARE PATIENTS

<i>Psychiatric Disorder</i>	<i>Low-Income Patients</i>	<i>General PC Population*</i>
At Least One Psychiatric Dx	51%	28%
Mood Disorder	33%	16%
Anxiety Disorder	36%	11%
Alcohol Abuse	17%	7%
Eating Disorder	10%	7%

- 35% of low-income patients with a psychiatric diagnosis saw their PCP in the past 3 months
- 90% of patients preferred integrated care
- Based on findings authors argue for system change

Source: Mauksch LB, et. Al. Mental Illness, Functional Impairment, and Patient Preferences for Collaborative Care in an Uninsured, Primary Care Population. *The Journal of Family Practice* , 50(1):41-47, 2001.

Safety Net Population Prevalence

	Washington State	Washington State	Colorado Access	Marrilac Clinic Grand Junction CO
Population	Medicaid Adults Aged, Blind, Disabled	General Assistance Unemployable	Medicaid Adults (all aid codes)	Uninsured
Number	100,171	22,917	6,500	500
Any MH/AOD Diagnosis	47% (claims)	52% (claims) MH 36% AOD 32%	40% (claims)	51% (PHQ9)
Percent Seen by MH/AOD system	52%	MH 22.1% AOD 13.7%	33%	n/a

National Comorbidity Survey Replication

- The National Comorbidity Survey Replication (NCS-R) is a household survey taken every 10 years
- Did not include homeless and institutionalized populations, or clinically complex disorders such as schizophrenia—likely that the prevalence rates are underestimates
- 26% of the general population reported symptoms sufficient for diagnosing a mental disorder in the past 12 months
- *Mental disorders gain the strongest foothold in youth: 50% of all cases start by age 14; 75% by age 24*
- Disorder severity: 22% of the 12-month cases were classified as serious, 37.3% moderate and 40.4% mild

Primary Care and Behavioral Health

- Most PCPs do a good job of diagnosing and beginning treatment for depression (Annals of Internal Medicine, 9/07)
 - 1,131 patients in 45 primary care practices across 13 states
- PCPs did less well following up with treatment over time—less than half of patients completed a minimal course of medications or psychotherapy
- Lowest quality of care occurred among those with the most serious symptoms, including those with evidence of suicide or substance use
- “Right now PCPs don’t have the tools necessary to decide which patients to treat and which to refer on to specialized MH care”

Morbidity and Mortality in People with Serious Mental Illness

- Persons with serious mental illness (SMI) are dying *25 years earlier than the general population*
- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases

Morbidity and Mortality-SMI

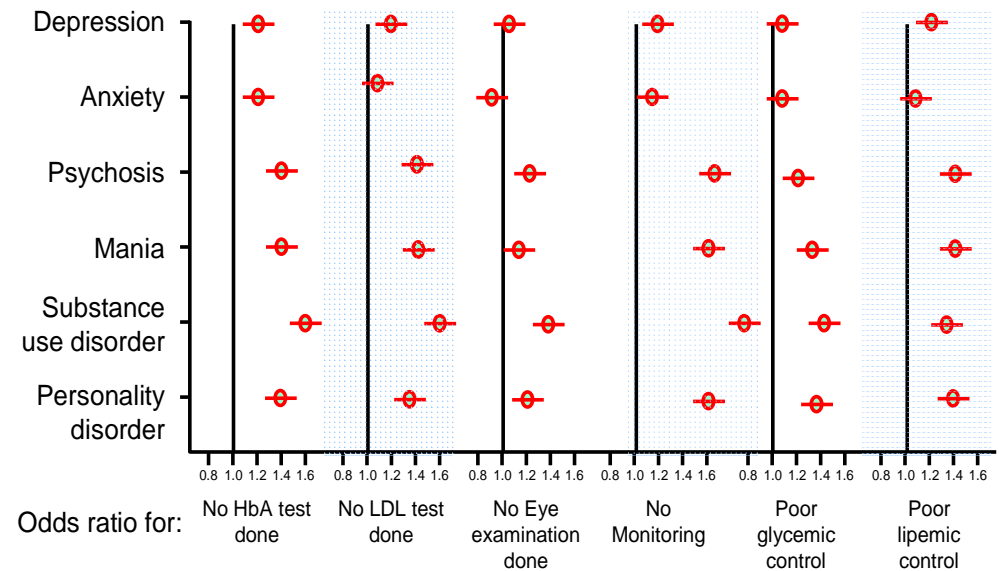
- *Higher rates of modifiable risk factors:*
 - Smoking
 - Alcohol consumption
 - Poor nutrition / obesity
 - Lack of exercise
 - “Unsafe” sexual behavior
 - IV drug use
 - Residence in group care facilities and homeless shelters
- *Vulnerability due to higher rates of:*
 - Homelessness
 - Victimization / trauma
 - Unemployment
 - Poverty
 - Incarceration
 - Social isolation

