Building a Strong Foundation

VOLUME 1

FOUNDATIONS
FOR INTEGRATED CARE
Behavioral Health Solutions for Primary Care.

Foundations for Integrated Care

LEARNING MAP

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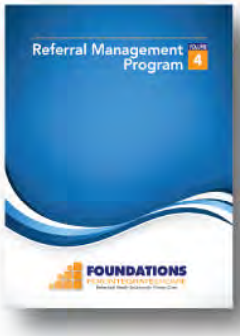
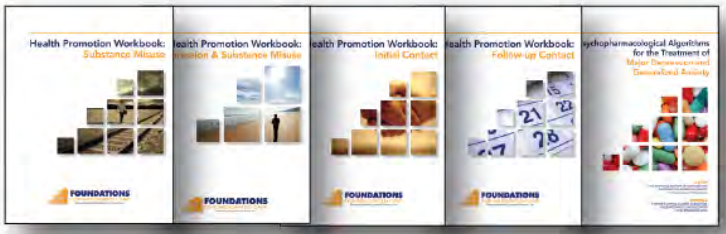


Additional Resource Materials



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CHAPTER 1

Using This Training Manual

This training program, entitled **Foundations for Integrated Care**, will assist you in expanding your knowledge and appreciation of integrated care, i.e. providing behavioral health care within primary care. In addition, the training manuals will serve as an ongoing reference guide. The current manual, *Building a Strong Foundation*, will introduce you to important concepts and skills common across successful integrated care programs. Illustrative examples will be provided from the private and public healthcare sector, most notably the Department of Veterans Affairs Healthcare system.

The primary intended audience is behavioral health providers (BHPs) working or intending to work within this model of care; however other primary care team members will benefit from this initial training manual as will anyone wanting a better understanding of integrated care. Behavioral health providers are strongly encouraged to supplement this training with additional training opportunities suggested throughout this manual as well as in the accompanying manuals that outline more specific evidence based treatment interventions. As the title suggests, this manual will help provide you with a strong foundation in the important components and practices within integrated care. It will be up to you to build the expertise to support your integrated care endeavor. The following icons are used as visual guides throughout this manual:

Graphic Icons/Cues		
		
Key Points Course content that plays an important role in the overall learning experience.	**Practice Dialogue** Course content that contains dialog that is best practiced by speaking the text aloud.	**Check it Out** Course content specific to Health Technician level staff.
		
Practice Discussion Course content that depicts typical patient interactions, best practiced as a role-play.	**Procedure / Steps** Course content that illustrates step-by-step instructions, procedures, or protocols.	**Tips: Learning** Course content that provides useful tips for enhancing the overall learning experience.

Building a Strong Foundation

Learning Objectives

Completion of this training program will achieve the following objectives:

- Understand and articulate the principles of Integrated Care and how it differs from specialty mental health and substance abuse care
- Gain a basic understanding of the evidence supporting Integrated Care
- Understand the essential functions within the Integrated Care model
- Become familiar with the basic clinical skills necessary to work in Integrated Care, in particular Motivational Interviewing, goal setting and working with other members of the primary care team
- Understand the importance of measurement based care (i.e. incorporating structured assessments into clinical contacts)
- Appreciate the importance of patient centered care, including the use of telephone visits to enhance access to care
- Understand the strategies necessary to sustain your program, including program evaluation and marketing

Welcome

Congratulations, you have decided to receive training in integrated care. Working on an integrated primary care team is exciting, dynamic and rewarding. This training will help you understand the essential principles of integrated care and will offer tools for providing treatment most associated with successful patient outcomes. This manual will provide you with a strong foundation, but it is not meant to be an all-inclusive training. Working in integrated care is often a huge culture shift for providers and requires the development of new skills. This manual will introduce you to those skills, but it will be up to you to hone them with additional practice and training in order to be fully successful in this healthcare model.

As a behavioral health provider (BHP) working on the primary care team, you serve a critical role in patient-centered, comprehensive healthcare.

Up to 70% of primary care patient appointments include:

- Psychosocial concerns covering the full spectrum of psychiatric disorders, from subclinical distress to serious mental health concerns
- Behavioral concerns ranging from insomnia, treatment adherence, and pain management
- Lifestyle issues such as exercise, quitting tobacco, weight management, and reducing alcohol use

Primary care is where many patients want their mental health treatment and where a majority of treatment is already happening [1]. More prescriptions of common psychotropic medications are written by primary care providers than mental health providers [2]. At the same time, the demands on the primary care providers have grown exponentially, limiting their ability to manage the volume of behavioral health problems.

The primary goal of integrated care is to support the primary care provider as the overall manager of a patient's health by helping to identify and treat patients with mental health diagnoses and/or patients who could benefit from behavioral interventions. This approach involves providing services to primary care patients in a collaborative framework with the primary care team providers and staff. In this sense, your role as the behavioral health provider is to function as a key member of the primary care team. Your tasks include providing brief assessments, triage, targeted treatment and collaborative management of primary care patients.

But does integrated care work?
The benefits of integrated care are clear and are based on decades of experience and research.

These benefits include:

- Improved identification of prevalent mental health conditions
- Improved access to appropriate evaluation and treatment
- Improved treatment engagement and adherence to recommended treatment
- Improved access to specialty mental health care by decreasing wait times and decreasing “no shows”
- Increased probability of receiving high quality and evidence based care
- Improved clinical and functional outcomes including reduced mortality
- Increased patient satisfaction
- Reduced use of emergency room and inpatient care

Getting the most out of these resources

To help you excel in your new role, the **Foundations for Integrated Care** program incorporates treatment protocols and guidelines for the treatment of commonly occurring diagnoses in primary care including depression and anxiety as well as alcohol misuse. These treatment protocols are included in the additional manuals, Volumes 2-4. Depending on your role within the integrated care program, you may want to read or reference one or all of these manuals. This volume, Volume 1, provides a framework for the program, while Volumes 2-4 provide detailed, evidence-based treatment protocols which rely heavily on available state of the art research findings to deliver specific clinical services through the integrated program. Important to note, these manuals are not meant to provide specific instruction on how to set up an integrated clinic (although some information on establishing services is provided in the manuals), but rather on how you function within integrated care. Volumes 2-4 can be used in a variety of ways including the establishment of more formal care management programs or as a guide for more seasoned providers to expand their repertoire of skills.

VOLUME 1: Building a Strong Foundation – is written to provide a general overview of integrated care focusing on information that is likely to be of interest and relevant to all program staff. It provides you with a clear understanding of the principles of integrated care as well as an appreciation of the differences between integrated care and specialty mental health care. Building a Strong Foundation outlines the basic clinical skills necessary for this model, the staff involved and strategies for sustaining your program

VOLUME 2: Depression and Anxiety Management – outlines a stepped care approach for the management of patients with depressive and anxiety disorders. The manual outlines the functions of the behavioral health provider (nurse, social worker, psychologist) in facilitating care and providing brief treatment in a manner that is consistent with the evidence base and treatment guidelines. The manual also describes a "watchful waiting" program, a telephone-based mechanism for monitoring patients with symptoms of minor or subsyndromal depression in order to distinguish between those in need of more formal care and those that have symptoms that resolve relatively quickly.

VOLUME 3: Alcohol Misuse – provides a stepped care approach for the treatment of alcohol misuse. The manual outlines brief interventions as a way to talk to patients, who are drinking heavily, binge drinking or abusing alcohol, to help address ambivalence and increase motivation to reduce their alcohol use. For patients with alcohol addiction who prefer treatment in primary care, the manual outlines a care management model that allows the integrated care provider to collaborate with the primary care team to help engage the patient in reduction of alcohol use or abstinence.

VOLUME 4: Referral Management – outlines an intervention designed to improve low rates of engagement in specialty mental health/substance abuse care among patients with severe psychiatric needs who are better served in the specialty care rather than primary care setting. The intervention supports the use of a motivational interviewing style aimed at addressing ambivalence and also includes a problem-solving component to help address barriers associated with behavioral treatment.

Basic Definitions for this Training Manual

Although the terminology for integrated care is not yet standardized and continues to evolve, some useful definitions for the purposes of this training manual include:

Primary Care
Primary Care is the provision of continuous, comprehensive, and coordinated care to populations undifferentiated by gender, disease, or organ system. The definition from the Institute of Medicine describes primary care as the "provision of accessible, integrated, biopsychosocial health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Integrated Primary Care is an overarching term conceptually defined as:
A form of care where behavioral health and primary care providers interact in a systematic manner to meet the health needs of their patients.

- **Co-location/Co-located Service** – A behavioral health provider working in a space that is embedded in a primary care clinic. This is a necessary, but, in itself, an insufficient component of integrated care.
- **Collaborative Care/Collaboration** – The interactions between primary care and behavioral health providers for the purpose of developing treatment plans, providing clinical services and coordinating care to meet the health needs of patients.
- **Care Management** – Evidence based and algorithm driven treatment protocols developed for the treatment of commonly occurring disorders in primary care, including depression and anxiety. Involves a behavioral health provider providing treatment in collaboration with the PCP and most often under the supervision of a prescribing mental health provider.

Medical Home (Patient-Centered Medical Home or Patient Aligned Care Teams (PACT))
Accessible, coordinated, comprehensive, patient-centered care that is managed by a primary care provider with the active involvement of other clinical and non-clinical staff.

This team-based healthcare model allows patients to have a more active role in their health care and is associated with improved quality of care and patient satisfaction. Extended primary care team members within a medical home may include not only behavioral health providers, but also clinical pharmacists, nurses, health coaches, Health Behavior Coordinators(HBCs), dieticians, and program support assistants. Within the Veterans Health Administration, the medical home model is referred to as Patient Aligned Care Teams (PACT).

Specialty Mental Health/Substance Abuse Care
The provision of services by a specialty mental health or substance abuse provider including diagnostic assessment, psychotherapy, and advanced psycho-pharmacotherapy, individual and group recovery-oriented care for patients with more complex presentations including severe mental illness.

Stepped Care
Providing the patient the level of care needed based on the severity or complexity of symptoms, with each level involving increasing intensity of services. Typically a patient starts at a lower level and then steps up to the next level if symptoms do not improve. This type of care helps reduce over treatment of symptoms and encourages efficient use of health care resources.

Measurement Based Care
The term is used throughout the training to emphasize the use of standardized assessments, biomarkers and other “tests” to help guide treatment planning and assess outcomes at the patient and practice level.

Brief Treatments
The term used in these manuals for care provided by an integrated care provider that includes psychoeducation and assessment along with **behavioral interventions** and/or **medication management.**

- **Behavioral interventions** – A type of brief treatment that includes brief therapy techniques, counseling, behavioral activation, goal setting, and problem-solving, but does not include psychotherapy.

- **Medication management** – A type of brief treatment that involves following specific algorithms for psychotropic medications, encouraging adherence, assessing symptoms and side effects, and facilitating guideline-adherent care.

CHAPTER 2

Principles of Integrated Care

The integration of mental health/behavioral health care with primary care improves health outcomes. In an integrated and/or "medical home" model, the traditional emphasis on clinic-based individual patient-provider interactions is replaced with a more coordinated, comprehensive care model; the primary care provider (PCP) functions less as an individual consultant to the patient, and more as an manager for collaborative interdisciplinary teams which support patients in more active prevention and self-management of various chronic health conditions. Episodic illness and complaint-based care are replaced with proactive, preventive care and a long-term healing relationship with the healthcare team. As a behavioral health provider working within this model, you are acting as a part of the primary care team, collaborating on the treatment of patients at the sub-clinical, mild or moderate level of symptoms, and helping to facilitate treatment engagement for patients with severe or complex symptoms. In this way, you are working in a "stepped care" fashion and helping to care for the larger primary care patient population by providing brief, evidence based treatments for a wide range of presenting concerns and also helping to bridge patients with more intensive needs into specialty care.

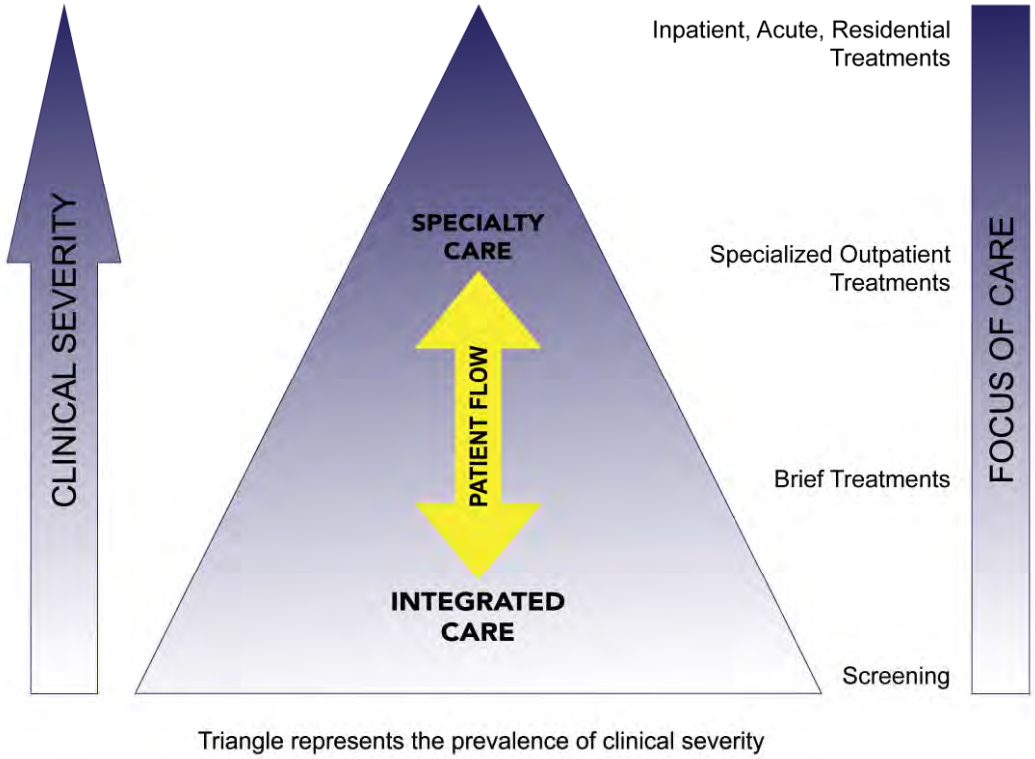
Most mental health providers have not received training in this approach to care. To be successful, providers may need to reevaluate some of their own behaviors and practice management techniques. The differences between integrated and specialty mental healthcare are substantial and require a culture shift for all stakeholders, from primary care providers to mental health providers and leadership. In addition, integrated care staff needs to develop a distinct skill-set to work effectively in this setting. These manuals represent one necessary, though insufficient, part of this skill acquisition. Practicing these skills is highly recommended as is participating in ongoing training, workshops and supervision. Additional written and on-line resources will be referenced throughout the manuals. The core principles of integrated care are explained briefly below and are built upon throughout the training manuals.

These principles include:

- Population-based, stepped care
- Open / advanced access
- Collaborative not simply co-located
- Care that is patient-centered, promotes self-management, and includes pharmacological support
- Longitudinal but brief treatments
- Measurement and registry based care

Population-based, Stepped Care
Integrated care strives to provide mental health and behavioral health care to the population of patients receiving treatment in the primary care setting. This is accomplished by providing the level of care needed in a proactive manner to help prevent escalation of symptoms. Thus you will focus much of your attention to the lower part of the triangle in figure 1., while facilitating specialty care for the top of the triangle.

Figure 1. Conceptual model defining the relationships between integrated and specialty care in relation to the overall population of patients being addressed in a health care setting.



One way this can happen successfully is to systematically screen for common mental health symptoms such as depression, anxiety, and alcohol misuse, paired with timely follow-up of positive screens to further evaluate treatment needs. For the larger number of patients with less complicated presentations, integrated care can provide brief treatments and successful management of symptoms in the primary care setting. This increases access to and engagement in treatment in primary care, and subsequently frees up valuable specialty mental health services for patients with more intense needs. Patients who are judged to require complex or long-term interventions are best served through referral to specialty care. This requires you to concentrate your efforts on a broader population of patients, sharpening your diagnostic skills and tailoring your therapy skills.

Integrated Care programs seek to assist not only those with mild to moderate mental health problems but also patients who may have distress or other problems but do not meet formal diagnostic criteria for a disorder. With this population, an important role is the delivery of prevention strategies and the promotion of self-monitoring skills. This may be very different from how you, and most mental health professionals, were trained and currently practice. Please note; prevention strategies are not just “therapy lite.” One of the challenges to practicing in an integrated care setting is the thoughtful and deliberate application of therapeutic strategies selected as appropriate for this target population, while actively avoiding the delivery of treatments appropriate for more severely ill patients. The emphasis in this model of integration is on life functioning, with the goal of early improvement of symptoms and a strong attention to function.

