Oregon Behavioral Health Integration Toolkit

A resource for Oregon's Community Health Centers.

Background and Acknowledgement

This Behavioral Health Integration Toolkit was created as part of a collaboration between the Oregon Primary Care Association and Creach Consulting Group. The goal is to start creating a common language and vision for behavioral health integration at Community Health Centers in Oregon.

When available, this toolkit references and links to existing resources developed by many individuals and organizations. Creach Consulting Group content and training materials remain the property of Creach Consulting Group and are subject to copyright laws.

This resource was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,491,396 with 20% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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Contents

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Integrated Behavioral Health in Oregon

Implementing behavioral health into primary care is a complex undertaking, but well worth it. The specialty behavioral health system in Oregon, as in many other places, is fragmented, difficult to access, and largely disconnected from the rest of the medical system. By bringing behavioral health access in-house, medical practices provide a much-needed service for their patients while relieving the burden on primary care providers to act as mental health specialists. Further, the skills of a trained behavioral health clinician often work to boost organizational effectiveness, morale, and holistic patient care. This resource is designed with the hope of creating a blueprint for how to create an Integrated behavioral health program in clinics throughout the state utilizing shared language, robust scaffolding, and pragmatic guidance.

History of Integrated Behavioral Health

- Relatively and surprisingly new. The first fledgling program was in New York in the 1970s.
- The term "Integrated Primary Care" was first used in 1994.
- The first meeting of the Collaborative Family Healthcare Association was in 1995. Integrated behavioral health grows in the Pacific Northwest with the work of Patty Robinson and Kirk Strosahl during the mid-late 1990s.
- In the early 2000s, the military imbeds behavioral health into primary care.
- The Affordable Care Act expands integrated care across the country.
- As of 2022, integrated behavioral health in primary care has proven to be so effective that it is considered a standard part of providing good primary care.[1]

[1] Blount, A. (2015, Apr 10). *A Brief History of the Integration of Behavioral Health in Primary Care.* Collaborative Family Association. Retrieved from https://www.cfha.net/blogpost/689173/213334/A-Brief-History-of-the-Integration-of-Behavioral-Health-in-Primary-Care

The Case for Shared Terminology

The healthcare system has some intersecting and sometimes conflicting definitions for frequently used terminology. This can create confusion and inconsistency in language, understanding and action.

Definition of Integrated Health in Oregon

From Senate Bill 832 (Oregon 2015), As defined in amended ORS 414.025:

Integrated health care means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following: (A) Mental illness (B) Substance use disorders (C) Health behaviors that contribute to chronic illness (D) Life stressors and crises (E) Developmental risks and conditions (F) Stress-related physical symptoms (G) Preventive care (H) Ineffective patterns of health care utilization.

Definition of Behavioral Health Clinician in Oregon

Adapted from amended ORS 414.025:

"Behavioral Health Clinician" means: (a) A licensed psychiatrist; (b) A licensed psychologist; (c) A certified nurse practitioner with a specialty in psychiatric mental health; (d) A licensed clinical social worker; (e) A licensed professional counselor or licensed marriage and family therapist; (f) A certified clinical social work associate; (g) A board-registered associate or psychologist resident working under a board-approved supervisory contract in a clinical mental health field; or (h) Any other clinician whose authorized scope of practice includes mental health **diagnosis and treatment.**

Helpful Resources:

- Lexicon for Behavioral Health and Primary Care Integration Concepts and Definitions Developed by Expert Consensus, (2020).
- Reiter, J.T., Dobmeyer, A.C. & Hunter, C.L. The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition. *J Clin Psychol Med Settings* 25, 109–126 (2018).

Overview of Behavioral Health

"**Behavioral health**" generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms[1]. The term implies prevention, diagnosis, and treatment of these conditions. For the purposes of this toolkit, it will be used as an umbrella term that includes:

Mental health and Substance Use Disorders- e.g., anxiety, depression, substance abuse, psychotic disorders, eating disorders, etc.

Health behavior and psychosocial well-being e.g., stress, substance use, prevention, habits, functioning, nutrition, exercise, relationships and attachment, resiliency, problem-solving, family factors, Adverse Childhood Experiences/trauma, etc.