Morbidity and Mortality-SMI

Access to Health Care

- VA system offers better health care access and more support for recommended monitoring and disease management than is available to many people with SMI
- Yet in the VA system, the odds were greater that a diabetic with a psychosis or substance use disorder would not receive standard of care diabetic monitoring
- Predictable results of poor blood sugar and blood pressure control

Disparities in Care: Impact of Mental Illness on Diabetes Management



Odds ratio for:
 313,586 Veteran Health Authority patients with diabetes
 76,799 (25%) had mental health conditions (1999)

Frayne et al. *Arch Intern Med.* 2005;165:2631-2638

Children and Collaborative Care

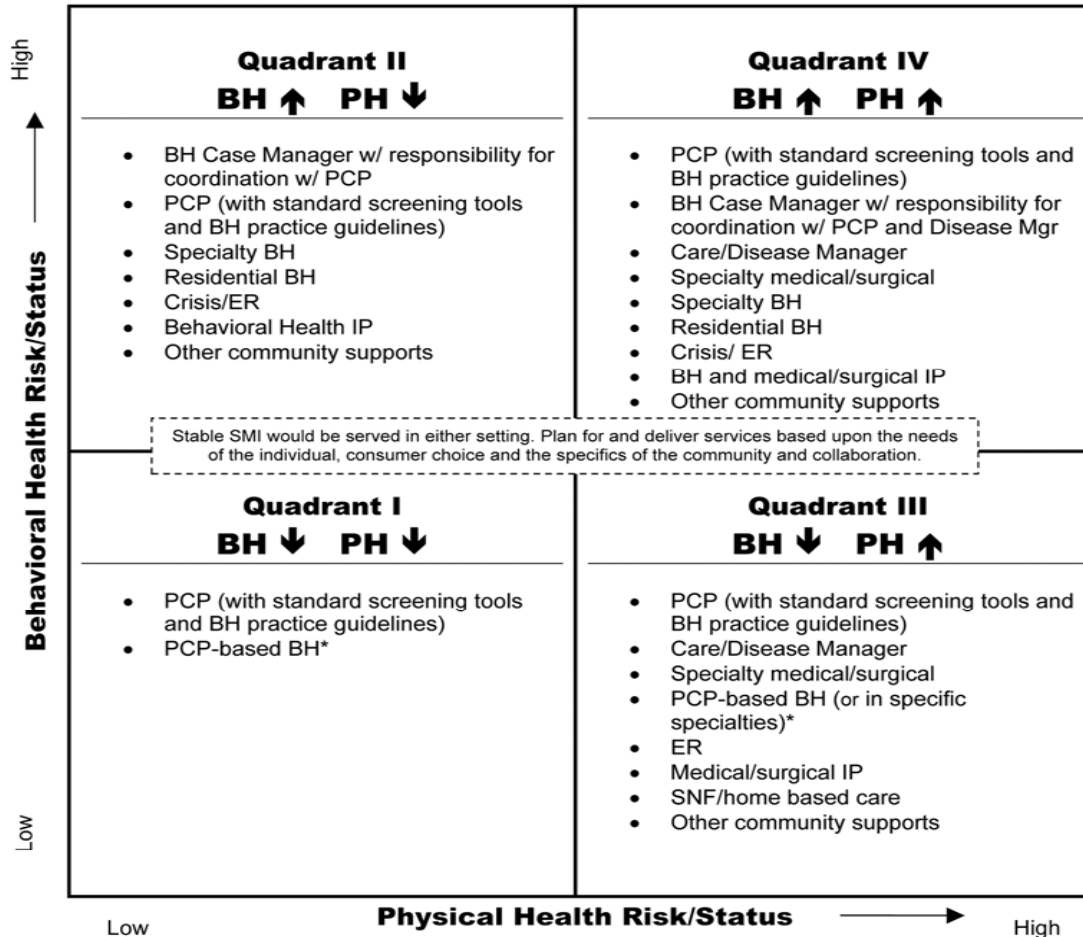
- Comorbidity in Medicaid-enrolled children in Florida
 - Health problems found in 42% of children with MH disabilities
 - MH problems found in 35% of children with health disabilities
 - Of children with MH disability and significant health problems, 11% were not receiving health services
 - Of children with health disability and MH problems, 14% were not receiving MH services
- 8.7% of children between the ages of 8 and 15 meet ADHD diagnostic criteria (using NHANES data, Arch of Ped/Adol Med, 9/3/07)
 - More than half not diagnosed
 - 2/3rds not receiving consistent treatment
 - Poorest children had highest prevalence, least likely to have consistent treatment

Where Should Care Be Delivered?