It is true that some patients with more severe psychiatric needs may be unwilling or unable to be referred to specialty care. While it may occasionally be necessary for the BHP in integrated care to evaluate and follow such patients you should also be careful not to make this a large part of your practice. The goals for such patients should be to understand the reluctance to participate in specialty care and to work on those barriers.

Open Access

Another core principle of integrated care is open access, or having the ability to see a patient at the time that he/she needs to be seen rather than on a fixed schedule.

Open access means you cannot fill up your schedule with follow-up visits or have a closed door; ideally you are always available, but at minimum you have consistent availability for warm-handoffs from within the primary care team. A "warm hand-off" is when a provider introduces you directly to a patient. A warm hand-off provides the opportunity to have a brief conversation with both the primary care provider and the patient about their concerns, getting everyone on the same page and demonstrating to the patient that you are a team working together for his/her care.

Open access does not mean that you must see all patients face to face at the time of their primary care visit. Rather, it means seeing patients on their schedule rather than our own. For some patients, it may be most efficient or helpful to see you at the time of the primary care visit, for others it may include brief telephone visits. For example, a patient who reports to the primary care provider feeling depressed and having to push themselves to accomplish daily tasks may be more willing to talk with someone about their depression at the time of their primary care visit rather than coming back to the clinic for an extra visit. Alternatively, a patient may prefer to receive a telephone call the next day rather than having to stay longer at the primary care office. Note, open access applies not only to the first visit when a primary care provider may walk a patient to your office, but also to follow-up care when a patient may call you or stop by when they are in the clinic.

Collaborative not simply co-located

Key to integrated care is that you are not simply located within the primary care clinic. The implementation of co-located care leads to parallel rather than collaborative care. A mental health provider who operates like a specialty care provider in primary care quickly fills up his/her schedule treating chronic, complex patients. This co-located MH provider ends up treating only a small percentage of primary care patients and is not supporting the needs of the primary care team. In contrast, a collaborative provider operates as an integral part of the primary care team: communicates with the team regularly and attends team meetings, provides education and consultation, and helps to treat the larger number of patients with less severe behavioral health and mental health needs. One example of this collaboration can be found in the prescribing of psychotropic medications: while the primary care provider is encouraged to initiate prescribing, perhaps with consultation, the integrated behavioral health care provider follows up with the patient over time to assess symptoms and medication adherence and side effects, and promotes self management while consistently reporting back to the PCP on progress and discussing the need to adjust treatment as necessary. The PCP is still the leader of the care and is being supported by the BHP.

Care that is patient-centered, promotes self-management, and includes pharmacological support.

Integrated care is patient-centered, meaning the content and structure of the treatment is flexible and is informed by the patient's needs and preferences. For example, offering appointments over the telephone or in the primary care clinic and having availability in the evenings or on weekends is centering care around the patient rather than around the provider. Patient goals may also differ from the provider's goals and this voice must be heard. The treatments provided within integrated care are different from the time intensive interventions found in specialty care clinics. Motivational interviewing and problem solving treatment are well suited to treatment delivered within integrated care and specifically to a patient-centered approach. Integrated care treatment appointments and follow-up contacts are generally 20-30 minutes in length and focus on goal-setting, education, assessing symptoms, and promotion of patient self-management. As interventions are time-limited, self-management strategies are an ideal skill for patients to learn and to be able to apply even after treatment has ended.

A key component of the research for integrated care is pharmacological support. First line pharmacological treatment of depression, alcohol dependence, or anxiety can be effectively delivered in primary care, but PCPs greatly benefit from the support of a BHP as well as the expertise in psychotropic medications of a psychiatrist/Advanced Practice Nurse/Physician Assistant. Integrated care programs that seek to support primary care psychotropic prescribing also include the activities of general assessment of changes in symptoms, medication adherence and side effects and the provision to seek psychiatric consultation or supervision as appropriate. These care components are similar for staff from different disciplines providing integrated care, though the nuances may differ across disciplines. For example, the content of the treatment may include more psychoeducation and goal setting for a nurse, while a psychologist may include more behavioral techniques as part of brief treatment.

Longitudinal but brief treatments

Integrated care also involves active follow-up of patients over a period of time, i.e. longitudinal albeit brief treatment. This care includes Prevention/Health Promotion and brief treatment protocols, including behavioral interventions and/or medication management. Patients typically stay in treatment for up to 6 months, but no longer than a year. At that point, you step back and allow the patient and PCP to continue; if your support is needed again in the future, they know they may involve you again. Patients whose symptoms do not improve in that time frame are likely in need of more intensive services and so specialty services may be appropriate at that time (see

population-based, stepped care above). Note, as treatments are brief, your panel of patients is constantly changing.

The second component of brief treatments is active follow-up. As the patients followed by integrated care are higher functioning and less symptomatic, they may be less likely to initiate follow-up on their own. In addition, as an integrated care team member, you realize the importance of the visit and go out of your way to track down patients even by telephone to make sure you are providing all that you can to assist the patient. Thus active outreach to these patients to follow-up on symptoms and treatment needs is often necessary and appropriate, particularly if a psychotropic medication has been initiated. This follow-up can be by telephone; treatment studies have shown that telephone treatment delivery for integrated care is equally effective as face-to-face follow-up, and allows for flexible and patient-centered treatment.

As active follow-up and caseload turnover is an inherent part of integrated care, the availability and use of a tracking tool to promote this type of treatment is necessary, whether the tracking tool is embedded in the patient's electronic medical record or simply created in a spreadsheet. Such tools can also be used to track symptoms over time and help promote use of data and measurement based care.

Measurement and registry based care

Measurement based care in treatment and program monitoring is also a key element of integrated care. Routinely using assessments to track treatment progress and inform treatment changes (measurement-based care) is associated with positive clinical outcomes. Using data also fits in with the culture of primary care where data (lipid levels, liver enzymes, etc.) are an accepted part of treatment. This data can be used by the clinician to help educate patients on the benefit of monitoring and to highlight treatment progress. Patients are often surprised seeing the trajectory of their scores on repeated standardized measurements of mental health symptoms and such tools can be very helpful in having the patient "see" their progress (or lack of progress). After all, it is not uncommon for any of us to be unable to accurately recall how we were specifically feeling weeks or months ago.

In addition, systematic monitoring of data at the provider and program level is essential to assess the quality of the program and lets you know that the treatment that you are providing is effective. Program level data can also help ***inform*** modifications to the program and can be used to educate your administrative partners and leadership to needs or successes. In essence, data can help inform changes and ultimately support program sustainability.

Contrast with Specialty Mental Health Care

As referenced in the principles above, there are several defining characteristics of Integrated Care service delivery (e.g., brief, targeted assessment, consultation, first line medications, and triage) that differ substantially from the delivery of specialty mental health care service delivery as outlined in Table 1. It is critical for administrators, supervisors and clinicians to gain conceptual mastery of these features in order to make decisions in support of effective functioning for both specialty and integrated care services.

	Integrated Care	Mental Health Specialty Care
Location	On site, embedded in the primary care clinic	A different floor, a different building
Population	Most are healthy, mild to moderate symptoms, behaviorally influenced problems.	Most have mental health diagnoses, including serious mental illness
Provider Communication	Collaborative & on-going consultations via PCP's method of choice (phone, note, conversation).	Consult requests, chart notes, Focus within mental health treatment team.
Service Delivery Structure	Brief (20-40 min.) visits, limited number of encounters, offer telephone follow-up	Comprehensive evaluation and treatment, 1 hour visits, scheduled in advance.
Approach	Problem-focused, first line psychopharmacology, solution oriented, functional assessment. Focused on PCP question/concern and enhancing PCP care plan. Population health model.	Diagnostic assessment, psychotherapy and advanced psycho pharmacotherapy, individual and group, recovery- oriented care. Broad scope that varies by diagnosis.

For the bulk of experienced mental health staff working in primary care clinics today, there was no academic training in this relatively new integrated approach. Few clinicians enter these roles with the practice management skills and core competencies to function optimally within the integrated service delivery structure. Simply assigning a traditionally trained clinician to work in the primary care setting presents a challenge for successful implementation, as often he/she does not have the skills to succeed. Training through formal conferences, reading recommended texts, shadowing experienced integrated care staff, and consulting with clinical leaders in the system can be instrumental in developing the skills for success in integrated care work.

What is the evidence for this model?

First, you should be aware that most patients with mental health concerns are seen and managed in primary care. Specialty mental health providers are often not aware of the needs in primary care, as their own clinics are booked. Because of the highly prevalent nature of mental health problems, most treatment guidelines support systematic screening as part of routine clinical practice. However, screening and identification, while necessary, are not sufficient in increasing access to treatment [3]. In settings without integrated care, few primary care patients receiving a mental health intervention receive an adequate course of treatment, and only a quarter to a third achieve full resolution of their symptoms; this is less than the usual placebo response rate observed in typical clinical trials conducted in the psychiatric sector [4-6]. Moreover, several studies have demonstrated that while screening or clinical reminders facilitate identification of depression, they have limited impact on improving care [7, 8]. It is also becoming increasingly apparent that educating PCPs is not the sole answer to improving treatment outcomes. Gallo and colleagues have demonstrated that family practice physicians and internists have interest in treating depression and are knowledgeable about the diagnosis and treatment strategies [9, 10]. However, clinicians report limited resources for conducting frequent monitoring and for overcoming patient barriers to successful treatment (e.g. lack of acceptance of treatment, low adherence).

Note: Each of the disease-focused manuals has a more comprehensive discussion of the research supporting integrated Care.

It is also very apparent that simply sending all patients to specialty care is not an appropriate response. Most patients do not want or need that level of care [11]. Based on the gap between the clinical need and the usual care received, dozens of randomized controlled trials of integrated or collaborative care have demonstrated a clinically significant effect for integrated care compared to usual care. In these models, positive effects have been observed in interventions that included frequent patient contact with ongoing monitoring of treatment adherence, as well as assessment of symptomatic outcomes with feedback and modification of treatment as needed [6, 12-20]. Most of the literature centers on the delivery of care management for depression but also includes a robust literature on brief interventions for excessive alcohol use. Evidence is accumulating to support the collaborative treatment of anxiety as well as chronic pain. The value of care management strategies appears to lie in its ability to engage patients who did not seek out treatment on their own and to facilitate guideline adherence.

These collaborative care/care management trials are not reviewed here but outcomes from such trials include:

Improved identification

- Improved identification of depression, psychiatric co-morbidities and substance misuse [21, 22] Improved identification of depression [23, 24]

Improved access

- Increased rates of treatment [11, 15, 23, 25-28]
- Reduced wait times [24]
- Increased PCP prescribing antidepressants[28, 29]

Improved engagement and adherence

- Improved engagement in mental health treatment [28, 30]
- Improved engagement and adherence in treatment for depression and at-risk alcohol use [11, 31]
- Greater antidepressant adherence [16, 32, 33]
- Improved no-show rates[24, 30]

Higher quality care

- Increased probability of receiving guideline-concordant treatment [23, 34, 35]
- Higher patient perceptions of quality of care [32]

Better clinical and functional outcomes

- Improved short and long term clinical (remission; symptom reduction) and functional outcomes compared to standard care for depression [15-17, 20, 24, 36-43]
- Similar remission rates and symptom reduction for depression compared to enhanced specialty referral [44]
- Decrease in at-risk alcohol use comparable to enhanced specialty referral [45]
- Decrease in alcohol use relative to usual care [46-49]
- More rapid clinical response [15, 25]
- Higher fidelity to integrated care model resulted in better patient response and remission rates [50]
- Improved health outcomes for minor depression [51]

Increased patient satisfaction

- Satisfaction [16, 24, 27, 52-55]

Other notable research outcomes include:

Telephone
Trials of collaborative care by telephone (telephone care management) have found equivalent results. The largest trial by Tutty and colleagues demonstrated that those patients identified by a PCP and then randomly assigned to telephone care had twice the chance of receiving a moderate dose of an antidepressant and twice the chance of having a 50% reduction in depressive symptoms compared with usual care[56]. Similarly, there is evidence within the VA that telephone care is effective for depression, as demonstrated through the Translating Initiatives for Depression into Effective Solutions (TIDES) program (for more information visit http://www1.va.gov/tides waves/. Several other smaller studies also demonstrate the efficacy of telephone care management for depression in primary care settings [57-63].

Inclusion of cognitive behavioral therapy
Enhanced access to short-term cognitive behavioral treatment has been shown to lengthen the outcome effect [15].

Cost effectiveness
Cost-effectiveness studies in a variety of settings, including the VA, show low relative cost for the clinical benefit of integrated care[26, 40, 64-69]. For example, in the Improving Mood: Promoting Access to Collaborative Treatment study, the patients receiving depression care management had on average 107 more depression free days over 2 years, coming to a cost of only $2.76 per depression free day [37] and had lower overall health care costs over a four year period [40]. However, the higher treatment engagement and adherence for patients receiving collaborative care for depression (compared to usual care) means that the savings of integrated care are likely offset by the cost of increased treatment delivery. For brief alcohol interventions, not only are drinking rates lower but health care costs and medical care utilization are all improved two years post randomization in the intervention group relative to usual care [70].

Though not yet evaluated, system costs may be reduced in integrated care due to:

- Decreased treatment of sub-threshold patients
- More treatment of patients to full remission and thus reduced need for ongoing sub-therapeutic antidepressants
- Improved patient self management through education and psychotherapy
- Improved patient overall health due to improved adherence to other treatments, better health habits, and less stress

In sum, the evidence is strong that collaborative care is effective. And these positive outcomes are not short-lived; outcomes tend to remain improved two to five years after participation in care management.

CHAPTER 3

Who are the Players and what are their Roles?

Depending on staffing and site resources, Integrated Care programs may look and feel very different and be at different stages of development. You may be joining a well functioning group with a long history of providing integrated care or you may be blazing a new trail in a brand new program. In this section we discuss your role in the program as well as other potential players.

A well functioning Integrated Care program includes involvement of Primary Care staff and specialty Mental Health Provider(s). Involving key players early on and continuing to engage and market to these players will go a long way in implementing and sustaining your program.

The Patient and his/her family

Integrated care is patient-centered care. Therefore the patient is the central member of the care team. His or her health and life goals are the number one priority for the team. Your goal and role is to provide the most appropriate, easily accessible services that honor patient preference. Including the patient's family in the process is also an important part of integrated care.

The Medical Provider

Primary care is built around the health care services provided to the patient by his or her medical provider. This person may be a physician, a nurse practitioner, or, in some cases, a physician's assistant. For convenience, we will refer to this group of providers as Primary Care Providers (PCPs). Typically, the PCP serves as the formal leader of the team who is responsible for the overall care plan developed in cooperation with the patient. Other staff on the primary care team, including the behavioral health staff, provides support to the patient and the PCP to ensure that the patient receives the best care possible. An additional role of the PCP is to address the health of the population in his or her practice. In other words, PCPs track population outcomes on important measures of health and adjust their practice to maximize the health of their population of patients. An example of population-based health would be tracking compliance with disease-specific guidelines and using continuous quality improvement practices to increase the proportion of patients with that disease who are receiving guideline concordant care.

Other Staff Traditionally Included in Primary Care Teams
Primary care teams traditionally include other staff members supporting the patient and PCP. These staff members include nurses, who may have differing levels of independent practice depending on their level of education and licensure, clerks and in some settings health technicians. Many primary care teams include general social workers whose role is to address the social and financial needs of patients by helping to ensure that patients have access to programs and services for which they are eligible. Some primary care teams include other professionals such as clinical pharmacists and nutritionists, health coaches, or Health Behavior Coordinators(HBCs).

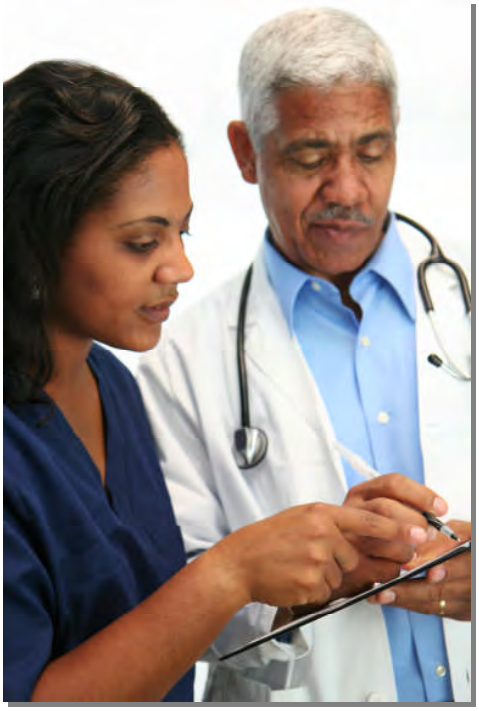
Specialty Mental Health Providers
Your colleagues working in specialty mental health programs, e.g., mental health clinic, PTSD clinical team, addiction clinic, etc., are also key players in integrated care. They must know about your program, and must understand the collaborative roles that integrated and specialty care programs play. Without mutual understanding and cooperation, patients will get "stuck" as they move through a continuum of care. If you are not in a healthcare system you will want to develop referral networks for specialty care.