Developmental disorders/disabilities - e.g., autism, attention deficit hyperactivity disorder, learning disabilities, developmental delay, communication, and motor disorders, etc.

[1]American Medical Association. (2022, Aug 22). *What is behavioral health?* Retrieved from What is behavioral health? | American Medical Association (ama-assn.org)

Integrated Behavioral Health versus Specialty Behavioral Health

Behavioral health is a ROUTINE part of primary care, including for patients with diabetes, high blood pressure, etc. (Behavioral health is not only a specialty or tertiary service)

Outside specialty behavioral health services continue to be needed for patients with mental health and substance use disorder complexity beyond what can be served in primary care (or by patient choice)

NO WRONG DOOR

Accessing Mental Health Care

Despite mental health parity laws which were first passed in 1996 and broadened in 2008, accessing behavioral health services continues to be very difficult. This is for several reasons, including the longstanding stigma and the related undervaluing of mental health care. Individuals struggling with mental health difficulties, especially those with severe and persistent mental illness often struggle to advocate for themselves (which is symptomatic of their struggles). Engaging with a behavioral health care clinician, for many, is an act of last resort after considerable isolation and suffering. The idea of behavioral health care as prophylactic is anathema to much of how many Americans approach psychic difficulties.

Barriers to access include:

- **Cost**
- **Pre-authorizations** *(these persist even for entry level care in some areas despite being in violation of parity)*
- **Scheduling burden:** The burden of scheduling and finding care is outside of the norms of scheduling any other kind of health appointment.
- **Stigma:** many patients are not comfortable walking into a mental health care clinic.
- **Clinician shortages:** more demand than supply, which is worsened by training pipeline issues.
- **Clinician reimbursement:** Even when payers provide no other barriers to care, they may be reimbursing Behavioral Health Clinicians at such low rates (with very high administrative and auditing burden) that these clinicians turn to being self-pay only.

The Integrated Behavioral Health Care Fix

- Integrated Behavioral Health Clinicians are credentialed in the same way as their Primary Care Physician colleagues. Most insurers have stopped "carving out" mental health coverage (a marked barrier to parity).
- In some places pre-authorizations are not necessary. A simple reference to a referral from another care team member (generally the Primary Care Physician) should be noted in the chart.
- Scheduling mirrors scheduling to see their Primary Care Physician (but often with much better access).
- Stigma is vastly reduced as care takes place in the same place as where they see the rest of their care team. Often, patients tell others in their life that they are just going "to the doctor's office".
- Integrated behavioral health is a desirable job for new and seasoned clinicians due to the team-based care, meaningful clinical impact, and competitive compensation.

Core Elements of Integrated Behavioral Health

Team-based care

There is clear identification of team members (virtual or on site) which includes primary care, behavioral health care, and care coordination staff along with processes in place to support team communication, coordination and functioning, team roles, and interdisciplinary planning.

Principles of Team-Based Health Care

Shared goals: The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.

Clear roles: There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.

Mutual trust: Team members earn each others' trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

Effective communication: The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

Measurable processes and outcomes: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. *Core principles & values of effective team-based health care. Discussion Paper*, Institute of Medicine, Washington, DC. www.iom.edu/tbc.

Core Elements of Integrated Behavioral Health (cont.)

Evidence-based clinical models – Intentionally chosen

The practice chooses an evidence-based model or models that fit their setting (i.e., co-located specialty, Collaborative Care Management, and/or Primary Care Behavioral Health) and educates staff in brief, evidence-based interventions like motivational interviewing, problem solving therapy, behavioral activation, etc.

Data-driven systems

Practices should be put in place that focus on population health and universal screening (with appropriate clinical exceptions). Workflows should be established for patient identification through screening and clinical pathways to guide intervention and planning. Outcomes and quality measures should be used to define, track, report, and modify care. Patient registries should be maintained, and staff should be accountable for patient improvement.