The National Council Four Quadrant Integration Model

- Organize our understanding of the many differing approaches—there is no single method of integration
- Think about the needs of the population and appropriate targeting of services
- Clarify the respective roles of PCP and BH providers, depending on the needs of the person being served
- Identify the system tools and clinician skill and knowledge sets needed and how they vary by subpopulation
- Population based for system planning, services should be person-centered

The Four Quadrant Clinical Integration Model



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

Application of 4Q Model to Various Populations

- Note that the vertical (behavioral health) axis incorporates both MH and SA
- The recommendation is that BH staff in general health care settings have skills in both MH and SA, and specialty MH/SA services incorporate integrated co-occurring care
- Service components vary for each quadrant—this example is for adults
- Service components would vary for children, older adults
- Service components would vary for ethnic and minority populations (language and cultural competence)
- Service components would vary for rural settings, regional markets

Where Should Care Be Delivered?

Stepped Care

- There is always a boundary between primary care and specialty care.
- There will always be tradeoffs between the benefits of specialty expertise and of integration
- *Stepped care* is a clinical approach to assure that the need for a changing level of care is addressed appropriately for each person—a person may begin receiving services in Q I and need specialty MH/SA services (Q II) or specialty medical services (Q III)

Q I and III: Research on Improving Care for Depression in Primary Care

1970s-1980s: Screening for depression: *screening may be necessary but is not sufficient*

1990s: Improved referral to mental health care: *only 50 % follow-up on referrals and few receive a full course of treatment*

1993: AHRQ practice guidelines and provider training based on guidelines: *guidelines and provider education may be necessary but are not sufficient*

Since 1990: over 30 studies in the US and abroad document that *systematic collaborative care is more effective than usual primary care for depression. Recent research also supports cost-effectiveness of this approach.*

Q I and III: IMPACT Model of Collaborative Care

- *Patient*
 - Chooses treatment in consultation with provider(s): antidepressants and / or brief psychotherapy
- *Primary care provider (PCP)*
 - Refers; prescribes antidepressant medications
- + *Depression Care Manager*
- + *Consulting Psychiatrist*

IMPACT: Stepped Care

- Systematic outcomes tracking
 - Patient Health Questionnaire (PHQ-9)
- Adjust treatment as needed
 - Based On Clinical Outcomes
 - According To Evidence-based Algorithm
 - In Consultation With Team Psychiatrist
- Relapse prevention

IMPACT: Evidence-based Collaborative Care

TWO NEW 'TEAM MEMBERS'

TWO PROCESSES

1. Systematic diagnosis and outcomes tracking

e.g., PHQ-9 to facilitate diagnosis and track depression outcomes

2. Stepped Care

a) Change treatment according to evidence-based algorithm if patient is not improving

b) Relapse prevention once patient is improved

Care Manager

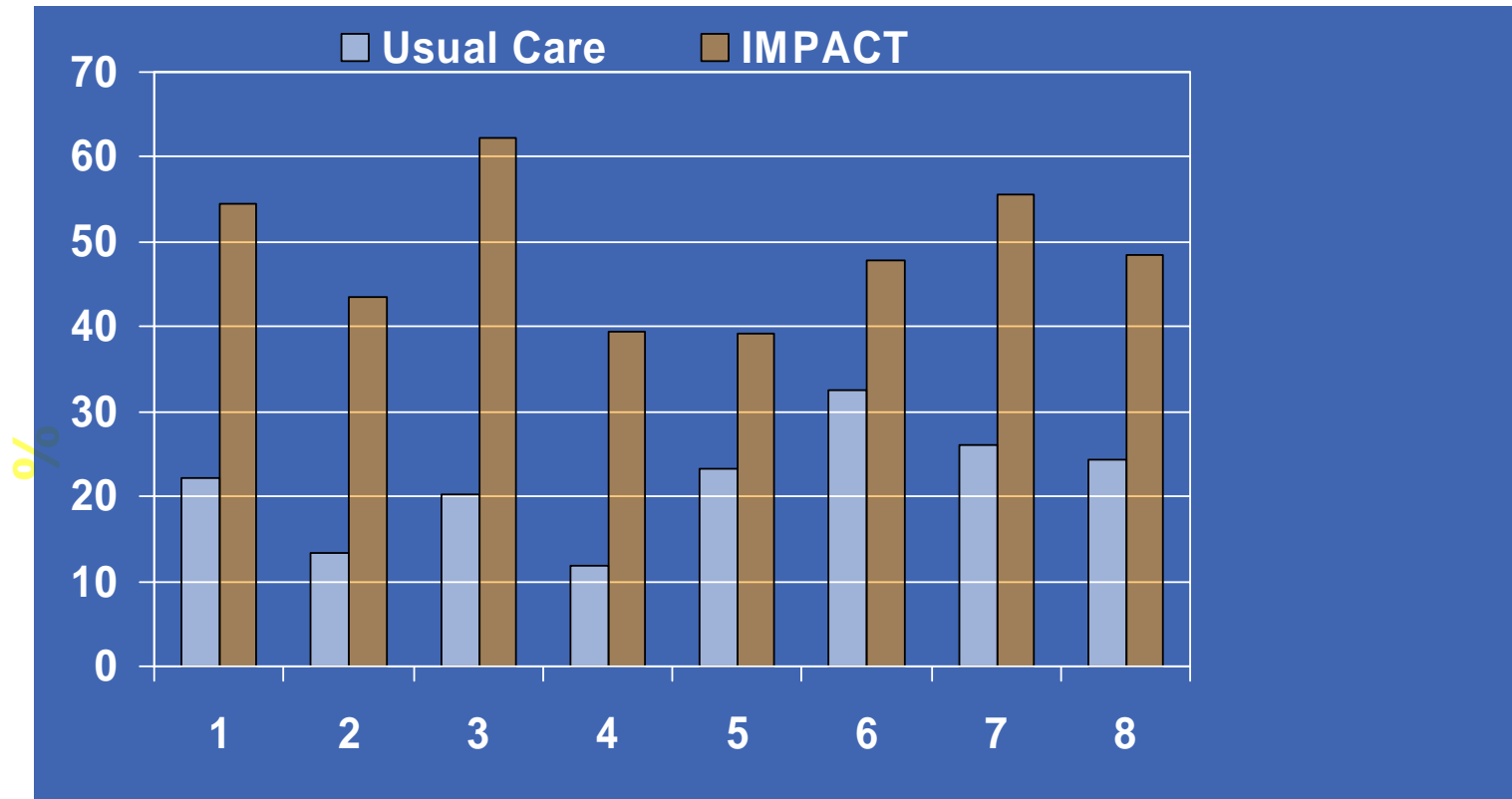
- Patient education / self management support
- Close follow-up to make sure pts don't 'fall through the cracks'
- Support medication Rx by PCP
- Brief counseling (behavioral activation, PST-PC, CBT, IPT)
- Facilitate treatment change / referral to mental health
- Relapse prevention