Leadership, Administrators, and other Support Personnel
Facility and system administrators and leaders are responsible for resources allocation. They need to understand the business case, or value to the system, behind integrated care in order to see the importance of expending scare mental health resources in the primary care clinic. Reaching out to leadership by reporting about improved access to services, numbers of patients receiving care, average improvement in symptoms, and numbers of referrals to specialty mental health, before and after the initiation of integrated care are just a few examples of reports to administrators that can be developed based on measurement-based care.

The Community
The community is also a key player in integrated care program. Your particular agency or program will likely not be able to provide for every need that your patients may have. As a result, there are times when you and the patient will have to rely on community agencies and resources for needed services. Even in large healthcare systems like the VA, an increasing emphasis on community partnerships is being encouraged so that a greater proportion of patient needs can be met.

Behavioral Health Providers
And last, but certainly not least in an integrated care program, are the behavioral health providers (BHPs) – most likely this is your role.

BHPs are clinicians on the integrated care team who deliver and coordinate patient care directly in the primary care setting. We have chosen to refer to the role of the integrated care clinician in this manual as the Behavioral Health Provider (BHP) as it may include any licensed professional staff with mental health expertise working within primary care. This includes psychologists, licensed social workers, psychiatrists, and nurses. Regardless of your professional background, basic competencies in motivational interviewing, problem solving and goal setting are highly recommended. Other interventions that you use in this role with primary care patients, such as specific brief therapies, will vary based on your skill set and areas of expertise.



The primary role of all BHPs is to support the primary care plan that the patient and PCP have developed. This focus may require a considerable shift in attitude and approach for BHPs that were prepared and credentialed to be independent practitioners in specialty mental health setting. BHPs may help patients to adhere to medical advice, such as following their diabetic diet and taking insulin as prescribed. They may help patients to make healthier choices and attain healthier lifestyles by supporting their weight loss efforts or helping them to stop smoking. Of course, a primary role for BHPs is to care for mental health disorders such as depression, alcohol misuse, or anxiety. Depending on their level of independent practice, BHPs may work directly with patients to develop a care plan for mental health diagnoses or consult with the PCP to support their prescribing practices. BHPs with the appropriate expertise may provide brief treatments. Again, depending on their level of independent practice, BHPs may provide or oversee care management protocols for commonly occurring mental health disorders. BHPs are also likely to serve in the important role of crisis management for suicidal or lethal patients and as liaisons to specialty mental health care, helping patient's access the appropriate specialty care in a timely manner.

As with medical care in the primary care setting, BHPs should take a population-based approach. This approach requires measurement-based care. Just as PCPs monitor measures of diabetes care, such as the hemoglobin A1C across their diabetic patients, BHPs should employ standard measures to assess the mental health of the population they serve.

These measures can be used to monitor and address lack of improvement at the patient level, but in addition, they can be used as markers of high quality care and as targets for quality improvement. Last but not least, BHPs often have specific expertise in interpersonal relationships and group dynamics.

They can provide a valuable service to the integrated primary care team by helping to address issues related to stigma and negative social reactions to patients with mental health and other diagnoses support the team to find ways to be more patient-centered and respectful of alternative lifestyle choices, and address challenging intra-team dynamics.

BHP roles include, but are not limited to:

- Monitoring patients and their symptoms
- Recognizing and overcoming patient ambivalence and other road blocks
- Encouraging patient self-management
- Providing patient/family education
- Providing brief, evidence-based interventions
- Monitoring medication adherence and side effects and providing timely feedback and recommendations to the PCP
- Discussing treatment goals with the patient
- Working with the primary care team on education and skill development

BHPs can be grouped into four broad categories of providers:

1. **Behavioral Health Prescribing Providers** – This category of BHPs includes Psychiatrists/Advanced Practice Nurses/Physician Assistants with specialized training and experience in mental health. With both medical and psychiatric training and expertise, this category of prescribers can most easily support the PCPs' prescribing of psychiatric medications and bring important understanding of the biological basis of behavior and medication effects and side effects to the team. Most prescribing providers also have training in non-pharmacological interventions and can therefore also support other types of brief interventions in primary care. Clinical Pharmacists sometimes also serve in the role of prescribers in integrated care settings.

2. **Behavioral Health Brief Intervention Providers** – This category includes behavioral health providers who do not prescribe medications, but who are experts in the delivery of therapeutic interventions. Integrated care therapy providers are typically Psychologists, Clinical Nurse Specialists or Licensed Clinical Social Workers who can provide brief assessments and mental health treatments in the primary care setting.

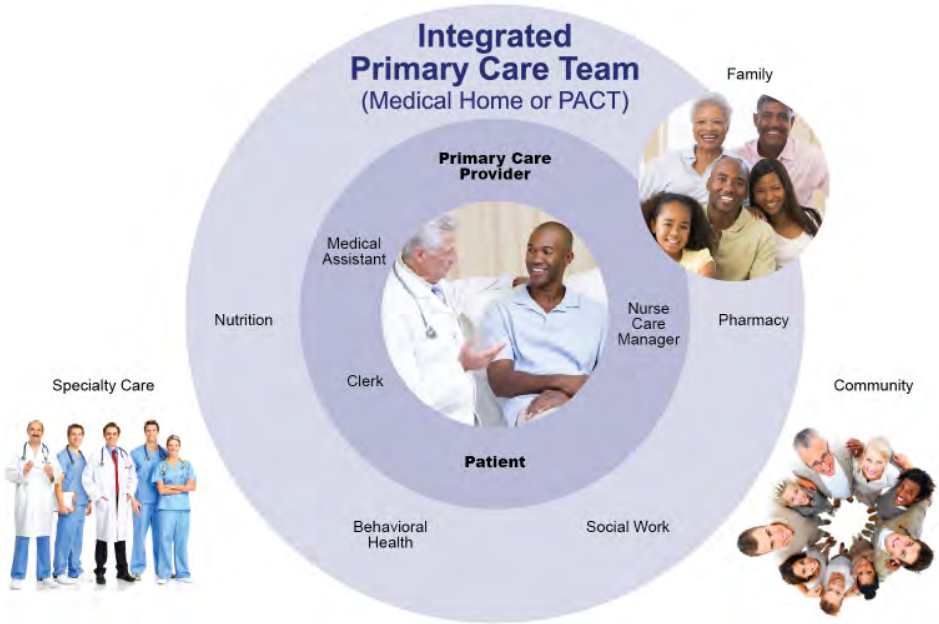
As experts in behavior change, this category of providers can provide a wide variety of services in support of mental and behavioral health assessment and intervention. Many patients reject the idea of taking medication for mental health disorders; BHPs can provide non-pharmacological treatments in the primary care setting helping to overcome barriers to care. Health psychologists have specialty training in addressing health issues such as pain, weight management, smoking and adherence that may be uniquely fitted to the needs of the primary care patient population. These providers can also serve the roles of care managers as described below.

3. **Care Managers** – Care management services can be provided by a wide variety of providers and components of care management can be incorporated into standard practice by most BHPs. Many care managers, however, are nurses who are not themselves prescribers. Care managers provide protocol driven interventions and insure that patients are contacted regularly and that their mental health is briefly assessed at each interaction. These tasks provide the backbone of measurement-based care.

4. **Health Technicians** – In facilities with a larger clinical flow, the addition of Health Technicians (HTs), called Psychology Technicians in some settings, to support the program and support the BHPs may increase efficiency. The role of the HT is to assist in administrative and structured responsibilities. HTs who participate in patient-directed activities are generally chosen based on a high level of interpersonal skills, attention to detail, and a background in the social sciences. HTs have been successfully employed in conducting standardized baseline and symptom monitoring interviews as well as facilitating administrative tasks. Software programs are available that utilize structured assessments and support measurement based care; these tools are utilized by all members of the integrated care team but lend themselves well to the addition of the HT role. HTs work under the supervision of the BHPs. Program clinical staff maintains responsibility for the quality and fidelity of the services delivered by HTs and review results all assessments completed by HTs.

Different disciplines bring unique strengths to the role of the BHP. For example, if you are a nurse you will find that the BHP role has strong ties to the nursing process and the analytical framework of nursing theory for the delivery of patient management. Psychologists and social workers bring a different skill set in terms of brief treatments available in their toolkit. In addition, social workers might also bring expertise in care coordination and utilization of community resources, while psychologists bring to the table their clinical training experiences and clinical skills.

If you are the BHP, your main role is to provide brief focused care to patients in collaboration with the rest of your PC team. As your interaction with the other PC team unfolds, other roles will likely develop that complement your background and skill set. For example, you may become your primary care team's defacto expert in all matters of mental and behavioral health, resulting in a role that includes consultant to any and all other team members. One day, the PCP may be asking you for advice in dealing with a patient who refuses to open up and discuss his health problems; and the next, the primary care nurse may be asking you how best to deal with an angry patient in the exam room. Many BHPs' training and background include expertise in facilitating group processes, and therefore a natural evolution of your role may be directed toward strengthening team functioning and cohesion.



Supervision

The issue of professional supervision within an integrated care team can be complex because of the wide variety of professional disciplines represented. Further complicating the issue is that often there may be only one nurse Care Manager, or only one BHP on a team, especially in smaller programs. Because of this we recommend that supervisory mechanisms be worked out at the local or facility level. Just remember three key concepts: 1) In a patient centered or patient aligned care team, your patient is at the top of the "supervisory ladder." Meet the patient's needs first and foremost. 2) The primary care provider is in charge of the patient's overall care, so meet his or her needs and the patients will greatly benefit. 3) Practice to the highest level of your professional standards. Seek consultation when you need it; ask for help when necessary. Remember, integrated care is a team approach in the truest sense of that word.

CHAPTER 4

Clinical Program

Clinical services that have been made available through the integrated care program include consultation, joint treatment planning/collaboration, patient education/activation, care management services, patient monitoring and tracking, the delivery of brief treatments, and tracking for engagement in MH services. The specific nature and procedures of the clinical program at your site is a reflection of the goals, target population, available resources, and other details addressed by your program's leadership as part of program development. This training program includes manuals that outline specific, evidence-based approaches to some of the more commonly delivered clinical services. While specific strategies for the delivery of integrated program's clinical services are based on the program manuals or reflect other preferences of the program clinicians, clinical treatment delivered through your integrated program is likely to involve several core features common to successful integrated programs:

- Collaborative treatment planning incorporating the preferences of the PCP and the patient
- Availability of a medication consultant to assist you in the selection/evaluation of treatment options and foster good clinical outcomes
- Performance of planned follow-up clinical contacts with the patient, either in person or by telephone, that include continued administration of standardized validated measure(s)
- Individualized discharge planning from you that reflects the patient's level of symptom resolution

This section focuses on general issues for program providers relating to providing clinical care and treatment planning as part of an existing integrated care program.

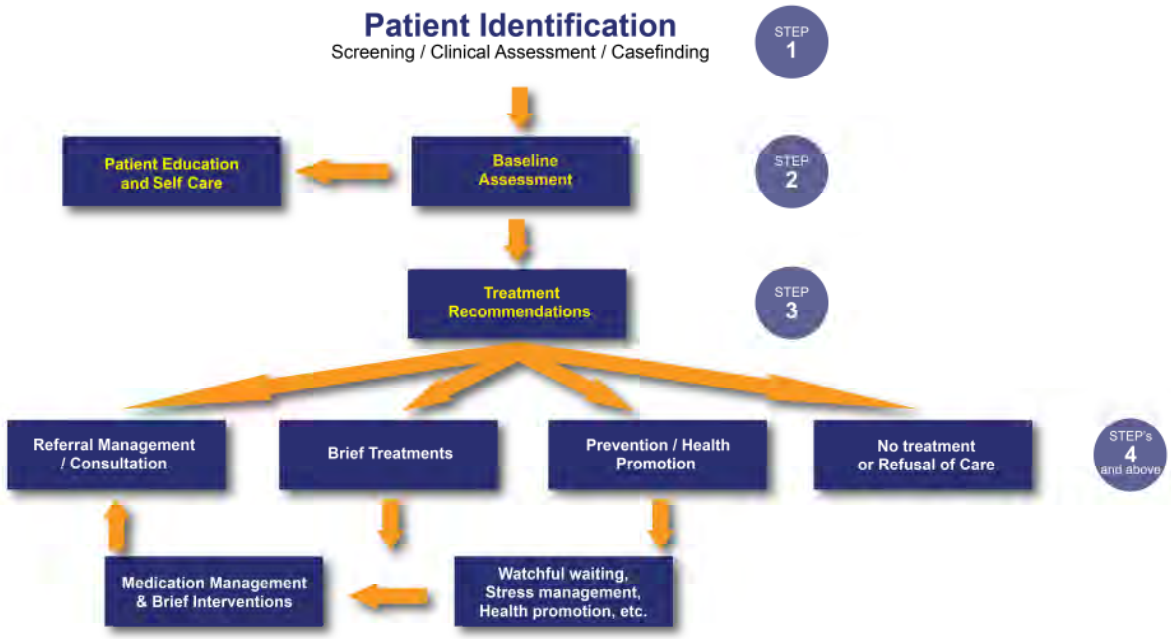
This section aims to:

- Provide a framework for conceptualizing the flow of services available in your program
- Offer suggestions for initial contact and assessment of patients including the use of the baseline assessment to guide treatment planning
- Serve as an introduction to the specific clinical services training manuals that are included as part of the full program materials

For program providers who are interested in learning more about typical activities that generally drive the development and implementation of a new integrated program, or modifying existing clinical services to support an integrated program, an overview of issues can be found in the “Program Organization” section.

General Flow of the Program

The flow of care through a typical integrated care program is depicted in the following diagram. Understanding the general flow of your program provides the context for the various staff functions. In general, patients are identified in the primary care clinic for completion of the integrated care baseline assessment, and the results of the baseline assessment are used to triage patients to appropriate clinical services available in your integrated care program or, if indicated, to services available through referral to other specialty care resources.



Decide what your program includes
Before beginning to see patients, you and your leadership need to decide what services your program will provide. This decision will guide the development of specific strategies for case identification (those who are potentially appropriate for integrated services). Types of services that have been provided in the integrated care model include monitoring of new antidepressants, monitoring of subsyndromal symptoms, management of depression, anxiety and/or alcohol disorders, promoting specialty care engagement, chronic pain management, sleep services, group therapy, the delivery of brief therapies, etc. The decision regarding what your program includes is conceived by program leadership during program development; however, as program staff come on board, new skill sets and novel thinking allow the opportunity for all program staff to participate in this ongoing process. In most settings, the program's interaction/coordination with primary care providers and the nature of the clinical program is an evolving process.

If you have clinical skills that you feel would be an asset to incorporate into your program's available clinical services or the primary care team voices other unmet needs that your program can assist with, discuss this with the team. Understanding the clinical services that your program offers, and your role in providing those clinical services, will help you assess how your skill set "matches up" to program needs as well as guide you in seeking out additional education/supervision in any areas in which you do not have expertise.

STEP 1 Identification of Patients

In making plans for identifying patients with mental health needs for your program, you will need to consider what resources are currently available in your setting as well as other potential resources that could be developed specifically to meet your program goals. In established integrated care programs, patient identification mechanisms are likely already in place and functioning. However, as your program matures, untapped opportunities for identifying patients may present themselves and/or current methods may become ineffective and therefore need to be reconsidered. You are encouraged to actively monitor the effectiveness of existing patient identification mechanisms, be alert for potential new program opportunities, and provide appropriate feedback to program leadership. If you see a potential unaddressed opportunity to expand or refine your program's method for obtaining patients, make sure you speak to your leadership about your ideas. To assist you with the goal of maximizing appropriate identification of patients for your program, the following discussion briefly describes some strategies that have been effective in generating an appropriate patient identification mechanism for integrated care programs.

