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| University of Vermont College of Medicine |
| 4 Integration Scenarios |
| Rating the Level of Primary Care Behavioral Health Integration |
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| Enclosed are 4 Medical Care practice profiles with varying degrees of integration. They are labeled A-D. Please read each one and based on your experience assign a single score of 1 (most integrated) through 4 (least integrated) to each description. Please do not assign the same numeric rating to more than 1 profile. |

**Rate the scenarios**

1 (most integrated) – 4(least integrated)

Scenario A= 1

Scenario B= 4

Scenario C= 2

Scenario D= 3

**Scenario A**

Emerald Family Practice, a primary care practice, identifies itself as an integrated care practice and has had a psychological presence for 15 years. The practice has a standard protocol for screening and referral integrated into its practice flow. Registries for major conditions including depression and substance abuse are in use.

One behavioral health clinician is employed by the practice 40% of the time while another is contracted to provide services three days per week. They are part of the medical care team and see both non-crisis and crisis patients. The contracted clinician uses traditional 50 minute sessions while the part time clinician uses 20-25 minute sessions. Though there is a focus on evidence based care, it is applied inconsistently. The primary care physicians target need based on behavioral conditions and complex medical presentations; however, due to limited patient willingness to see a clinician outside of the practice, mental health and substance abuse issues are often treated over longer periods of time due to schedule openings.

Community psychiatrists are available with good referral relationships to the practice and identified patients with need are able to get appointments within a decent time frame. Primary care physicians prescribe or refill most mental health and substance abuse medications; however, most feel uncomfortable with lack of psychiatric consultation or management of specific or multiple medications. There are currently no shared care plan protocols in place, but a major quality improvement project involving moving to protocoled panel-based care is in the beginning stages of implementation. The care manager of all patients in need of service is available and has the responsibility to attend to issues of gender, language and culture.

The behavioral clinicians and physicians share space fully, including waiting room, offices and clinic exam rooms, and have frequent interactions and warm handoffs. Patient treatment and care plans are documented in a shared EHR with essentially simultaneous access by each provider.

There is a plan in place to implement a common health risk appraisal that will be completed annually for all adult patients and recorded in the EHR. The appraisal will be part of the data used with patients to create a shared care plan. The data will be summarized and used in patient care protocol decisions alongside an ongoing quality improvement project. Protocols for using registry data are in place to identify patients meeting criteria for specified collaborative treatment. Specific behavioral measurement instruments are located in the EHR for use as needed. Data are summarized and presented to patient and provider with evidence supported care recommendations.

**Scenario B**

Opal Mental Health Services is a specialty mental health clinic. They do not provide primary care. It has no standard protocols for screening and referral processes. There are no registry tracking processes in place for tracking different health problems.

Behavioral health clinicians are employed to see patients with mental health conditions. However, substance abuse problems are referred to the community substance abuse program located downtown. Assessment of medical issues is not generally done. When serious medical problems are identified, patients are advised to contact their physicians or go to the emergency room. Psychiatrists primarily manage pharmacology for mental health issues while care management is included for patients with severe and persistent mental health conditions. Care managers provide patients with information about community resources if there are issues of gender, language and culture but provide no further assistance because clinicians are too busy.

This practice has its own waiting room and clinic exam rooms. There is an electronic system for billing, but it has no capacity for clinical data. Records are not shared with external health professionals except in crisis, because of confidentiality issues. Billing and service data and clinical records are not linked and there are no regular clinical or resource use reports.

Need is identified by an initial assessment from which the behavioral clinician generates a treatment plan, which is in a file in the behavioral clinician’s office. The patient is asked to sign the treatment plan after it is generated.

**Scenario C**

Ruby Community Health Center a federally qualified community health center is located in a multi-ethnic community. Regular behavioral health screening and referral processes have been identified but are used intermittently because of time constraints. Registries for major medical conditions are present and inclusion of depression and alcohol use is in initial development stages.

There are multiple part-time behavioral health clinicians contracted by the practice to see patients with a range of mental health and substance abuse issues. These clinicians are mostly social workers trained in mental health treatment. Referral assistance for patients with medical problems in conjunction with mental health issues is sometimes provided. It is provided less frequently for substance abuse issues. Behavioral clinicians are a part of the medical team.

Among the physicians, there is frequent contact and discussion of the progress of patients’ care. The primary goals for the behavioral clinicians are treating problems related to mental health and substance abuse along with trauma treatment. Patients are seen as needed for prescription or refilling of mental health medications. Community psychiatrists see patients upon referral within the community, however resources are difficult to obtain. There are protocols for depression and alcohol abuse care that include care management as well as CBT. Case managers regularly assist the physicians to attend to issues of gender, language and culture and connect the patient with community resources.

The behavioral health clinicians share waiting room space and offices with physicians. These are located across the hall from the medical exam rooms. Behavioral clinicians enter data into a common EHR. However, sharing those data with medical clinicians requires a patient release of information. The PHQ, GAD and Audit are built into the common EHR. The behavioral clinicians fill it out after a patient is seen and the results are shared with the treating physician. The data obtained from the post-referral appointment are part of the protected behavioral data and are summarized and presented to the patient and the provider if a release is given. The summarized data are also to be used in ongoing quality improvement.

**Scenario D**

Sapphire Internal Medicine is an academic internal medicine practice. There is a standard protocol for screening and referral of behavioral issues. However, it is not currently used and has not been integrated into practice workflow. Registries of medical conditions are available but behavioral health registries are not.

There is access to an off-site community health team including a social worker. That social worker’s task is to take referrals, see them off site, and arrange for referral to the specialty care system if needed. Care management is available for patients upon referral to the community health team. The community health team manages issues of gender, language and culture. Psychiatric referral to the affiliated practice on the academic health center campus is available. There are multiple care protocols in place for medical problems but not for behavioral health problems.

There is a shared EHR designed to provide rapid information to each of the practice providers. The offsite community care team associated with this practice uses its own note template and sometimes shares with medical providers.

Patient need is identified through physician assessment. If seen by the community social worker, PHQs, GADs and AUDITs are done and recorded in a special section of the EHR. Data are not summarized or used in ongoing quality improvement. There are specific behavioral measures located in the EHR and used by physicians intermittently. Data are not summarized and presented to patient or provider.