Consulting Mental Health Expert

- Caseload consultation for care manager and PCP (population-based)
- Diagnostic consultation on difficult cases
- Consultation focused on patients not improving as expected
- Recommendations for additional treatment / referral according to evidence-based guidelines

IMPACT: Doubles the Effectiveness of Usual Care for Depression

50 % or greater improvement in depression at 12 months



Participating Organizations

Unutzer et al., JAMA 2002; Psychiatr Clin N America 2005

Q I and III: Pilot Projects and Financing

- Aetna project provides financial support for the same service components proven in the IMPACT trials, identified in the RWJF sites and being tested in state Medicaid pilot sites (MA, NC):
 - Screening
 - Care management
 - Psychiatric consultation (principally by telephone)
- These service components are currently missing from public and private sector billing codes and financing policy

Q I and III: Pilot Projects and Financing

- Minnesota ready to begin a joint project between private payors and Medicaid agency using the IMPACT model
 - CPT code already in place for psychiatric consultation
 - CPT code for care management created
 - Must submit PHQ9s to bill the CPT code
 - After a year, must achieve 50% reduction in PHQ9 scores to be reimbursed on the care management code (Pay for performance)

About the Public Sector BH Money...

- Different delivery models in every state
 - Community based non-profit agencies
 - County operated agencies, either separate or in larger agency with public health
 - State operated agencies, regional areas of responsibility
- Licensing and regulatory activity (documentation requirements, data dictionaries, etc.) also differs by state
 - Most states have considerable paperwork requirements related to initial and ongoing service delivery (e.g., 20 page initial assessment and enrollment packets)

About the Public Sector BH Money...

- MH and SU administrative structures and relationships also differ (state, regional, county)
 - Some states with minimal funding for SU services
- Different Medicaid financing structures in every state (or county or region)
 - Carved out (risk or ASO contract)
 - Carved in
 - FFS billing
- The principle use of State general funds for BH
 - Medicaid match
 - Coverage for low income uninsured
- Population focus varies (SPMI/SED, TANF)

More About the Money

- HRSA PIN 2004-5 clarifies that Medicaid agencies are required to reimburse FQHCs and RHCs for behavioral health services provided by physicians, physicians assistants, nurse practitioners, clinical psychologists, and clinical social workers—but there has been little action at the state level, especially in managed care states
- CPT codes for BH services in primary care (for a physical health diagnosis) have been adopted by Medicare, but little action by commercial insurers or Medicaid agencies—some states talk about these as the method for implementing PIN 2004-05

Integrated Behavioral CPT Guidelines (2004)

Health and Behavior Assessment/Intervention (96150-96155)

Health and Behavior Assessment procedures are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems.