In general, the patient identification mechanisms that have been successful for integrated programs include direct consultation with a patient's primary care provider, self (patient)- identification, identification from positive standardized screens for mental health symptoms or substance misuse, and routine review of available records to identify potential program participants (e.g. those newly prescribed an antidepressant or benzodiazepine medication in primary care). PC settings that have incorporated the routine use of a brief standardized depression

screen, such as the 2-item PHQ, or a brief standardized screen for alcohol misuse, such as the AUDIT-C, have been found to be a very effective in systematic and early identification of those patients who could potentially benefit from the integrated program services. Medical Centers within the Veterans Health Administration, for example, utilize routine screening measures built into the patient's electronic medical chart. Reminders are also built into the chart so providers are prompted at set intervals to administer these screening assessments allowing for early identification of patient symptoms/problems. If staffing and resources allow, a policy of "there is no wrong door" is ideal to simplify the process for PCPs. Work with your leadership and primary care team to devise a patient identification process that will work best for patients, primary care providers, and your program.

With specific "day-to-day" identification of patients for your program, your goal as "front line" program staff is to be available to the other primary care staff, to be accessible to the patient, and to facilitate program engagement for both patients and other primary care providers. Be visible to the other primary care clinical staff– let them know you are there. Go to team meetings- remember, you are a member of the primary care team. Take the time to check in with providers to remind them of your services and to inquire about any potential patients for the program. Keep an open door and an open schedule – nothing will destroy your program more than you being scheduled 9-5 with your office door closed. Be helpful with "problem" patients. Provide feedback to providers about successful engagement. Judiciously tout your successes to support the demonstrated as well as perceived value of your efforts. Make a habit of asking primary care providers and other primary team members for feedback on the program in order to make improvements, facilitate the "integrated" aspect of the program, and maintain a good line of communication within the primary care team.

STEP 2 Initial Contact and Baseline Assessment

Overview
The integrated program incorporates a “stepped care” approach to meeting patients’ needs. The goal of the baseline assessment is to identify patients that have MH symptoms or behavioral health needs, perform relevant assessment(s) including measurement-based MH symptom surveys, learn patient treatment preferences, generate treatment recommendations to the primary care provider, and triage the patient to the appropriate care level. It is likely that your role as a BHP will include responsibilities across this entire process as well as the delivery of recommended clinical services to appropriate patients.

The completed initial/baseline assessment is used as a triage assessment to assist in determining whether the patient remains in your integrated care program or needs to be referred to more intensive specialty MH care.

Specific content of the initial evaluation for your program should address core integrated program foci including assessment for depression, anxiety, and alcohol misuse, as well as screening for MH symptoms that would potentially exclude being managed in integrated care (e.g. active psychosis or mania). You need to become familiar with conducting any standardized questionnaires chosen for your program so that these can be consistently integrated in your baseline and follow-up clinical assessments. Remember that inclusion and continued administration of standardized validated measure(s) is seen as integral to the delivery and outcome measurement of all integrated care programs. Also, as you should avoid long comprehensive intake exams as long intakes may “turn off” the patient or, on the other hand, may lead to unrealistic patient expectations about the scope of services the program is designed to deliver.

Initial Evaluation at the time of the PC appointment - Warm Handoff

When you are located in the primary care clinic, you may receive many of your potential patients on the same day as the primary care visit from other members on the primary care team. Good hand-off communication is very helpful in these circumstances (i.e. understanding the primary care provider's concern or what they see as the main problem). When receiving a hand-off, you also want to clarify with the provider how to best provide them feedback (i.e. a phone call, knocking on their office door, charting in a shared medical record, etc.). This is one opportunity to educate providers on the types of services you can provide and on the importance of collaboration. Because you may receive a lot of patients as hand-offs, you will also need to arrange your schedule to allow for this kind of open access. Booking up every slot with appointments, as is typical in specialty mental health care, will not allow you to be available to the primary care team and will quickly diminish opportunities for collaboration.

It is ideal if the provider introduces you to the patient. This sets up your interaction with the patient in a positive way. How the provider can most effectively introduce you may be a useful topic at team meetings.

An introduction of your services to the patient by the PCP might look like:

PCP says to patient: *"I'd like you to meet with a colleague of mine, Dr. Smith, to talk a little bit more about your current stress. She is a psychologist on our team, and she can help us come up with a treatment plan for addressing your current stress and difficulty sleeping. She is just down the hall, and I trust that she will be able to help us."*

For an example of what your introduction to a patent you meet in primary care might look like, please see the 5A's description in Chapter 5 Basic Skills for the BHP.

Initial Evaluation after the PC appointment

Other patients may come to your attention after the primary care visit, for example patients who do not want to stay to be seen that day, patients identified later perhaps due to a positive screen, or a systematic review of records indentifying the patient due to a recent antidepressant prescription. In these cases, reaching out to patients in a timely manner after the primary care visit is important. For example, contacting the patient by telephone within a few days of the primary care visit is helpful so that the patient can more easily link your contact to the primary care visit. Your integrated care program must have distinct guidelines and standards for following up with identified patients and communicating back to the PCP. Even in cases when you are unable to reach the patient in the expected time frame, it is important to follow a set of procedures to update the PCP on the status and your efforts.

If you reach out to the patient by telephone after their visit, one way to introduce yourself would be:

> *"Hello Mr./Mrs./Ms ____. My name is (your name) and I work with your primary care provider, Dr. Bones. He asked that I give you a call today to follow up on some of the concerns you spoke about at your appointment yesterday (e.g. depressive symptoms, sleep problems, etc.). What I would like to do is ask you some questions to get a better idea of how you are feeling. It would take about 20-30 minutes. Would you have the time to do that today? Afterwards, we could talk about some options that might best fit your needs and get you feeling better. (If it is not a good time for the patient ask when a good time would be to call back.)"*

The Baseline Assessment

The initial evaluation is used to determine whether the patient remains within the integrated care program or needs to be referred to specialty care. If completed in the primary care clinic, this may be conceptualized as the "assess" phase of a 5A's assessment that will be discussed in Chapter 5 Clinical Skills for the BHP. You do not need to learn everything there is to know about the patient at this time. The assessment should be conducted using a combination of clinical skill and validated questionnaires (measurement based care).

The use of structured questionnaires is important for several reasons, but does not replace good clinical judgment. Indeed, the best practice balances structured questionnaires with clinical skill and knowledge (for a discussion of this topic see Valenstein, et al. 2009). The value of structured questionnaires includes:

- The ability to select specific symptom criteria for when to refer to a specific clinical program
- Questionnaires produce data that can be used to show patients, providers, and administrators key outcomes
- Questionnaires can be easily administered in person, by telephone, web, or other means
- Responses to questionnaires are much easier to read and interpret by providers other than yourself
- Questionnaires are often easier for patients to answer
- Questionnaires can be valuable educational tool for patients, especially in tracking progress
- If included in your program, non-professional staff can administer structured assessments that can greatly streamline the program and free up valuable clinician time

Your program may dictate specific questionnaires that are to be incorporated into the initial evaluation or the selection of appropriate questionnaires may be left to your clinical judgment. Programs should be mindful of copyright laws and use of instruments that are in the public domain. When choosing assessments it is important to consider whether they are in the public domain and whether they can be used to track progress. Copies of some well-validated self-assessments and interview-based instruments are included in the Patient Resources Volume. Also evident is the notion that an electronic medical record or specific software can be invaluable to assisting in measurement based care and is critical to following patients over time (registry based care). Finally, not all assessments work well in all settings such as over the phone. Most of the following recommended questionnaires listed in parentheses below have been validated for use by telephone (See the Patient Resources Volume for the full assessments)

Recommended to include in the baseline assessment:

- A measure of social support
- A screen for cognitive problems, administered to older patients (Blessed Orientation-Memory Concentration Exam) [71]
- Screening assessments for Psychosis, Mania, Generalized Anxiety Disorder (GAD), Panic Disorder (subsets of the MINI) [72]
- Quantity and frequency of recent alcohol use and a DSM checklist for Alcohol Abuse/ Dependence when appropriate
- A screen for illicit substance, use of nonprescribed medication, or misuse of prescribed medications
- A brief depression severity measure (Patient Health Questionnaire-9 (PHQ-9) [73]
- A measure of symptoms and severity of Post Traumatic Stress Disorder (PTSD Check List (PCL) [74]
- Treatment history including

    - Current Antidepressant Medications
    - Current Care (i.e. whether followed by a mental health provider, location of primary care)
    - Questions about adherence to treatment and side effects
- A screening assessment for suicide (Paykel Scale) [75]

PROGRAM ? DECISION

Specific content of the initial evaluation at any particular site may be individualized considering factors such as the nature of anticipated target population, mission and scope of the program, integration of expressed preferences of primary care providers, and level of clinical skill of anticipated interviewer(s). However, we suggest a treatment algorithm(s) for the management of depression and anxiety based on the use of the PHQ-9 and GAD7 respectively as the standardized depression and anxiety measures and thus these assessments would be considered essential. Similarly, quantity and frequency of alcohol use is critical to managing excessive drinking or alcohol dependence. In summary, the initial evaluation should involve the completion of all program -specified structured, standardized assessments supplemented by unstructured assessment/interaction driven by your clinical judgment.

Helpful tips for Engaging Patients in the Baseline Assessment
All patients should be encouraged to complete an initial baseline evaluation. Answer any questions the patient may have and encourage them to speak with their primary care provider about your conversation.

The following scripts serve as examples that may be developed at your site to encourage participation if a patient is hesitant or resistant to engage in the baseline interview:

> *"Mr. /Ms X, even if you are feeling fine, your provider would still like us to do this follow-up interview to make sure you are doing well. Sometimes there is a misunderstanding and this interview would help to clear things up and give your provider a more detailed description of how you are feeling."*

> *"Mr. /Mrs. X, I can assure you that this is a confidential conversation and will only be shared with those involved in your health care."*

As we mentioned before, all interviews can be conducted either in-person or by telephone. Remember it is more important to complete the interviews than worrying about where it is conducted. The assessment should only take 25-30 minutes, thus if you are regularly taking longer you may want to evaluate your evaluation process and content. When conducting telephone interviews, most people will only be attentive for about 30 minutes. It is helpful to inform the patient at the beginning of the meeting or call that in order to make sure the interview or assessment is completed in a timely manner, answers should be kept brief and you may need to interrupt them at times. When patients veer off topic or elaborate on answers, gently guide the patient back to the interview while being respectful and listening to what they have said.

Baseline Assessment Tips for Non-professional Staff (e.g., Health or Psychology Technicians)

Your program may incorporate non-professional staff into the administration of the baseline assessment. Program interviews designed to be conducted by non-professional staff are expected to be structured, scripted, standardized assessments and not allow for a clinically-driven component. The following points can facilitate the timely and accurate successful completion of the baseline assessment by non-professional staff.

- Examine and practice the interview before beginning the assessment. Do not conduct any assessments until you have practiced them extensively
- Ask questions exactly as worded
- Speak slowly and clearly
- Repeat and clarify questions that the patient has misunderstood
- Use probes on patients as a non-directive way to clarify answers (e.g., if you ask a patient a True or False question and they cannot decide on an answer, probe them with, "What would be your best guess?" or "Which answer comes closest to how you feel?")
- Never paraphrase a response in your own words; always use patients' exact wording
- Be friendly, courteous, interested, patient, and professional
- Always use last names when speaking with a patient
- Maintain a respectful attitude at all times
- Never diagnose patients while conducting an interview
- Avoid using language within the baseline interview such as, "Those symptoms are signs of X," "You are showing signs or symptoms of X," or "I think that...."
- Never give any suggestions within the baseline interview (e.g. "It may be helpful if you do this or try that")

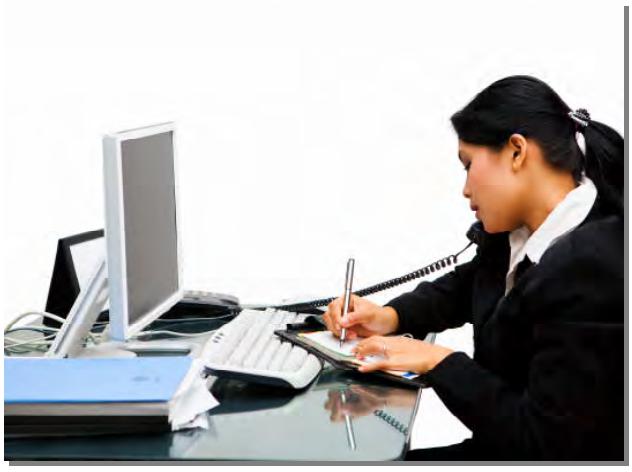
Do not generalize within the baseline interview (e.g. "It is very common in a case such as yours..." or "It's common...")

- Do not recommend a specific treatment pathway (e.g. an appointment in specialty care) if it is not recommended per your site's triage algorithm, unless requested by the PCP or the patient. If the patient requests a specific treatment pathway, program recommended treatment options should also be offered so that the patient may make an informed choice

In general, the most common difficulty encountered with the baseline assessment is that patients may feel some of the questions are too personal. Patients should be reassured that all responses are kept confidential and only made available to those providers directly involved in his/her care. Patients may also feel that their PCP should already know these responses. It may be helpful to answer this concern by communicating to the patient that some questions are asked to confirm the accuracy of previous information and that the interview serves to assure better quality of care. Some patients may feel that the questions do not pertain to them. It is helpful to express this possibility before beginning the interview, noting to the patient that these are standard questions that are asked of every patient in order to get a more complete picture of their story.

It is important for program non-professional staff to role-play with other staff to gain the skills and techniques necessary to complete these interviews in a timely and accurate manner. Role-playing should include interviews that are straightforward as well as interviews that deliberately involve some common areas of difficulty (e.g. hostility, cognitive impairment). Role playing may be especially beneficial in helping non-professional staff balance respecting the patient's right not to answer specific interview questions, often because they are perceived as too personal or upsetting, with encouragement to complete as much of the interview as possible to allow for appropriate patient triage.

Telephone Tips



The availability of telephone assessment and treatment is a great asset in increasing your accessibility. It also can present unique challenges. In an effort to reach patients, you may need/be expected to place calls during varying timeslots. This may include your availability to contact patients outside the usual Monday-Friday 9-5 workweek. Some patients may have a "pay as you go" phone, which can lead to reluctance to engage in a comprehensive telephone interview. Leaving voicemails/messages for patients that are informative yet protect their privacy can be challenging.

How does your call show up on the caller ID feature that many phones now offer-is that identifier a potential turnoff to the patient? What procedures, if any, are in place in your program to ensure that the person with whom you are speaking on the phone is actually the patient?

Simple Tips for Scheduling

Whether being conducted in person or by telephone, the scheduling of specific day/time appointments with the patient is encouraged. Your time as well as the patient's time is valuable. Ask the patient you successfully contact for the initial evaluation if he/she has the time to complete the interview at that initial contact. Include upfront specific information as to how long the interview will take to complete (e.g. about 30 minutes). If the patient is unable to complete the baseline evaluation at the initial contact, your goal becomes the scheduling of a mutually convenient time to conduct the interview. For patients who are enrolled in ongoing services with you, at the end of the each completed contact, make an appointment for the next scheduled follow-up contact, according to program timelines. Remember you can only enable the treatment plan if you make yourself available to the patient. Have the materials you need to conduct program assessments/clinical services at hand and ready to go in the event that patients are available to speak to you at an unscheduled call time. Be sure all your assigned patients have your contact information- not everything goes as scheduled despite your (and the patient's) best efforts.

Triage Decision and Treatment Recommendations

At this point, you have completed a baseline assessment with the patient and have a general idea about the patient's goals and concerns. The next most important step is to decide how you can be of assistance to the patient and to formulate a treatment plan. The first concrete decision you need to make is whether the patient can be managed within primary care or needs the resources available in specialty care. This decision is based on many factors including the patient's preferences, the complexity of care needed, the resources available from primary care, and the scope of your own practice. In general the more complex the patient needs, the more likely the patient will benefit from specialty care. It is highly recommended that your program think through the issue of resources and who is best served in which programs. For instance is someone with drug dependence or PTSD going to be managed in your integrated care clinic? The more transparent these decisions are, the better understood they will be for all stakeholders.

The second critical piece at this time is to formulate a treatment plan. Treatment planning in integrated care should leverage the existing evidence-base. Treatment recommendations will often be very different in a primary care program than in specialty care. The emphasis is more on first line treatments, prevention, and brief treatments. While you may be a seasoned and secure clinician who has a good grasp on treatment planning, we highly recommend that you consider the treatment algorithms in the depression and anxiety manual and the at-risk drinking and alcohol dependence manual. These manuals will provide you with a fresh approach to care in the primary care setting.

In addition, the manuals for the delivery of specific program clinical services also propose algorithms to assist in treatment planning and evaluation. While program treatment algorithms are evidence-based and conform to clinical practice guidelines, clinical judgment is crucial in guiding treatment planning and may lead to "trumping the algorithm." Thus, the planning, delivery and evaluation of treatment outcomes are expected to incorporate standardized assessments, but also rely on your clinical skills.