Clear leadership

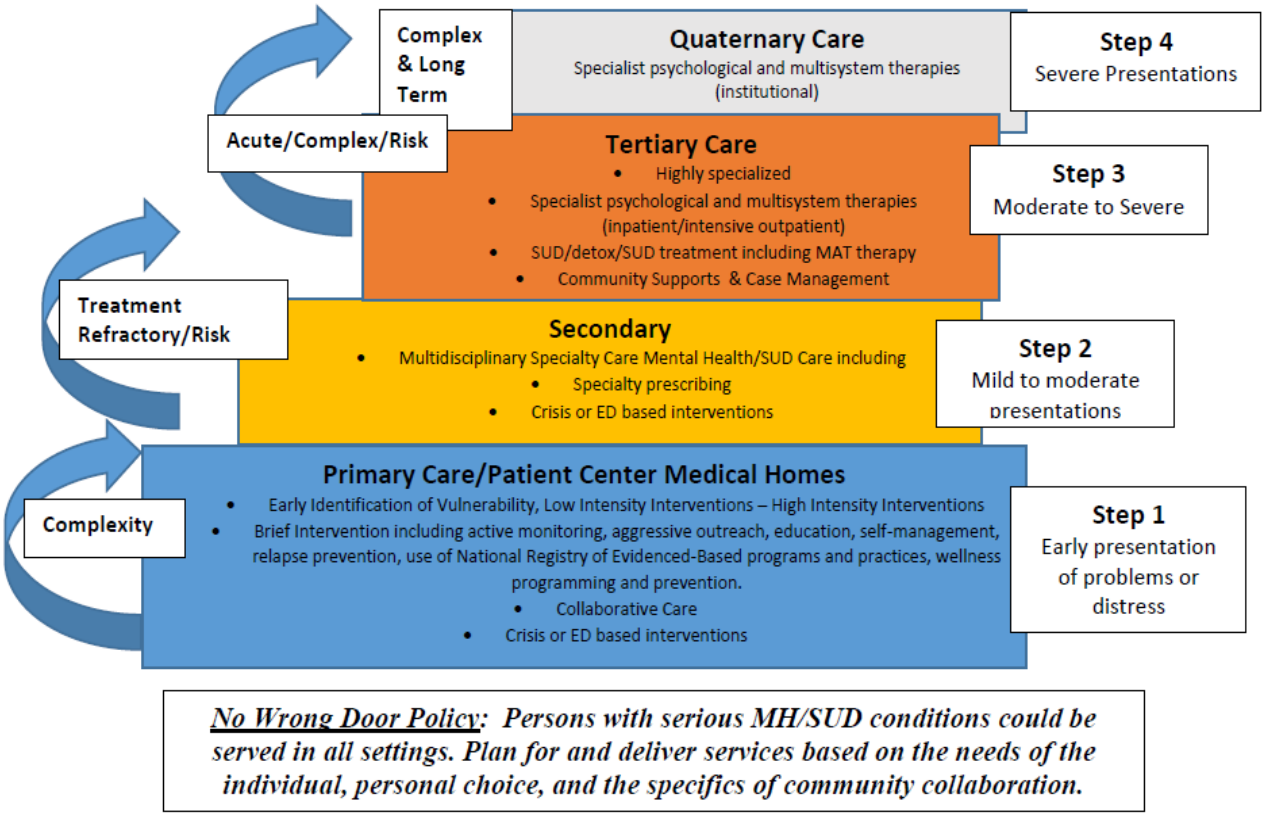
Practices should have clear leadership that sees behavioral health not as an add on but as a key element of health care. This type of leadership should articulate a clear vision from the top down and the bottom up on how to improve patient care, develop policy and procedures supporting integrated behavioral health, and support performance management strategies that focus on integrated behavioral health.

Stepped care

Stepped care is a system of delivering and monitoring treatments so that the most effective, yet least resource intensive, treatment is delivered to patients first; only 'stepping up' to intensive/specialist services as clinically required. Primary care is the clinical home, everyone in the practice is trained to manage health as a combination of physical and behavioral health, all staff “work at the top of their license".

Core Elements of Integrated Behavioral Health (cont.)

Mental Health Stepped Care



***No Wrong Door Policy**: Persons with serious MH/SUD conditions could be served in all settings. Plan for and deliver services based on the needs of the individual, personal choice, and the specifics of community collaboration.*

[4] Franx, G., Oud, M., de Lange, J., Wensing, M., Grol, R. (2012), "Implementing a stepped-care approach in primary care: results of a qualitative study", *Implementation Science* 7(8), doi: 10.1186/1748-5908-7-8.
[5] Franx, G., Oud, M., de Lange, J., Wensing, M., Grol, R. (2012), "Implementing a stepped-care approach in primary care: results of a qualitative study", *Implementation Science* 7(8), doi: 10.1186/1748-5908-7-8.