96150 – Initial Health and Behavior Assessment – each 15 minutes face-to-face with patient

96151 – Re-assessment – 15 minutes

96152 – Health and Behavior Intervention – each 15 minutes face-to-face with patient

96153 – Group (2 or more patients)

96154 – Family (with patient present)

96155 – Family (without patient present)

Q II and IV: Emerging Healthcare Models for People with SMI

- Nurse Health Care Management and Health Skills Training for Elderly with Severe Mental Illness
- Nurse Health Care Case Manager: monitoring, facilitation, and coordination of primary/preventative health care
- Health education and illness-management skills training
- Pilot Study Results:
 - Increased rates of preventive health care, eye care, and dental care
 - Newly detected medical problems in 1/3 of sample : gall bladder disease hypothyroidism, ischemic heart disease, cellulitis, esophageal web
 - Improved illness self-management skills

Bartels SJ et al

Q II and IV: Healthcare Services in MH Settings

- 2005 National Correct Coding Initiative Policy Manual for Medicare Services, Chapter XI, Evaluation and Management Services, C; Psychiatric Services, contains the following language:

When medical services, other than psychiatric services, are provided in addition to psychiatric services, separate evaluation and management codes cannot be reported. The psychiatric service includes the evaluation and management services provided according to CMS policy.

Review of Populations and Financing

<p>Quadrant II – Low Physical Health , High Behavioral Health</p> <p>Payment Tools:</p> <ul style="list-style-type: none"> • MH Medicaid FFS • MH Medicaid Capitation • State General Funds for MH • Medicare and private insurance 	<p>Quadrant IV – High Physical Health, High Behavioral Health</p> <p>Payment Tools:</p> <ul style="list-style-type: none"> • MH Medicaid FFS • MH Medicaid Capitation • State General Funds for MH • Medicare and private insurance
<p>Quadrant I – Low Physical Health, Low Behavioral Health</p> <p>Payment Tools:</p> <ul style="list-style-type: none"> • E&M Code for Physicians • “Incident to” for MH staff, care manager (some payors) • If FQHC, PIN 2004-05 if implemented, Medicaid FFS • CPT Code Series 96150 – 96155 	<p>Quadrant III – High Physical Health, Low Behavioral Health</p> <p>Payment Tools:</p> <ul style="list-style-type: none"> • E&M Code for Physicians • “Incident to” for MH staff, care manager (some payors) • If FQHC, PIN 2004-05 if implemented, Medicaid FFS • CPT Code Series 96150 – 96155

The Money and the Business Model

- Financial models (FFS, case rates, global payments) are critical to selection of business models-how does Medicaid reimburse for care?
- In one FFS state, for psychiatric medication service 90862
 - A university medical center clinic is reimbursed \$12.50 via fee-for-service (FFS) Medicaid
 - The same visit at a community mental health center would be reimbursed \$39.92 FFS
 - At a FQHC, the visit with a psychiatrist would be reimbursed at \$80-88 (variable due to quarterly recalculated cost basis)
- In a FFS and managed care nearby state, for 90862
 - A university medical center clinic is reimbursed \$19.53 via fee-for-service (FFS) Medicaid
 - The same visit at a community mental health center would be reimbursed \$210.87 FFS
 - At a FQHC, the visit with a psychiatrist would be reimbursed at \$66.82-\$155.64(variable due to quarterly recalculated cost basis)

Q I and Q III Business Models— Who Owns the Staff?

- **Placed staff:** CMHC places staff on site
- **Joint Venture:** Common shared cost or grant
- **Service contract:** Primary care “purchases” BH services like lab or physical therapy [note that a barrier may be malpractice coverage]
- **Primary care staff:** BH clinicians are hired and supervised by primary care clinic
- In any circumstance, need to assess workload and productivity drivers
- In any circumstance, need to build relationship between primary care and specialty BH system

Trends in Locus of Mental Health Services for Underserved Populations

- Restricted scope of CMHCs (target populations SMI and SED) in many states
- Four-fold increase in patients treated for mental health/substance abuse at CHCs between 1998-2003
- CHCs had 1.4 million visits for depression in 2004, third most common presentation after diabetes and hypertension
- All *new* HRSA primary care sites must also deliver BH and dental services—CHCs may contract for or directly deliver these services
- CHCs are becoming the nation's community mental health system

Implications for Collaborative Care

- Safety net populations generally obtain healthcare from safety net providers
- Many hard-to-engage populations are also found with safety net providers, and may not accept referrals to specialty MH/SU services (e.g., elderly, ethnic/language groups)
- Brief CBT and care management interventions in primary care, along with medications, have been shown to be effective with populations not requiring specialty MH/SU services
- Mental health centers have responsibility to address the health care status of their patients and there are promising models for providing primary care services in specialty MH/SU settings

Implications for Collaborative Care

- Public MH systems are frequently under-funded to serve their target populations (for both numbers of people and amount of service), much less populations that are not SMI/SED
- Many states are reducing coverage of the uninsured in their public MH systems
- The safety net populations may also have higher utilization rates of ER and other healthcare services which shows up as medical system costs, but in most states, these cost centers are silos
- The barriers to financing MH in primary care appear to be replicated when financing primary care in MH—apply all of the research to date and say *ditto!*