Tracking your Workload

Your program may utilize a software program to assist with many integrated program functions, such as patient registry, assessment, tracking, and generating reports. Software programs are also available to assist in characterizing patients into risk categories and provide decision support based on clinical practice guidelines. In general, such programs triage patients into several principal referral/program pathways based on symptom severity and can be customized by individual integrated programs to meet program-specific goals and needs.

General Advice about your Clinical Work

Your caseload is ever changing with new patients coming and patients graduating or being referred on to specialty programs. Workload estimates will be largely dependent on the services you provide and the program's algorithm for inclusion in those services. It may be helpful in conceptualizing workload estimates to look at the experience from existing programs. Experience suggests that about 40% of patients identified will need some ongoing contact with a program BHP, 40% will need specialty referral, and 20% monitoring of sub-syndromal symptoms. Based on experience only, each BHP is assumed to be able to handle 7-8 new patients for brief treatment per week, therefore one full time BHP per 8-12,000 unique patients served in the clinic is a manageable number in this program which also has HT level support staff. This number also depends on the breadth of services being offered for instance if you are focusing only on depression or if you are managing other disorders or providing health promotion activities. Without the HT support the BHP will not be able to manage as many new patients.

Charting and Documenting Your Work
The BHP documents the outcome of the contacts and provides this information to the PCP and primary care team. The format of clinical notes, and the route of communication to the PCP, is expected to be highly specific to site, provider, and your preference. Sample formats include the reports generated from the BHP interview, copies of which can be found in the Sample Clinician Reports section of the Clinician Reference Guide.

Each clinical program uses a variety of methods for charting program activity. In most instances, telephone evaluations and consultations are not billable, but should be documented as part of the ongoing clinical care of the patient. A progress note should be written and provided to the primary care provider for medical records documentation.

In addition to the progress note, completion of billing or encounter information should include appropriate use of International Classifications of Diseases (ICD) codes and appropriate CPT coding. The chart below has some commonly used ICD and CPT codes used in integrated care.

ICD Codes	
Disease Classifications	**Code**
Depression	311
Anxiety Disorder	300
Alcohol Abuse/ “At-Risk”	305
No Diagnosis or Condition on Axis	v71.09
Depression in Remission	296.25
Dysthymic Disorder	300.4
Generalized Anxiety Disorder	300.2
Panic Disorder, without agoraphobia	300.1
Adjustment Disorder	309.9

Current Procedure Terminology (CPT) codes are used to describe health care services. For each service, there is a five-digit code accompanied by a text description (e.g. 82270 – Fecal Occult Blood Test). CPT codes can also be used as a system for classifying services for reimbursement. The following are CPT codes that are commonly used:

CPT Codes	
TELEPHONE	**Code**
Non-physicians: (5-10 min)	98966
Non-physicians: (11-20 min)	98967
Non-physicians: (21-30 min)	98968
Physicians: (5-10 min)	99441
Physicians: (11-20 min)	99442
Physicians: (21-30 min)	99443
FACE-TO-FACE	
Psychologist, Social Worker, NP, CNS, etc.	
New patient – Initial Psychiatric Interview	90791
Established patient (30 minutes)	90832
Established patient (45 minutes)	90834
Health & Behavior Assessment	
Requires physical health diagnosis (15 min increments)	96150
Health & Behavior Intervention	
Requires physical health diagnosis (15 min increments)	96152
Other	
Brief intervention for substance use (time dependent)	99408
Brief intervention for substance use (time dependent)	99409
Review of records (does not require patient contact)	90885
Group Psychotherapy	90853

Note that the codes in the above chart changed in January 2013.

CHAPTER 5

Basic Skills for a Behavioral Health Provider (BHP)

The next section outlines a series of basic skills that you should master. Some of these may already be familiar and some may be new to you. We introduce them here, but strongly encourage you to seek more training if you are not already expert in their application. Learning and practicing these skills will make your time with patients more efficient and will improve your outcomes.

Collaborating with Primary Care Providers (PCPs)

Collaborative care means that you are working as an integral part of the primary care team. Collaboration is the essence of the medical home model (also known as the Patient Aligned Care Team (PACT) model in the VA). Therefore, collaborating with PCPs and the other PC staff successfully is a key skill to master. Successfully working with the other members of the PC staff begins with understanding the organization and overall function of the shared practice setting in which your PCPs provide care. What goes on in the PC clinic? How are they organized? Who are the players and what are their roles? Behavioral health providers such as yourself also need to get to know as much as possible about individual PCPs' work styles and preferences for communication and support. It is important that a relationship develops in which you have open lines of communication and feel comfortable interacting with the other PC staff when there are concerns about a patient or to make recommendations. To build effective working relationships and programs, the BHP needs to be accommodating to the PCPs. In other words, the BHP should be readily available to the PCPs when needed, provide a broad scope of patient care, and provide feedback to providers in a timely manner.

Successful collaboration with the primary care team does not happen overnight. Being supported by and having “buy-in” in from the PCP staff comes with time and develops into collaboration. Educating the primary care team members about the purpose and scope of the services you provide will help them learn how you and your program can be an asset to them. Opening lines of communication, providing provider and team education, and using marketing strategies for your services and program will put you on the road to develop collaborative interactions with your teammates in primary care.

Methods of Communication

Establishing effective communication among BHPs and PCPs is critical to meeting the goals of your program. Informal forms of communication with the PCP can include leaving a voicemail, sending a secure email, sending a paper note or better yet taking a walk down the hallway. In communicating with providers, it is best to clarify beforehand how the provider would prefer to receive feedback on referred patients, when he/she would like the feedback (immediately after seeing the patient, at the end of the day, etc.), and what information he/she would like included in the feedback. When you are working in a clinic with multiple PCPs, you will need to learn and respect their individual preferences for communication. It may be a bit complicated for you at first, but it will result in better working relationships with each individual, which will mean increased collaboration and better patient care.

Written feedback:

The medical record is often the primary form of communication between the PCP and BHPs. This is especially true in settings utilizing electronic medical records. The PCP should be included as a signer on formal clinical notes such as the initial assessment and treatment notes, notes including treatment recommendations or changes to the treatment plan, and any note that contains information that the PCP will need in order provide seamless care to the patient. For example, if you know that the patient will see the PCP shortly after your visit, you can include a brief update on the patient's progress so that the PCP can mention to the patient that he/she is aware that the patient is working with you and acknowledges the progress that has been made. You may also cue the PCP to reinforce something that you and the patient have been working on. "I see you are working with Dr. Jones (the BHP), and that you've been exercising more. That might be part of the reason that your blood sugar has been in better control lately." In other cases, the BHP should consider whether the PCP needs to be included. As with all forms of communication, the BHP should be communicating with the PCPs about the process, getting feedback and adjusting their style to fit into the clinic's practice style. It is important to remember that communications and written documentation in primary care differ from the detailed reports and lengthy notes typically used in a specialty mental health clinic. Your notes need to be clear, concise, and easy to read. Long paragraphs or “process” notes will not be useful to a PCP. Consider making a section at the top of your note entitled “Action Plan” or “Treatment Plan” where you include the items you want the PCP to see and act upon. Clearly delineate who will be doing what with the patient and differentiate between actions that are recommendations and those that are necessary for patient care. In initial notes, make sure to address the provider’s referral reason even if it differs from the patient’s presenting complaint. This will reinforce with the PCP that you are aware of his or her concerns even when the patient chooses to focus on a different goal for your work together.

Verbal feedback:
Generally, verbal feedback to the PCP should be given in less than one minute with a focus on the referral question and include at the minimum significant findings, your impressions of the patient and the problem(s), and your recommendations. Remember, PCPs are typically very busy and if they want more information, they will request it. When communicating with providers avoid psychological jargon. Learn and use more commonly understood medical terms. If you are making recommendations to the provider regarding patient care, keep this brief, specific, and action oriented. We encourage you to take a high level of personal responsibility for the welfare of patients. We recommend you practice communicating information to PCPs in a manner that is as concise, direct, and as helpful as possible.

Here's an example of verbal feedback after meeting with a patient in primary care:

> *"Dr. Gold, I just met with Mr. Lane, and I wanted to follow-up with you briefly, do you have a minute? You mentioned that his mood seemed low, and you were right. He meets criteria for depression, and his score on the depression scale was pretty high—in the moderately severe range. He said he has been feeling this way for a few months. We talked about some strategies to try and get him engaged in some activities outside of the home; we set the goal of going to church and also contacting his friend to go for a walk, which he says he used to do all the time. I am going to follow-up with him in 1 week. He is also interested in trying an antidepressant. If you'd like, I can talk to the psychiatrist on the team, or if you'd rather start an antidepressant that is fine. I'll follow-up and check on adherence and side effects, and monitor his symptoms. Does that sound okay?"*

One skill related to communication is finding opportunities to get your message to the PCP and the rest of the team. There are many different opportunities to communicate if you are physically present in the clinic and do not choose to stay in your office and wait for patients. One step towards becoming part of the primary care team is to be sure to attend team meetings. When you have program updates, ask to be on the agenda, but otherwise just attend and demonstrate that you are part of the team. Be willing to volunteer to help when the team is discussing challenging patients or quality improvement efforts. Volunteer to give a 10-minute talk on a mental health topic if continuing education is included in the meeting. Oftentimes, sites following a patient centered medical home or PACT model have "morning huddles" to briefly talk about the patients coming in that day. If you are at one of these sites, ask to attend these informal gatherings. Volunteer to see patients that fit your program or to help out with challenging patients that are often discussed at these meetings.

Another great way to make you available to PCPs is to make daily “rounds” in the clinic, if logistics allow. Find a time when most providers are in their offices but not seeing patients – in the morning, at the end of the day, or during lunch - and walk around to say hello and ask if there are any patients they would like you to contact. This technique may be a good reminder about your service and allows PCPs to ask you questions they have about patients you are following or to refer a patient from earlier in the day or from the day before. As always be respectful of your colleagues' workload and be aware of their non-verbal cues suggesting that they might be too busy to talk.

PCP Education

One of the most important activities is to educate the other PC staff about your role in the PC Clinic. When you are starting your service and periodically thereafter, it is important to train the other PC staff on how to identify patients that may benefit from services, how to discuss with the patient the recommendation for behavioral health services, and the procedure that follows after a patient has been identified and handed off to the BHP. A core component of this education effort will be to educate staff on mental health disorders and evidence-based treatments. As a result, the PCPs and the rest of the team will be better able to identify and discuss common mental health disorders with patients and will be more likely to provide the most effective treatments. The more educated the staff is, the more likely the team will identify appropriate patients and the handoff for your services will be smoother. When a patient’s trusted PCP is able to identify mental health problems and describe treatment options, the patient will be more likely to follow-through with his or her provider’s recommendation. Additionally, education about early warning signs and comfort with discussing mental health and behavioral health issues will help providers identify patients early in order to intervene before the problem(s) become exacerbated. Staff education can be conducted in a number of ways. You can provide a brochure to providers with an overview of symptoms and the evidence-based treatments for the disorders. You can send weekly or monthly emails with information on specific disorders and symptoms, along with the services you provide. You should also plan on presenting at team meeting and provide presentations on common mental disorders and their treatment.

Marketing to PCPs

As a clinician, marketing may not be a skill you expected to use in your position or a skill that you have spent much time developing. However, you are involved in a unique program and the younger your program is the more marketing is important to increase its utilization. All program staff members are encouraged to be enthusiastic, responsive ambassadors of the integrated program across all potential stakeholders including patients, PCPs, other PC clinic staff, and clinic managers. Attend pre-existing regularly scheduled meetings with Primary Care to address any programmatic concerns and new approaches to care. Get their input frequently on how to best to structure your interactions and what services you provide. When PCPs feel included in the success of ongoing services, it helps maintain their support and engagement.

You should also take advantage of informal opportunities to engage other PC providers and staff. Consider opportunities to market your program such as contacts in the hallway or the break room, as these settings can often allow for more individualized interpersonal interactions than those that tend to occur in formal meetings. Your program will only be successful in achieving its goals if your PCPs are actively engaged and view the integrated program clinical service as a valued resource in their efforts to provide quality care to their patients. So you must be sure to understand what aspects they feel add value to the clinic and patient care.

Here's an example of a "break room speech" to a primary care provider:

> *"Hi Dr. Brown, my name is Julie Miller – I've been wanting to touch base with you briefly. I am a psychologist working in the primary clinic, and my goal is to help you manage your patients with common mental health diagnoses such as depression, anxiety, drinking too much, chronic pain and insomnia. I can do a brief assessment at the time you are seeing the patient or follow-up with them later either in person or by telephone. Then I'll help you provide brief treatment for patients with mild to moderate symptoms, and for patients with more severe symptoms I will help arrange for specialty care. I work closely with a psychiatrist who can make recommendations for first-line psychotropic medications as well. My office is just across from Dr. Bird, and I am available during clinic hours. Please feel free to stop by any time for a consultation or to let me know how I can be the most helpful."*

While marketing to the PCP staff begins at program implementation, often initiated by program leadership, you also have a crucial role because marketing is an ongoing process even in fully established integrated programs. It serves your program well to be aware that all your interactions with primary care staff are potentially critical pieces of ongoing marketing efforts.

Resources for clinicians that may be helpful are:

- Hunter, C.L., Goodie, J.L., Oordt, M.S., and Dobmeyer, A.C. (2009). *Integrated behavioral health in primary care: step-by-step guidance for assessment and intervention.* Washington, DC, American Psychological Association

- Robinson, P.J. & Reiter, J.T. (2007). *Behavioral consultation and primary care: a guide to* integrating services. New York, NY. Springer Publishing

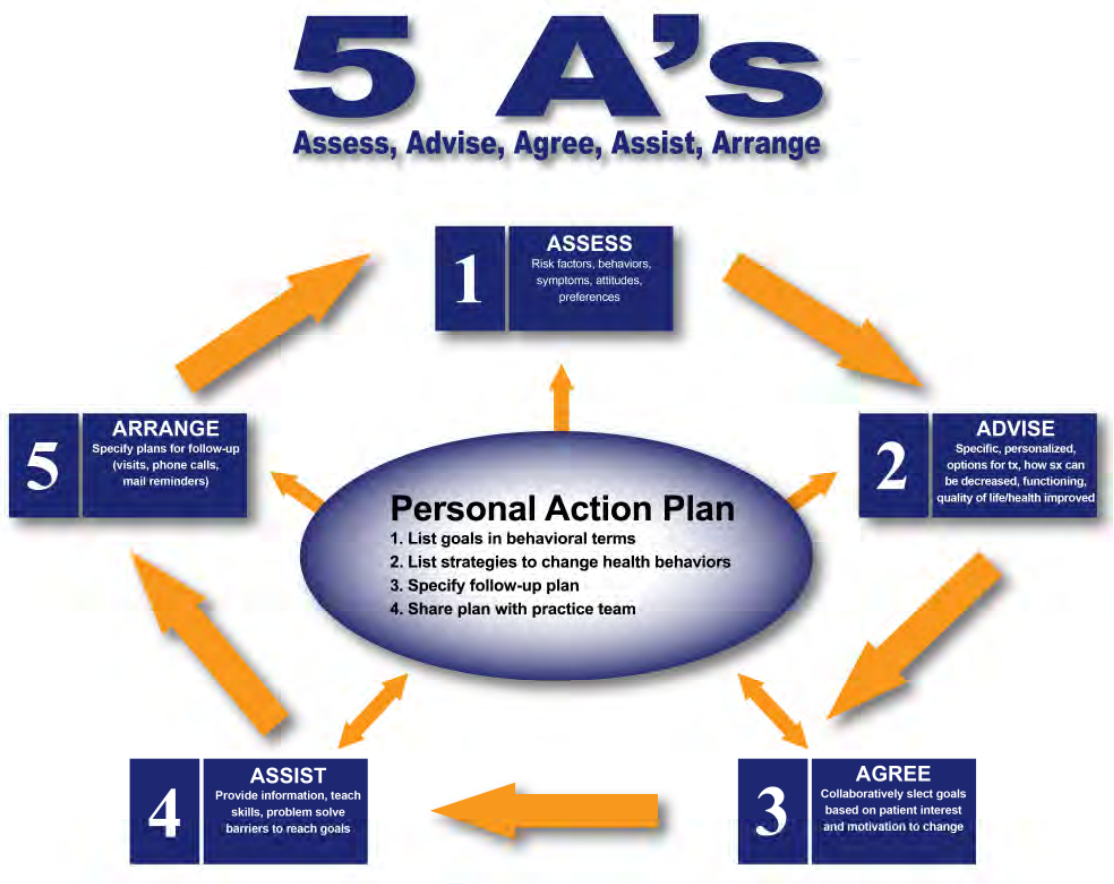
Successful Interviewing in the Primary Care Clinic (5A's)

As a BHP working within the primary care setting and collaborating closely with PCPs, your service delivery and practice management patterns should be consistent with the context and culture of the primary care environment. This means that you should provide population-based care.

Providing population-based care involves offering limited service to a large number of patients as opposed to intensive services to a small number of patients. This practice management pattern is congruent with the pace and flow of primary care. However, this often requires a substantial shift in mindset and behavior for BHPs who are used to working within the traditional mental health service delivery context. In order to increase your availability and provide population based care, appointment and treatment duration must be kept brief (i.e. under 30 minutes) and problem focused. This is important whether your sessions are in-person or telephone based. This is NOT the traditional full psychosocial interview you may be accustomed to; rather it is a brief interview focusing on the functional aspect of the patient's particular presenting problem. The goal of population-based mental health care is to provide services to those experiencing mild to moderate symptoms within the primary care environment and reserve intensive mental health care for patients with more severe concerns. Although this may be a cultural shift for providers with a traditional mental health background, with practice it is possible to obtain only the pertinent information in a brief amount of time.

One framework has been identified as being particularly helpful for providing structure and improving efficiencies for behavioral health care within the primary care setting is the 5As. The 5As is a framework that can be applied to both initial and follow-up appointments, allowing a BHP to efficiently conduct an assessment and/or a brief intervention within a 30 minute timeframe. Although a brief introduction to the 5As framework will be provided below, this information will not be sufficient to fully incorporate these skills into your clinical practice. To learn more about using the 5As as a technique to structure your appointments, it is highly recommended that you read the book by Dr. Christopher Hunter and colleagues referenced in the previous section, and practice structuring your appointments. Applying the 5As is a skill that can take some time to master, and you may also want to consider attending a workshop that teaches you how to most effectively apply these skills.

The 5As include the following phases: Assess, Advise, Agree, Assist, and Arrange
Each phase is further broken down into component parts with specific goals and objectives for each component. The goal of the Assess phase is to gather specific information about the nature of the patient's primary presenting concern (i.e. the reason for the handoff from your primary care colleagues and the focus of the appointment). The goal of the Advise phase is to provide specific information about potential interventions, treatment options, and recommendations for addressing the primary concern. Within the Agree phase, the patient and the BHP should collaboratively determine which options are most consistent with the goals of the patient, and are most likely to be incorporated into the patient's routine. In the Assist phase, the provider should begin a brief intervention, set initial goals, and develop an initial action plan for behavior change. The goal of the Arrange phase is to ensure that all necessary actions on the part of the BHP to ensure that the most appropriate care occurs are completed. For example, the BHP may schedule a follow-up appointment, may provide a referral to the community, and may provide immediate feedback to the other primary care team members. When combined together these steps should result in a personalized action plan to initiate behavioral change. The following sections describe the objectives of each phase within the context of an initial appointment.



Assess

Within the Assess phase there are 4 specific steps that should occur. Step 1 is providing an introduction to your role. This should take 1-2 minutes. It is very important that the patient understand the role of the BHP, the type, nature, and scope of the services to be provided and the collaborative nature of the BHP with the entire primary care team. Several example scripts have been developed to assist BHPs in learning this critical skill.

> Example script: *"I am one of the Behavioral Health Providers who work in the Primary Care Clinic and I am a (nurse, social worker, psychologist, etc). I work with the primary care team in situations where good health care involves paying attention to physical health, habits, behaviors, emotional health and how those things interact with each other. Anytime (PCP name) wants, he/she can call me as a consultant to help the two of you better manage the difficulties you are currently having. To help the two of you do this, I'm going to spend about 20-25 minutes with you (over phone or in person). I want to get a good idea of what is working well, what's not working so well... take that information you give me and together we'll come-up with a plan to help you best manage your current problems or concerns. I'll be giving your primary care provider some feedback on the plan we come up with. Do you have any questions about who I am or my role in the clinic? Is now a good time for you to talk or is there a better time for you?"*

It is critical to immediately address any questions the patient may have regarding your role. You're your role has been clarified, either continue with the interview or schedule another time when the patient is available.

The next step is clarifying the reason for the handoff from the PCP. This step ensures that both the BHP and the patient understand and agree about the identified concern and the focus of the appointment. Clarifying the main concern or question allows the BHP to more accurately hone the assessment to the specific needs of the patient and provides increased focus for the appointment. This should take no more than a minute or two. An example is below:

> Example script: *"(PCP name) is concerned about (primary concern). Is that what you see as the main problem or is it something different?"*

If there is a discrepancy, or the patient is unclear about the reason he/she is meeting with you, take the time needed to clarify the focus and identify what the patient views as the primary concern.

> After reason is clarified, *"I am going to be asking you a number of questions about (reason) to better understand the problem".*

The next step within the assess phase is to conduct a functional assessment of the problem which should take approximately 12-15 minutes. Note that this step is the same as the previously discussed "Step 2 -Initial contact and Baseline Assessment" in the clinical process if this is your first encounter with the patient. If this is the first program encounter (Step 2), the assess step might be a bit longer than follow up sessions as you incorporate elements of the Baseline Assessment.

Remember the goal is not to cram every known question into the first session; this should take approximately 20 minutes for the first session and 12-15 for follows up sessions. The goal of the BHP is to answer the question: "How does the problem functionally impair the patient?" In addition to the questionnaires mentioned in Step 2, the following functional life domains can be considered either during step 2 or during follow-up sessions.

- Work performance/relationships
- Family relationships
- Social activities
- Engagement in fun/recreational activities
- Exercise
- Sleep, energy, concentration, and appetite
- Caffeinated drinks
- Tobacco use
- Medications

It is also important to understand how the patient is functioning in the following domains:

- Physical (What is going on in the patient's body?) e.g., sleep, pain, blood pressure, blood glucose, etc
- Emotional (How do they feel?) e.g., sad, angry, worried, anxious, stressed
- Behavioral (What are they doing or not doing?) e.g., too much or too little of an activity, saying or not saying things
- Environmental/Social (Where does the problem occur and who is around?)
- Cognitive (What thoughts are they having? What are they thinking in association with the symptoms or problem?)

Along with the functional analysis, the assess phase also includes the completion of brief screening assessments appropriate for the presenting problem and consistent with the primary concern identified by the patient, such as the PHQ-9 for depression. These may be completed while the patient is waiting or during this phase of the 30 minute appointment (see also Fitting Structured Assessments into your Clinical Interview later in this chapter).

The final step of the assessment phase is summarizing your understanding of the patient's problem(s). This should take approximately 1-2 minutes.

> Sample script: *"I'd like to summarize my understanding of what you've told me to make sure I have it right. If I've missed something or have it wrong, it's important that you correct me to make sure I have it right... (give summary of problem)... Do I have it right or did I miss something?"*

Advise

The goal is to advise the patient of specific treatment recommendations and options based on their presenting problem(s), with a discussion of how these treatments will serve to decrease symptoms and improve the patient's quality of life and functioning. In the discussion part of this phase you are essentially "selling" the treatment recommendations to the patient. This should typically take 1-2 minutes.

Within this phase the BHP should:

- List out possible treatment options (e.g., brief interventions, medication, groups, in-person or telephone appointments)
- Provide clear, specific, and personalized change advice
- Discuss what changes will be involved and how they might be beneficial

Agree
The agree phase involves working collaboratively with the patient to agree on specific goals taking the patient's motivation to change and preferences into consideration. This phase should take approximately 1-2 minutes.

Assist
After goals are developed and agreed upon, you will assist the patient in developing a personalized behavioral change plan by providing education, teaching skills, and problem solving barriers to reaching the patient's goals (5-10 minutes). This phase includes the "intervention" and may include an action plan or change plan similar to those in the appendix section. As a BHP, your goal in this phase is to assist the patient in learning new information, developing new skills (e.g., self-management, relaxation), identifying and overcoming barriers, solving problems, and developing confidence for change.

Arrange
Lastly, arrange a specific follow-up plan and ensure that the plan is implemented. This may include completion of baseline-structured assessments if not already completed, future in-person or telephone contacts, referral to the mental health specialty clinic, etc. Finally, it is absolutely critical that you consult with the primary care team member, who initiated the referral.

Additional Clinical Skills and Styles of Communication

Although the 5As are a framework that can be used to structure your appointments, in order to function effectively and efficiently within the primary care setting [76], there are additional clinical skills that will be important to master. If you are not already well versed in these skills, it is important to seek additional training and ensure that you achieve a high level of competence for each of these skills. These include motivational interviewing, goal setting, action planning, and problem solving. These skills are highly applicable and effective interventions for multiple common conditions frequently occurring within the primary care population.

Motivational Interviewing
The following paragraphs will provide an overview of Motivational Interviewing (MI). They are not intended to replace intensive, competency-based training. MI is considered a form of effective communication, rather than a form of therapy. MI will be reviewed only briefly, and it must be emphasized that MI truly takes practice to master. There are many useful tools and resources for MI. The newest text is *Motivational interviewing: Helping people change*," by Miller, W.R., & Rollnick, S. [77]. Consider taking a formal training course either as a seminar or on-line.

Motivational interviewing is client-centered and directive but a non-confrontational communication style developed for addressing the common problem of ambivalence about change. It is a supportive and respectful approach to discussing a patient's problems, concerns, and symptoms, with the aim of assisting the individual in recognizing their reasons for change within an atmosphere of acceptance and compassion. MI helps to enhance the patient's intrinsic motivation towards making a change. This style of interaction involves meeting patients where they are in terms of confidence and motivation to make changes. You will find patients will vary in their level of motivation to change. The Stages of Change Model [78] outlines the stages a person may progress through when making a behavior change.

The 5 stages in this model are:

- **Precontemplation** – Not thinking about making any changes in the near future
- **Contemplation** – Thinking about making a change in the future
- **Preparation** – Getting ready to make a change in the next month
- **Action** – In the process of making the change
- **Maintenance** – Maintaining the changes made in an effort to prevent falling back into the targeted behavior

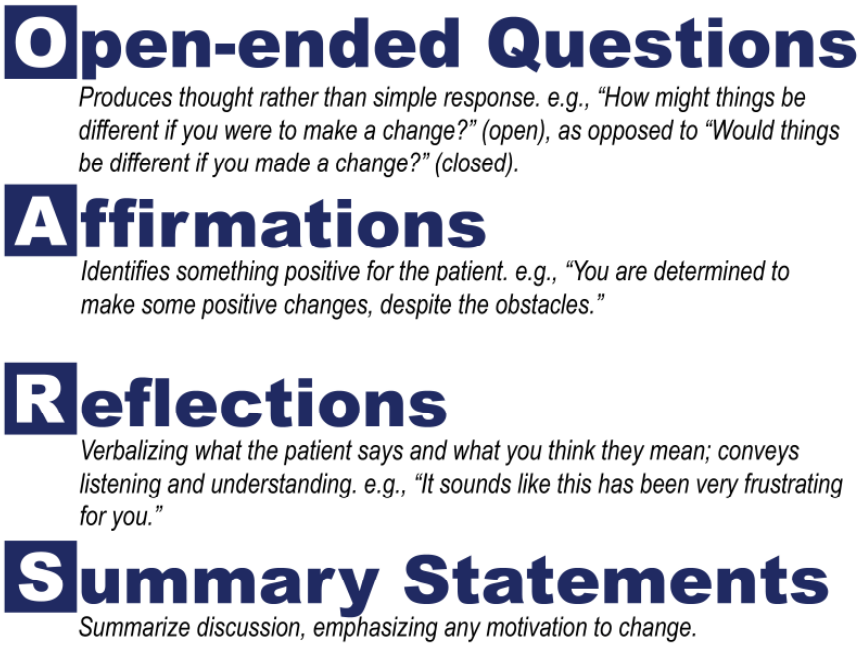
Keep in mind that while you, as a BHP or the PCP, may want the patient to change a behavior, he/she may not be ready, able, or willing, and you should consider movement through the stages as a step toward success and acknowledge this progress with the patient.

> *"People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others."*
>
> *-Blaise Pascal in his work, Pensées, 1660*

You may encounter many roadblocks when it comes to engaging patients in treatment. Some key points taken from MI when dealing with roadblocks to treatment include:

- Avoid arguments with the patient
- Express empathy
- Support self-efficacy
- Roll with resistance
- Develop discrepancy by helping the patient identify where they are now and where they want to be in the future

A simple but useful guide for remembering the principles of MI is found in the mnemonic **O.A.R.S**. (Open Questions, Affirmations, Reflections, Summaries)



It is also useful to consider the following principles of motivational interviewing in all of your communications with patients, as well as with other members of the primary care team.

Effect communication, including MI, is:

- **Collaborative**
  - Avoids an authoritarian approach: working in partnership.
  - Supportive consultation approach
- **Evocative**
  - Not imparting as much as eliciting.
  - Listening more than telling.
- **Accepting:**
  - Values inherent worth and potential of all clients.
  - Communicates accurate empathy.
  - Supports autonomy and affirms strengths.
- **Compassionate**
  - Focus on welfare and best interests of the client.

Although MI may seem simple and like good clinical practice, the importance of practicing this style of interaction cannot be over-emphasized enough. If you have not received prior training in these skills, consider seeking training, mentoring, and consultation.

Goal setting and developing an action plan

Another technique that can be used effectively in integrated care is the use of action plans. This is consistent with the advice and assist framework of the 5A's. One objective of population-based behavioral health interventions is to promote patient self-management of their symptoms. This not only fully incorporates patient preference into treatment planning, but also reinforces mastery and recovery-oriented care. Ideally, patients will become more active and engaged in activities that will promote overall well-being and will be rewarding. Teaching patients to set appropriate goals will improve his or her chance of achieving the goals and promote continuation of symptom self- management. A BHP needs to understand how to help patients appropriately set goals as an integral part of treatment. Additionally, the BHP should assist the patient in putting the goals into action.

A goal is defined as any positive behavior one wants to increase. When setting goals with patients, it will be important to help patients stay on track with the SMART goal setting technique. This acronym includes setting goals that are:

Specific

Measureable

Attainable

Realistic/Reasonable

Time-based or can be completed within a given time frame.

When patients are able to accomplish goals, increased self esteem and improved mood are likely to follow. The following are important tips to help patients set SMART goals.

A key factor in setting goals is to have the patient to develop his or her own goals with guidance from the BHP. This means that you should not be telling the patient what their goals should be. By having the patient develop his or her own goals, it is more likely that he or she will be committed to completing the goals. This helps to promote self-management of their symptoms. However, you can assist the patient in exploring possible goals based on his or her problems and refining his or her goals to meet the SMART goals criteria.

One approach is to inquire about any activities that the patient may want to engage in or reengage in and determine with the patient if this activity is practical given their current condition. Keep in mind goals should be something physical, social, and most of all rewarding to the patient. If the patient has difficulty generating activities, you can ask, “What was life like before the problem(s) began?” or “What did your life look like when things were going well?” Then explore what about these times made the patient happy and what would he/she be willing and able to do to return to that point. This will help the patient to generate ideas for potential goals. You may find that the patient persistently attempts to set vague goals (e.g., I want to exercise more; I want to walk more). In this example, it will be important to identify the patient’s current activity level (i.e. engages in no activity, or currently walks 3 days a week for 15 minutes) and begin to devise goals towards gradually increasing this behavior. If a patient is not engaging in any physical activity at all, a goal for the first week may be to devise a 5-10 minute walking path and/or implement a 5-10 minute walk for two days out of the week. Based on the patient’s success with weekly goals, you can adjust accordingly and eventually the patient may achieve a long-term goal of walking consistently for 40 consecutive minutes for 6 days a week.

After establishing SMART goals, assist the patient in developing an action plan in order to increase the patient’s success in reaching their goal.

- This can include particular techniques to be taught by the BHP such as relaxation training, a prescription for a psychiatric medication, or particular activities set by the patient to address their target problem.
- This may also include brief interventions by you, which should be tailored based on your discipline and your area of expertise.

You will find descriptions of brief interventions in the disease specific manuals along with references for more in depth information. You will also find in the appendices specific action plans for different presenting problems including depression, anxiety, pain, and sleep. These action plans briefly review the most effective treatments for these target problems followed by a section that provides opportunity for the patient to list their SMART goals.

Problem solving therapy techniques

Patients who feel "stuck" in terms of managing particular problems in their life will benefit from this technique. This approach helps to encourage patients to be creative in developing solutions to problems and effectively choosing and evaluating the best course of action. Teaching this technique is another basic skill necessary for a BHP to possess. Patients will be able to use this skill to overcome future barriers to reaching goals as well, which will promote continued progress and increased self-esteem. Problem solving therapy involves several basic steps.