Local Considerations in Choosing and Implementing Collaboration

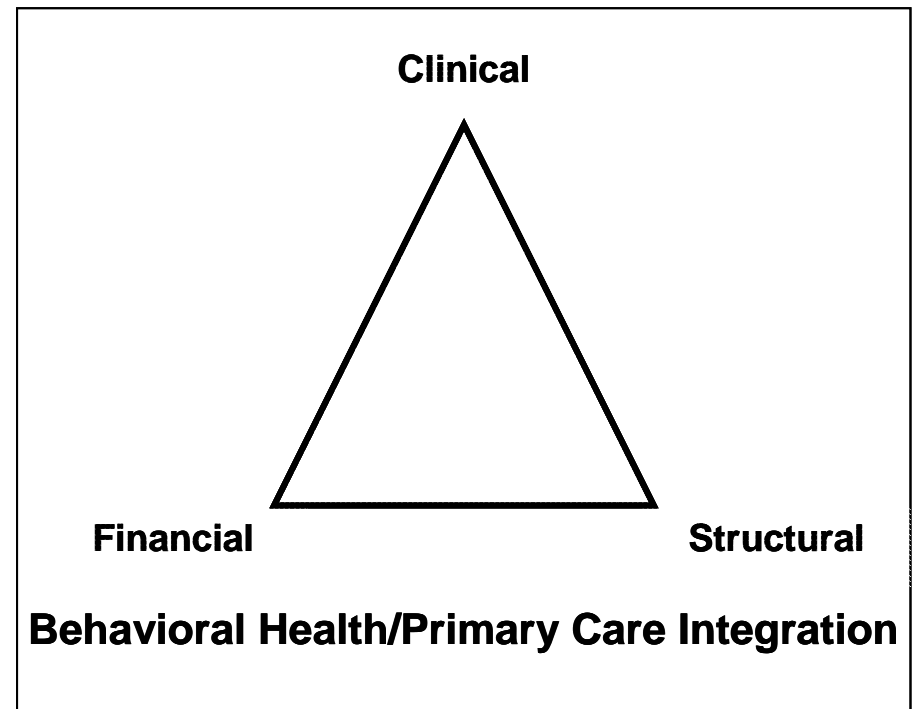
- *Array of and capacity of services in the community*—what services are available and is there access to sufficient amounts of the services that are needed?
- *Trained workforce*—do current MH/SU and primary care staff have the right skills to deliver planned services onsite?
- *Organizational support in providing services*—do managers provide encouragement and support for collaborative activities and what is the impact on operations, documentation, billing and risk management?

Local Considerations in Choosing and Implementing Collaboration

- *Reimbursement factors*—do payors support collaborative care and make it easy or difficult for the MH/SU and primary care sectors to work together?
- *The population that is targeted for services*—is the focus on older adults, adults, children, ethnic populations, privately insured, publicly insured, uninsured?
- *Consumer preferences*—are people more likely to accept care in primary care or specialty settings?

Elements of PC/BH Collaborative Care

- Financial or structural integration does not assure clinical integration
- Clinical integration helps us focus on what people need
- Public sector efforts focused on financial integration (carve-ins) have had limited success
- Clinical integration requires financial and structural supports in order to be successful
- Public sector financing is a major barrier to achieving clinical integration in most settings
- Washtenaw County and Cherokee Health are outstanding examples of attending to all aspects of integration





Primary Care-Mental Health Collaborative Care Project

- Intended as a systems improvement activity that will be ongoing after the project is completed--piloting the use of the collaborative learning model pioneered in the healthcare system
- Started with 4 sites—each site is a partnership between a CMHC and CHC—in January 07
 - Massachusetts
 - Iowa
 - Montana
 - Washington
- Expanded additional 8 sites in September 07
 - Florida
 - Indiana
 - Illinois
 - Texas
 - South Dakota
 - Colorado (2)
 - Washington
- Will create toolkits based on learning and materials

The Goals of The Collaborative Care Project

- Increase ability of primary care clinics to screen for bipolar, substance use and suicide risk as a part of conducting depression screening.
- Increase capacity of primary care clinics to provide proactive follow-up and management of patients identified with depression in primary care.
- Increase community mental health organization's provision of psychiatry training and clinical support for primary care, to support a more comprehensive stepped care model.

The Goals of The Project

- Establish processes for ongoing communication regarding collaborative care between primary care and community mental health organizations, including:
 - Protocols for referral of individuals with bipolar and suicide risk from primary care clinics to community mental health organizations, to assure seamless transition from primary care to specialty mental health (MH) care.
 - Return of stable patients to primary care follow up as appropriate.

The Goals of The Project

- Establish shared methods for medical management of patients at risk for metabolic syndrome who are treated in community mental health settings.
- Increase capacity of both primary care and community mental health organizations to document and track care processes and performance.