Step 1:	Identify the problem (Be specific)
Step 2:	Generate a list of any possible solutions (Brainstorming) E.g., one exercise to help patients learn to be more creative in generating solutions is the brick exercise. Ask patients to think of as many possible things that can be done with a brick (e.g., building a wall, doorstop, holding up an air conditioning unit, etc.).
Step 3:	Weigh the pros and cons of each solution to determine which option would be most effective
Step 4:	Putting the chosen option into effect
Step 5:	Evaluate the effectiveness of the solution
Step 6:	Repeat as needed

You will find handouts in the appendix to assist you in helping the patient with problem solving techniques. It is important to teach patients how to generate ideas on their own and to evaluate their solutions in order to encourage using this skill in other appropriate situations. A good resource for clinicians is "A Problem Solving Approach: Helping Cancer Patients Cope" by A. Nezu, C. Nezu, Friedman, Faddis, and Houts (1998).

Crisis Management

As you receive referrals from PCPs and screen for suicidal ideation, you and other staff members will encounter high-risk patients. The experience of dealing with suicidal patients can be highly stressful and requires an immense amount of patience, understanding, and composure. It is essential that you be trained on how to cope with patients in crisis. It is important to note that the suicidal ideation you will encounter is typically more passive than that seen in specialty care settings; many patients report thoughts they don't intend to act on or ideation that is not current.

Although passive ideation should be taken seriously, special procedures should be established for patients at immediate risk.

E**stablishing a High Risk Protocol**

Although suicidal ideation or other high risk behaviors requiring urgent attention is uncommon in the primary care setting, every integrated care program needs to have a site-specific, detailed high risk protocol to be followed for patients who report suicidal ideation, homicidal ideation, or other high risk situations. The protocol should clearly state the parameters that mandate implementation of the high-risk protocol. Asking standard questions about suicidal ideation during the initial evaluation is strongly recommended. Utilizing the PHQ-9 and Paykel scales in the initial assessment, both of which inquire about suicidal ideation is also suggested. A potential advantage of the Paykel is that it asks about ideation for the past year and not just 2 weeks as in the PHQ-9. Your program parameters should specifically reference what outcome(s) on these measures mandate implementation of the suicide risk protocol.

Assessment of Suicide Risk

The most important issue about suicide is to remember to ask about suicide. Be willing to say the word "suicide" without flinching. You will never make someone suicidal by asking, but you will have trouble explaining why you didn't ask if the patient does make an attempt after your interview. When presented with a potentially suicidal patient, the first task is to safeguard the patient and gather sufficient information to make a clinical decision. If you have non-clinical staff or Health Technicians (HT) completing assessments with patients and in the course of completing the assessment the HT identifies a patient who meets the program criteria for implementation of the high risk assessment protocol (e.g., Paykel scale results, item 9 on of the PHQ), the HT should follow your site's procedures which likely includes notifying the appropriate clinical staff immediately. If you are following up on a positive suicide screen by telephone, efforts to contact the patient may need to include calling in the evening or on a weekend day if you are unsuccessful in reaching the patient during usual working hours. Resources for conducting off-hour assessments will vary from site to site, but a detailed, well -communicated plan is expected to be in place regarding the handling of such issues as part of the standardized procedures developed at program implementation. The standardized procedures should also address those cases in which you are unable to reach the patient despite repeated efforts.

When a suicidal patient is identified, a clinician that allows a decision to be made about whether or not the patient needs to be hospitalized conducts a risk assessment. The immediate goal is to determine if the patient is in immediate danger of harming himself. If a clinical member of the team becomes aware that a patient might be a danger to himself, the patient should be asked about the duration, frequency, and intensity of the suicidal ideation; whether or not he has impulses to hurt himself; whether or not he has a plan to make a suicide attempt; whether or not he has made a suicide attempt in the past; and whether or not he has the means available to make a suicide attempt.

Health Technician Tip:
It is expected that clinical staff will conduct all suicide risk assessments; therefore HTs conducting baseline interviews need to have a mechanism specified in the suicide risk protocol for referring patients who have a positive suicide screen to a clinician for further assessment of risk. A script for HTs to utilize with patients in whom the suicide risk protocol will be implemented should be developed, for example: "*Based on some of the feelings you reported, I am going to have a clinician talk with you a little further. He/She will be giving you a call after the end of our interview."* Note that the patient cannot refuse this intervention and therefore the HT script should not include dialogue that appears to ask permission to allow the clinician to call the patient. If the patient is resistant to this secondary call, a script such as the one following should be developed to guide the HT response: "*The Behavioral Health Provider (nurse, social worker, psychologist) will speak with you for a few minutes, just to check in and make sure that you are o.k."* If the patient further refuses this call, the HT is still expected to alert the clinician. The HT needs to communicate to the clinician the patient's name and contact telephone number, a brief summary of the results of the interview and any other information that the HT feels is relevant/important.

After information about the nature of the ideation, intent, and/or plans is obtained, the clinician should consider the presence of risk factors. The following factors have been demonstrated to be associated with increased risk:

- Presence of suicidal ideation/ plan
- Morbid pre-occupation
- Depression, esp. with hopelessness
- ↓ reasons to live
- Access to lethal weapons
- ↓ social support
- Alcohol/substance use
- Psychosis/mania
- Recent severe life stressor
- History of abuse-physical, sexual, emotional
- Rage/ seeking revenge
- History of psychiatric diagnosis
- Impulsivity/poor self-control
- Recent discharge from MH inpatient unit
- Family history of suicide
- Co-morbid medical problems- esp. new diagnosis or worsening symptoms
- Age, gender, race-elderly/young adult; unmarried; white, male, living alone
- Same-sex sexual orientation
- Feeling trapped- like there's no way out
- Cavalier risk taking

The assessment of suicide risk also involves the exploration of potentially available protective factors that may be present. Factors that may decrease risk include:

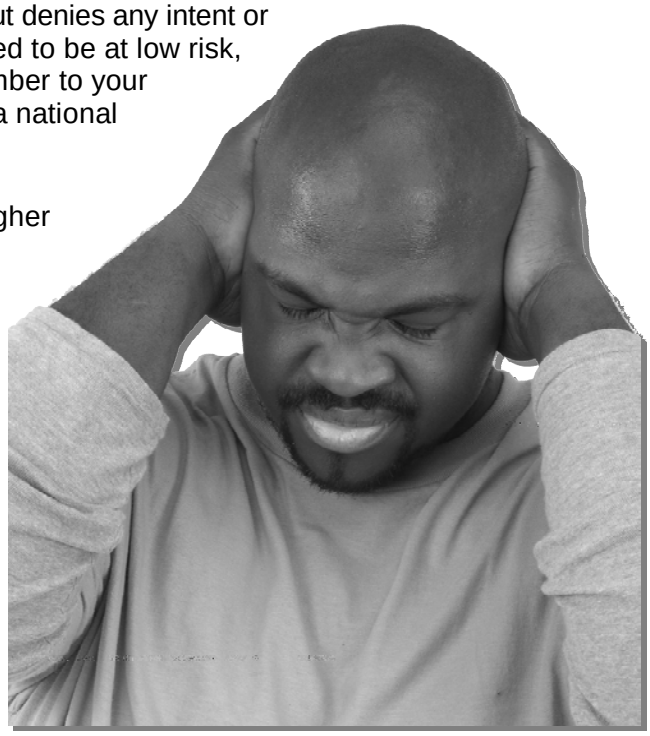
- + Social support
- Spirituality
- Sense of responsibility to family
- Children in the home; pregnancy
- Life satisfaction
- Reality-testing ability
- + Coping skills
- + Problem-solving skills
- + Therapeutic relationship

You need to be familiar with existing local and institutional policies, support personnel, and available resources to the patient at the site and locally. For instance the VA has a suicide prevention program at all facilities. If you are working in the VA system, get to know who the staff is and how you will interact with them.

Once the assessment is completed, information regarding risk assessment and planned follow-up need to be documented into a patient report to be communicated to the PCP.

Suggestions for Management
Example guidelines are provided below for managing high risk patients:

If the patient reports suicidal ideation but denies any intent or plan to commit suicide and is determined to be at low risk, provide the patient with the phone number to your program, and the toll-free number for a national suicide (or crisis) hotline.



If the patient is determined to be at higher risk, due to recent plan with intent or suicidal attempt or extensive risk factors, but is not imminently in danger, arrange the appropriate outpatient care and complete a safety plan with the patient (see patient material for a copy of the safety plan). The safety plan should include activities the patient can engage in when s/he starts noticing warning signs of developing suicidal thoughts, friends or relatives the patient can call, contact information for providers, and emergency phone numbers/instructions.

If the patient is determined to be at imminent risk for serious self-harm, the patient should be hospitalized/referred to an Emergency Department (ED). The clinician should facilitate the patient going to the nearest Emergency Department. It is preferable that someone (relative or friend) accompanies the patient to the ED. If you are talking by telephone, you should contact the local ED in advance of the patient's arrival so that the patient is expected and will seek confirmation that the patient arrived at the ED. If the patient refuses to go to the ED, then you are obligated to call the police through the 911 system.

Ongoing Management of High Risk Patients

Patients who report suicidal ideation, or other risk factors for suicide, often continue to receive outpatient treatment, and the presence of suicidal ideation or risk factors does not, in itself, necessarily mean that the patient is not appropriate for management by the BHP. Suicidal ideation covers a spectrum of severity, ranging from feelings that life is not worth living, progressing to passive death wishes, and then on to active planning that may lead to suicide attempts. It can also include indirect behaviors such as refusal of necessary treatment. The decision to manage the patient with suicidal ideation in integrated care is a decision that requires consultation with your team, as well as ongoing risk re-evaluation for appropriateness.

Documentation Suggestions

Due to the potentially high stakes involved in assessing suicide risk, it is common for clinicians to feel compelled to include all possible details when documenting information related to high-risk patients. In general, the amount of documentation required for those patients judged to be at low risk will be less than those patients who are judged high risk. It is a good idea to include relevant patient quotes (e.g. "My religion forbids killing yourself so I could never go through with it.") Some settings may provide templates to guide documentation of risk assessment and outcome. Documentation should minimally include:

- The presence or absence of current suicide ideation, including any intent or plan,
- The presence or absence of past suicide attempt
- Listing of risk factors assessed as present
- Listing of protective factors assessed as present
- Clinician's impression of risk (e.g. judged to be moderate risk)
- Preventive service(s) info provided to patient (e.g. National Suicide Hotline number given)
- Follow-up plan

Fitting Structured Assessments into Your Clinical Interview

We have stressed the importance of providing measurement based care, but fitting these assessments into your clinical interview may be a new skill for you. Once you are used to incorporating measures into your patient visits, it will become second nature to you. Structured assessments (such as the Patient Health Questionnaire-9) provide valuable data to you, the PCP, and the patient on the patient's progress. Anecdotally, patients really like to see the change in their scores over time. Furthermore, providing data to PCPs fits in very nicely to the way they think about treatment, like getting the results from a lab.

You will need to develop your own style in using structured assessments. Many questionnaires are also designed to be self report and can be done as homework, on the web, or in the waiting room. In follow -up visits, quickly completing structured assessments near the beginning of the session allows the data to be incorporated into the clinical discussion and facilitates treatment planning. Also, don't forget that this might be an excellent opportunity to introduce technology such as the web, patient direct entry on paper, or patient self-entry electronically – touch pads or similar devices. This will inevitably be a growing part of how we deliver care.

The potential challenges of incorporating assessments into your clinical contacts are definitely outweighed by the many advantages of moving to measurement -based care. Incorporating standardized measures into the clinical workflow may facilitate a more balanced clinical interaction where time is spent systematically assessing both the disorder affecting the patient and the patient who has the disorder. Traditionally, mental health clinicians have sometimes failed to routinely and systematically assess core symptoms of their patients' psychiatric illnesses or functional capacities. Medical and psychiatric comorbidities, such as concurrent substance use or cognitive impairment, may remain unrecognized even though they can reduce treatment effectiveness or require the addition of alternative services. Clinicians may also fail to routinely ask about suicidal ideation, even though it can emerge unexpectedly and requires immediate attention. If these critical clinical factors are routinely assessed with standardized scales and detected in a timely manner, patients may be safer and clinicians' medical-legal liability may be reduced.

Example scripts for introducing the measure:

At initial visit:

In treating your depression it is important to use a standard questionnaire to track progress. I also like to use some questions for all patients to get a good baseline of your symptoms now so that we don't miss some important issues. Let's spend 5-10 minutes on some of these assessments.

At follow-up visits:

Let's start by taking a couple of minutes on some structured questions to see how you've been doing since we last spoke?

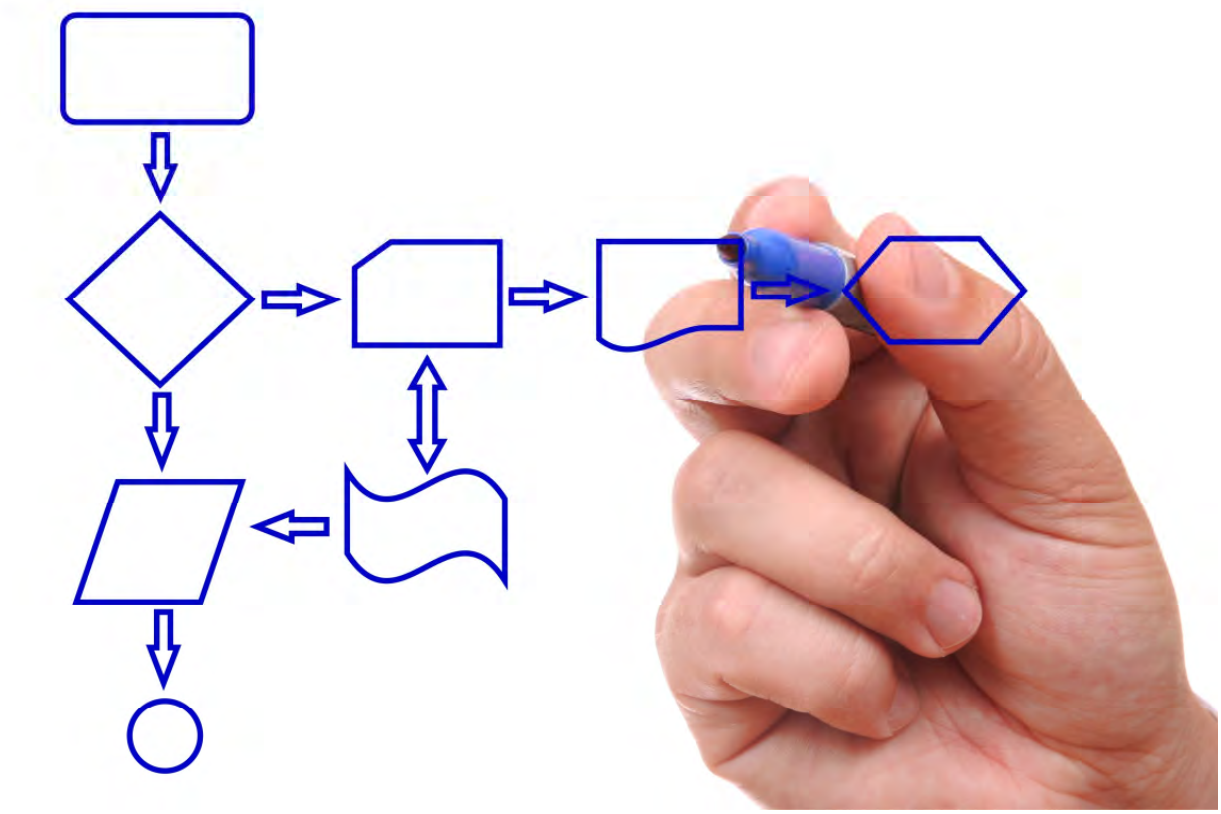
CHAPTER 6

Examples of Implementation

This section is designed to provide interested program staff an overview of some of the typical considerations and activities involved in the design of the integrated care program. It is NOT intended to be a comprehensive guide for senior leadership charged with the development and implementation of a new integrated care program, but rather to increase program's staff appreciation of "how we got here" and to help generate ideas for future implementation or program changes.

What Organization Changes are Required to Implement the M odel?

Implementing an Integrated Care program likely involves changing many of the current processes at your site. In addition, Integrated Care programs can be a major culture change for many of the players involved. During the implementation stage, completing a needs assessment to look at what organizational changes are necessary to implement the program can be extremely helpful. A needs assessment systematizes the consideration/documentation of specific decisions related to program planning and development which then can lead to the formulation of specific action plans to meet the program need. A sample needs assessment can be found in the Clinician Resources Manual.