Learning Collaborative Approach

- All sites receive training at initial Learning Session:
 - IMPACT model and tools
 - STABLE toolkit (bipolar)
 - Suicide risk and substance use assessment
 - Rapid Cycle Improvement
 - Performance measures
 - Tools for planning and reporting
- Site-based teams develop implementation plans
- Series of conference call learning sessions with coaching from consultants and learning from each other
- Final results/Learning Congress

Rapid Cycle Improvement

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Project Goals Diagram

Current Referral Chasm

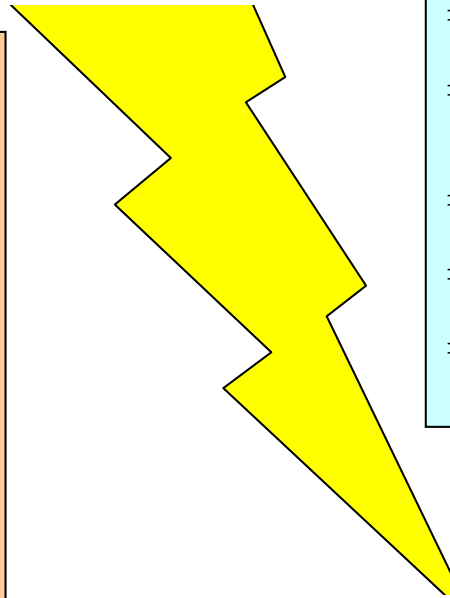
- ⇒ Only 50% get to MH upon referral
- ⇒ Little information flows between PCP and MH
- ⇒ Patients get pushed back and forth, rather than jointly served

Primary Care Clinic

- ⇒ Screen all patients for depression
- ⇒ Screen all depressed patients for bipolar, suicide, substance use
- ⇒ Refer per protocols for specialty MH, referral includes medical co-morbidity information
- ⇒ Provide depression care and care management for those not referred
- ⇒ Use PHQ – 9 for proactive follow-up and management of depression
- ⇒ Access to psychiatry to support PCP and care management and assure stepped care
- ⇒ Provide primary care services
- ⇒ Support/information from PCPs to MH regarding health status, joint planning for patients with medical co-morbidities
- ⇒ Data tracking regarding care processes and patient status

Community Mental Health Provider

- ⇒ Expedited support for referrals and engagement
- ⇒ Psychiatry training and support for PCPs
- ⇒ Psychiatric evaluation and treatment for referrals
- ⇒ Track weight, lipids, glycemia for patients on SGAs
- ⇒ Support/information from PCPs regarding health status, joint planning for patients with medical co-morbidities
- ⇒ Evidence based MH services and case management
- ⇒ Transition stable patients back to PCP per protocols
- ⇒ Data tracking regarding care processes and patient status



Improved Referral Process

- ⇒ Agree on who needs specialty MH and 100% of them get there and get engaged
- ⇒ Information flows between PCP and MH
- ⇒ Patients are collaboratively cared for, with attention to medical co-morbidities exacerbated by SGAs

What Change(s) Can This Project Make?

- There are multiple broad areas for potential improvement
 - Assessment for differential diagnosis of bipolar disorder, substance use and suicide risk
 - Psychopharmacology protocols
 - Tracking of patient status and protocols for stepped care
 - Protocols for referral from primary care to specialty MH
 - Specialty MH attention to health status issues
 - Ongoing care coordination between primary care and specialty MH

Project Goals Phase I Impact Based on Interim Data (Final Data in October 2007)	Site 1 (targeted PCP practice)	Site 2 (targeted PCPs and diabetic patients)	Site 3 (targeted PCP practice)	Site 4 (targeted PCP practice)
Increase ability of primary care clinics to screen for bipolar, substance use and suicide risk as a part of conducting depression screening.	Major focus, at 76% for bipolar, 34% for suicide, 61% for SU	No data available	Not working on this goal, other sites have care managers to assist	Major focus, at 78% for bipolar, 100% for suicide, 94% for SU
Increase capacity of primary care clinics to provide proactive follow-up and management of patients identified with depression in primary care	Requires final data	Requires final data	Requires final data	Requires final data
Increase community mental health organization's provision of psychiatry training and clinical support for primary care, to support a more comprehensive stepped care model.	Series of training sessions with all PCPs regarding mood disorders, bipolar screening, medications, communication and joint planning between MH and PCP	No data available	Developed referral protocol between MH and PC. Training for PCPs on a new referral protocol, not clear if MH participated.	Developed referral protocol. MH and PC organizations have hired a psychiatric ARNP jointly, to split time between their clinics
Establish processes for ongoing communication regarding collaborative care between primary care and community mental health organizations including protocols for referral of individuals and return of stable patients to primary care	Good success at connecting pts to MH services (MH and PC across street, MH has Spanish speaking staff).	No data available	MH psychiatry waiting list, cross-walked to PC pending referrals, identified MH pts that could return to PC, to free up MH capacity, which is major issue. Referral follow through of pts no better than usual (50%).	Developed standardized form for referrals to MH and response from MH. Issues of capacity in MH, so trying to manage pts in PC. Referral follow through of pts no better than usual (50%).
Establish shared methods for medical management of patients at risk for metabolic syndrome who are treated in community mental health settings.	MH receives labs. Developed method for psychiatrist to query PCPs regarding health concerns and assure response from PCPs, joint planning as required	No data available	Developed protocol for management of patients on SGA in PC, as many pts are managed there, due to lack of access at MH center	Not working on this goal
Increase capacity of both primary care and community mental health organizations to document and track care processes and performance.	PECS in use, but difficult to pull information.	PECS in use, but data problematic, moving to new registry system	PECS in use, but difficult to configure to measures	Have instituted spreadsheet to track, PECS not useful

Performance Measures for The Project

1. % of patients screened annually for depression in primary care
2. % of primary care patients with depression with PHQ-9 on initial evaluation, 4-6 weeks, 12 weeks, 6 months
3. % of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors
4. % of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide
5. % of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for current or past alcohol or chemical substance use

Performance Measures for The Project

6. % of primary care patients with major depressive or bipolar disorder meeting severity/complexity criteria for specialty MH services (as established by state and local payors) referred for specialty MH care
7. % of patients referred to MH specialty care who attend initial visit
8. Average time to initial visit after referral to MH specialty care
9. Average number of contacts (phone and in person) between primary care and specialty MH to coordinate care
10. % of patients with bipolar disorder with evidence of level of function evaluation at the time of the initial assessment and again within 12 weeks of initiating treatment

Performance Measures for The Project

11. % of patients with bipolar disorder with evidence of monitoring for weight twice within the initial 12 weeks of treatment
12. % of patients with bipolar disorder who were assessed for change in their symptom complex within 12 weeks of initiating treatment
13. % of patients treated for bipolar disorder with evidence of screening for hyperglycemia within 16 weeks after initiating treatment with an atypical antipsychotic agent
14. % of patients treated for bipolar disorder with evidence of an assessment for hyperlipidemia within 16 weeks after initiating treatment with an atypical antipsychotic agent
15. % of patients with diagnosis of depression with depression symptoms meeting remission criteria at 12 weeks, 6 months



Action is Needed to Create Collaborative Healthcare for People with SMI

- In early 2007, the National Council conducted a survey of its membership regarding general medical priorities, capacity and current practices
- Among 181 respondents, 91% reported placing a high or medium priority on increasing quality of general medical healthcare for their clients
- More than two-thirds of CMHCs reported having the capacity to screen for common medical problems (hypertension, obesity, dyslipidemia and diabetes)
- However only one in two had the capacity to provide any treatment for those conditions, and one in three had the capacity to provide the services onsite
- The most common barriers to providing general medical services were problems in reimbursement (72.1%), workforce limitations (68.4%), physical plant constraints (60.8%) and lack of community referral options (55.8%)

Federal Legislation to Improve Primary Care for people for Serious Mental Illness

- S. 2182 – Community Mental Health Services Improvement Act

Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings

\$50 million would be authorized to support the co-location of primary care services within community mental health and addiction treatment provider agencies. This initiative seeks to meet the primary care needs of persons with serious mental illnesses via demonstration projects to fund the co-location of integrated primary care services in community-based behavioral health settings. Funds may be used to cover a wide range of costs associated with providing these services, including: diagnostic and laboratory services, information technology needed to accommodate the clinical needs of primary/specialty care professionals, and facility improvements.

Federal Legislation to Improve Primary Care for people for Serious Mental Illness

■ S. 2183 – Community-Based Mental Health Infrastructure Improvements Act

\$20 million would be authorized to support the construction or modernization of facilities used to provide mental health and behavioral health services. Grants would be made to states and Indian tribes or tribal organizations, which would then be authorized to make sub-grants to individual community behavioral healthcare providers. To be eligible for the grants, states must be recipients of both a Community Mental Health Services Block Grant and a Substance Abuse and Treatment Block Grant.

Funds may be used for a variety of improvement-related activities, including:

- construction, expansion, or modernization of facilities;
- acquiring/leasing facilities and equipment;
- construction, structural modifications, and equipment acquisition to allow integrated delivery of co-located behavioral health and primary/specialty care services to people with co-occurring behavioral health and chronic medical or surgical conditions

National Council Collaborative Care Resources

- Thanks to researchers and to presenters at the 2003-2007 NCCBH Conferences for their materials, which have been integrated into the preceding discussion
- Visit the National Council Website www.nccbh.org and click on the Primary Care Integration button for more information
 - Background Paper / EBP Paper
 - *Finance, Policy and Integration of Services*
 - State Assessment Tool/List serve
 - Articles and tools
- See also www.nasmhpd.org for *Morbidity And Mortality In People With Serious Mental Illness*

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