In the planning and development of an integrated program, it is important to conceptualize the structure and the goals that the program wants to achieve, as well as thinking about many other details. The following are some examples of the wide variety of areas that are likely to need consideration in the development of a new integrated program.

- How varied/large of an area will the program be serving?
- What service(s) do leadership want the program to provide? Is this vision realistic given available resources?
- What is the anticipated patient flow? How many patients a week are expected to be identified for the program?
- What is the program Staff structure? Is there funding to hire staff? Re-train existing staff?
- Is there space in your center?
- Do the settings/providers the program serves have routine screening available?
- Do the settings/providers served have an electronic medical record system that program staff will be able to access?
- Will the program implement a “case finding” tool through pharmacy records to identify patients started on new antidepressants?
- Will the program use a software package for tracking and other program needs? If so, is there IT support for implementing/troubleshooting the software program?
- Who will provide coverage when encountering high-risk patients? Who will provide back-up coverage for this person and for the clinical staff when necessary?
- What is the timeline for implementing your program? Will the program start with certain services and add others over time?
- How will marketing and provider education be incorporated into the timeline?
- What is the business plan? Will it allow measurement of program success?

Models

Most integrated programs utilize a local model though some are designed as regional resources. In a local model, the integrated team serves a single Primary Care clinic or practice. In a regional model, staff may or may not be physically present in a clinic but offer all the same resources to several clinics from a central location. This is sometimes used for small primary care practices or remote practices where having full time staff present may not be realistic.

A regional model is feasible as many services offered in an integrated program may be completed over the telephone. In the regional model, administration, training, and the majority of the telephone operations are located regionally or centrally and serve a number of primary care practices. This model works well for larger organizations such as an insurance plan, HMO plan, or regional medical center with many associated clinics. Centralizing HT staff allows for better quality assurance of non-clinical staff, provides flexibility in hours of operation to include evenings and weekends, and improves efficiency in cross coverage, which reduces the overall Full Time Equivalent

Employees needed compared to a local model. In the regional model, the option exists for BHP staff to be located at or in close proximity to the primary care practices to enhance interaction.

Institutional Experiences in Implementation of Integrated care
Integrated care programs have been successfully implemented in different healthcare systems throughout the country. Taking a look at some of these programs can demonstrate how the principles and research described above are operationalized in a real world example.

While reading these examples, keep in mind that integrated programs vary in terms of scope, size, expertise and degree of implementation. All of the examples described below have the shared strength of implementing the principal of measurement-based care.

The Department of Veteran Affairs (VA)
The VA has a history of integrated care, both clinically and through research, with a recent push to implement programs throughout the system. In 2008, the VA required that all hospital based primary care programs and large community based outpatient clinics implement integrated care programs. The VA's brand name for integrated care is Primacy Care Mental Health Integration (PC-MHI) and the requirements for these programs are outlined in the VA's Uniform Mental Health Services Package (http://www1.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=1762). Throughout the VA system, there is tremendous variability in how sites have implemented PC-MHI programs. Many of these programs are highly integrated with primary care. The VA has also implemented a medical home model for primary care entitled Patient Aligned Care Teams (PACT). The mental health integration programs have provided strong and successful leadership in developing the PACT teams. With so many programs in such a large system, one weakness of the VA PC-MHI programs would be lack of fidelity to a specific model across facilities. As an example, few of the integrated care programs initially included care management.

An important strength for PC-MHI programs is that the VA system is set up in a way that strongly supports a population-based, stepped care approach. With specialty mental health and primary care services at the same facility and care delivered within a shared electronic medical records system, VAs have the luxury of utilizing specialty MH effectively. Facilitating MH visits and enhancing engagement may have its own local challenges, but it is certainly a more streamlined process than in systems where MH care is outside of the system. In addition, the VA requires routine screening for depression (PHQ-2), alcohol misuse (the AUDIT-C) and PTSD. Screening is a great tool for identifying patients that will be ideally cared for in an integrated care program, and as mentioned above supports a population based approach.

Diamond (Depression Improvement Across Minnesota, Offering a New Direction)
The Diamond Project is a depression care management program in Minnesota[79]. It was started in 2008 by a Minnesota based non-profit group, the Institute for Clinical Systems Improvement (ICSI), with participating primary care practices and insurance companies. The project is based on the IMPACT study. It is not a co-located care model, as those delivering the care are not embedded in the clinic, but they are providing evidence base care management very successfully and almost exclusively by telephone. One of the program's main strengths is its high fidelity to the model. The Diamond Project also utilizes a web tool to manage patients. In integrated care programs, informatics is a key to a successful program. In regards of routine screening, while MH screening is not mandatory, the insurance companies do provide a reimbursement to the primary care practice to screen.

PACE is another example of an evidence based care management program[80]. PACE provides care management services to elderly adults in the state of Pennsylvania. Patients are identified for care management through pharmacy records only; enrollment is based on a patient receiving a prescription for a new psychotropic medication. Its two main disadvantages would be that the program does not utilize MH screenings to identify patients and it is not integrated within primary care.

The program serves patients all across the state and so the team works with a variety of different PC practices with all care delivered by telephone. Primary care providers are notified that the service is being offered to their patients and are provided with summary reports of patients' symptoms, mediation adherence and side effects. Its main strengths are its high fidelity to the model, use of an informatics tool for patient tracking and quality assurance, as well as that it leans heavily on promoting patient self-management.

Kaiser Permanente health insurance offers disease management services for a variety of chronic conditions, including depression care through its Kaiser Permanente Complete Care program. The program utilizes routine screening to help identify patients appropriate for targeted interventions, again a method consistent with a population-based approach. In addition, informatics tools are available to manage patients and their progress and to provide decision support to providers. Patient self-management is encouraged in this model.

Group Primary Practices
There are many examples of mental health providers partnering with a small group primary care practice. This is often done as a way to share space and foster referrals. In most of these collocated practices there is no attempt to provide algorithm or measurement based care and often the behavioral health provider accepts referrals from outside of the practice to supplement their workload. The model is usually one of collocation of specialty services rather than collaboration or integration.

Thus the care is seldom population based, treatment is not coordinated, and seldom integrated.

With the variability in these programs, it is clear that while there are key elements to integrated care there is also much flexibility in tailoring programs to fit a practice or system. Programs have emphasized different principles based on need as well as available resources. As such, your local needs and resources may drive your program in a different direction. Make the most of what your system does well and avoid replicating those services in your program. Your program's processes should be outlined in an operations manual or standard operating procedures document. Routinely review your processes and available data to ensure your success and make adjustments as necessary.

Programming Options and Model Adaptations

Potential clinical programming options for integrated programs vary broadly. While this program includes evidence-based manualized protocols for clinical interventions related to anxiety, depression, and alcohol misuse, other intervention strategies for these same clinical services are available for implementation in any particular integrated program. In addition, other clinical needs/services are appropriate for targeting by integrated programs. Some clinical areas that have been chosen to target in integrated programs include tobacco cessation, stress management, sleep hygiene, and anger management. These may be delivered individually or group based. The selection of clinical services/choices for any particular program is likely to be site specific based on such factors as program mission, available resources and clinical skills of program personnel.

In addition to providing clinical program options, the integrated program may also allow the opportunity to provide other services. For example, information collected in planned program assessments may provide a path for patient referral to appropriate facility research protocols. Such protocols may include research being conducted within the integrated program or collaborations with investigators in other clinical services or settings. Additionally, program monitoring activities and early intervention can be used as a platform for prevention services across the spectrum of mental health concerns.

CHAPTER 7

Keeping Yourself Trained and Helping with New Staff

While you have already been hired and hopefully are eager to get started, you also play an important role in training of new staff and in maintaining your own expertise. This section is a brief suggestion about how to stay current and how to help new staff, including yourself, perform at the top of your capacity.

Behavioral Health Providers
Key competencies required for this position include:

- Knowledge of current treatment, key symptoms, for MH conditions your program will treat (see additional manuals)
- Knowledge of assessment and care coordination
- Knowledge of or comfort in becoming familiar with medications prescribed in the Primary Care setting for patients with mental health needs, including patient responses and possible adverse reactions.
- Ability to communicate effectively, both orally and in writing, with professional, administrative, technical staff and patients

The BHP needs to have clinical knowledge across a wide variety of MH symptoms, syndromes, and disorders, as patients referred for assessment and treatment planning are likely to present with a broad range of psychiatric symptoms. Although such symptoms may or may not be directly related to a primary depressive or anxiety disorder, they still need to be evaluated and addressed in the BHP treatment-planning role. Broad-based clinical skills allow the BHP to assess, educate, and advise patients referred to the program, as well as effectively articulate and negotiate issues related to treatment planning and implementation with the primary care provider.

Training BHPs may vary based on discipline of the clinician but will focus on core components, such as the importance of measurement-based care and working collaboratively with PCPs.

For all disciplines, it is highly recommended to obtain further training in Motivational Interviewing, as it is an essential skill to develop for integrated care programs. New providers should receive adequate training to support attainment in all domains of core clinical competencies (i.e. clinical skills, practice management, consultation, documentation, teamwork, and administrative skills)[81].

Other important activities for learning are the management of subclinical symptoms, assisting with getting patients to make behavior change, and facilitating engagement with your service and/or further mental health care. This can include motivational interviewing, goal setting, or other brief techniques that can be easily incorporated into the session. This training will depend on your area of expertise as a BHP. Staff should also be trained by the prescribing provider for your service on prescribing antidepressants along with how your service provides medication monitoring for medication adherence, side effects, and effectiveness. This will help to ease provider's minds on prescribing antidepressants to their patients and decrease the need to make unnecessary referrals to the specialty mental health clinic for patients with minor symptoms.

Health Technicians
Key competencies required for this position include:

- Displays excellent communication skills
- Displays excellent interpersonal skills
- History of strong organizational, record keeping and attention-to-detail skills
- Demonstrated to be a successful team player
- Interested in serving/interacting with patients with MH needs
- Is flexible and responsive
- Recognizes limitation of role and need to seek out clinical supervision as appropriate

Training curriculums for HTs should focus heavily on role-playing patient interactions. We recommend creating a structured training program that should include the following:

- Guidelines/procedures for conducting structured assessments and interviews
- A didactic teaching program by board certified psychiatrists on the recognition of signs and symptoms of at-risk drinking, depression, and other mental illnesses.
- Observation of live interviews, role-played interviews, and direct experience with in-person supervision
- Customer service and other soft skills for interacting with patients
- Procedures for at risk situations

All Integrated Care Clinical Staff
When interviewing applicants, look for candidates that possess the following characteristics:

- Possesses at least some of the core competencies or demonstrates potential for learning them
- Expresses interest in continuing to learn
- Is interested in doing something different, as opposed to traditional mental health services
- Interested in expanding outside of current practice patterns
- Has a desire to see more patients and extend services to a greater percentage of the population
- Interested in working with a variety of populations
- Likes to be in the middle of the action
- Is flexible, persistent and able to function well in novel situations
- Familiar with motivational interviewing techniques
- Recognizes the importance of behavior change interventions and "buys in" that this is something that they can assist the medical providers with
- Possesses an out -going personality that will be well suited to on-going program outreach to all team members

Ongoing Training and Supervision
To keep your team and your program at their best, training should be an ongoing process. Take advantage of educational opportunities offered at your site (i.e. Grand Rounds); they are a great way to keep your team up to date on current treatments and research. Monitor the need for training on particular issues through feedback from the integrated care team, primary care, and mental health as well as by looking at your program data. Regularly scheduled team meetings (discussed in the Quality Assurance and Program Monitoring section to follow) and clinical supervision meetings are a great place for training and supervision as well.

Ongoing Training and Monitoring Activities for BHPs
Your ongoing training will depend on your discipline as well as training opportunities available. Regularly scheduled clinical supervision is a great opportunity for ongoing training. All non- prescribers will benefit from supervision and/or scheduled consultation with a prescribing clinician for recommendations to take back to the PC on psychotropic medications when appropriate.

In addition, the BHPs may present patients that are particularly complicated or challenging to the team. Formally scheduled consultation and supervision allows for opportunities to:

- Provide ongoing education about issues in the clinical management of disorders your program targets, as well as increase sophistication in diagnostic differentials;
- Facilitate appropriate treatment planning
- Expand problem-solving strategies
- Maximize utilization of resources
- Promote continued delivery of evidence-based care

While routine formal consultation/supervision is a crucial component of the BHP intervention, the format of the supervision is flexible. Supervision may be conducted in person or by telephone by group or individually. Criteria for case selection/presentation are expected to reflect the style, needs, and other factors related to the specific composition of the work team. In conjunction with your supervisor's expressed preferences, integrated care programs may develop standardized formats to assist the BHP in organizing a case presentation for supervision. These manuals include specific situations in which the BHP is directed to seek out consultation and supervision. You are also encouraged to seek out additional consultations whenever you feel it would benefit the patient or practice management.

Ongoing Training and Monitoring Activities for HTs

Ongoing training and supervision of non-clinical staff can be completed on a formal and informal basis. Clinical staff works closely with HT staff, reviewing all assessment results and discussing treatment recommendations. In these interactions, educational opportunities will arise of which clinical staff will want to take advantage. For instance, discussing how a situation could be handled differently in the future or praising HTs for a job well done. These learning experiences can also be shared with the team when they could benefit the group. In addition, HTs will benefit from regular psycho-education tutorials focusing on the symptoms and diagnoses seen in primary care or screened for during the baseline assessment, as well as tutorials on soft skills as the need arises such as strategies for keeping the initial assessment on track or strategies for working with a disgruntled patient.

Additional monitoring may take the form of sitting in on a baseline assessment (phone or in- person) with the permission of the patient, as well as completing taped mock interviews for the supervisor to review and then provide feedback to the HT.

Quality Assurance and Program Monitoring

Your program should include plans to provide management and conduct regular quality assurance and quality improvement activities. One example of such activities includes holding regular team meetings that give the team a chance to come together and communicate with each other as a group. Team meetings serve as an opportunity to address important issues, discuss the progress of the program, and ensure that all members of the team are up to date on all policies and procedures.

Remember to consider the details when focusing on quality assurance. For instance, ensuring that the staff's voicemail messages are of a high quality is an important activity for quality assurance and customer service. Voicemail messages should be welcoming, friendly, and professional, in order to help engage patients. Program quality assurance also includes having procedures in place for responding to voicemails in a timely manner when staff members are out.

One of the core elements of integrated care programs is that it is measurement based. We highly recommend the use of a software package to track structured assessments for a variety of reasons; one being that you will have clinical outcome data at your fingers tips. For programs utilizing software programs, reports can be generated targeting indicators of program as well as individual program staff success in meeting program goals (e.g. number of baseline interviews completed within selected time frame). Review of these reports among team members can be very effective in highlighting potential areas of concerns, but can also serve as concrete evidence of "a job well done" to be shared with team members and other program stakeholders.

Other examples of potential program activities to address ongoing program quality assurance include direct observation of patient interviews, random chart reviews to check for competency within administrative and documentation skills, soliciting input from other primary care team members in order to gauge team skills and integration with other PC members, and ongoing monitoring of individual program provider's practice management trends, including the number of patients seen, the total number of encounters, the number of encounters per patient, the number of encounters per day, average session length, and the most common diagnoses seen in the provider's practice.

Other potential evaluation activities focus more on the preferences and practice management styles of the PCPs, and may also lead to refined marketing strategies. For example, tracking the number and types of referrals to the integrated care program along with referral sources provide valuable information with regard to future education of the staff on the types of referrals that you will take or who is not taking advantage of the benefits of your service. Another way to track your progress is to obtain feedback directly from the PCPs and patients. You can do this formally by creating a brief satisfaction scale or informally asking for feedback directly about likes/dislikes of the service and any future recommendations. Be genuinely welcoming of feedback from PCPs about your clinical program and share the feedback with other program staff. Both positive and negative feedback has an important role in facilitating ongoing efforts to ensure a good working relationship. Remember, the PCP is your customer therefore you want to make him/her happy. Evaluation of your program will also be important if you need to justify adding additional staff.

Database Management

Collecting assessment data in tracking software and ensuring data integrity is an essential aspect of running a successful integrated care program. One aspect of this process is training staff on the importance of data completeness and accuracy and asking questions if there is any uncertainty. It is also important for a member of the team to routinely monitor the data sets, ideally by someone with data management experience. It is also a way to identify staff members who need further education or areas for team education. If utilizing tracking software, workload for staff members as well as individual program provider's practice management trends (see above), may be monitored through the data collected in the database.

Congratulations!

Having completed your general training, you should feel ready to get started and apply your new skills. You need to make sure you keep asking questions and keep broadening your mind. Refer back to this manual often as a resource and link with providers outside of your institution for help.

We encourage you to continue on to the accompanying disease specific manuals relevant to the services being provided by your program.

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