Core Elements of Integrated Behavioral Health (cont.)

Defined continuum of care

Each provider in the practice knows when to treat, when to consult, and when to refer. Agreements should be in place with external partners for specialty care referrals and communication.

Care coordination

The practice should have a plan in place for how to ensure smooth movement of patients from one provider or one level of care to another. This plan should consider health-related social needs and community resources and be based on a data tracking system.

Psychiatry consultation and services

Each practice should have a plan for consultation with Psychiatrists or Psychiatric Mental Health Nurse Practitioners. Consultation may be face to face, through telehealth, e-Consults, or through embedded clinicians. The plan should include easy transition back to primary care for people who reach a point of stability. Practices should work on developing the consultative psychiatry role where psychiatry consults with Primary Care Physicians for most patients and only sees clients directly with the most complex needs. More advanced practices may choose to implement a fidelity Collaborative Care Management model as articulated by the University of Washington AIMS Center.

The Montana Integrated Behavioral Health Steering Committee. (n.d.). *Core Elements of Integrated Behavioral Health.* Retrieved from https://18vtj92co9zb1qy8011oc0fw-wpengine.netdna-ssl.com/wp-content/uploads/Core-Elements-of-Integrated-behavioral-health.pdf

Patient Centered Primary Care Home

One of the must-pass requirements for Patient Centered Primary Care Home recognition (3.C.0) is that all practices must have universal behavioral health screening and resources for managing behavioral health concerns. While this can certainly be achieved by referring to outside specialty providers, behavioral health integration is the most efficient way to provide whole-person care.

Co-located specialty mental health providers can only assist to a point. Typically, these providers will only see patients with a diagnosed mental health and/or substance use disorder condition and their schedules will become full. Additionally, their documentation may be siloed from the rest of the care team.

Integrated Behavioral Health Clinicians also assist with other Patient Centered Primary Care Home standards as they can help build a robust system for treating patients with chemical dependency issues, chronic disease management, as well as workflows for referring and coordinating with higher levels of care.

Oregon's Patient Centered Primary Care Home Program

PATIENT CENTERED
PRIMARY CARE HOME PROGRAM
The Patient-Centered Primary Care Home Program is part of Oregon's efforts to fulfill a vision for better health, better care and lower costs for all Oregonians.

Created by Oregon state legislature in 2009	Voluntary accreditation program administered by the Oregon Health Authority (OHA)	Clinics in Oregon and within 75 miles of the border are eligible to apply at no cost
Goal to support and encourage all primary care clinics to transform and adopt the Patient Centered Primary Care Home standards of care	Encourages consumers to choose high quality care	Serves as central place for payers to verify "quality" – support move towards value-based payments

Helpful Resources:

- Patient-Centered Primary Care Home Program

Patient Centered Primary Care Home recognition (3.C)

Standard 3.C.
Behavioral Health Services
This is a must-pass standard. Practices must, at a minimum, meet measure 3.C.0 to qualify for Patient Centered Primary Care Home recognition.

Measures

Check all that apply – Select all levels that describe your practice's activities (max 30 pts):

3.C.0	Patient Centered Primary Care Home has a screening strategy for mental health, substance use, and developmental conditions, and documents on-site and local referral resources and processes.	**Must Pass**
3.C.1	Patient Centered Primary Care Home collaborates and coordinates care or is co-located with specialty mental health, substance use disorders, and developmental providers. Patient Centered Primary Care Home also provides co-management based on its patient population needs.	**5 Points**
3.C.2	Patient Centered Primary Care Home provides onsite pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	**10 Points**
3.C.3	Patient Centered Primary Care Home provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.	**15 Points**

Please see full specifications in the Oregon Health Authority Patient Centered Primary Care Home Technical Assistance Guide https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Standards.aspx

Patient Centered Primary Care Home Standards and Integrated Behavioral Health Alliance Standards Self-Assessment Tool

The Integrated Behavioral Health Alliance standards were developed in Oregon by a group of expert stakeholders. They build off national work by the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and others but were developed to fit within the context of Oregon's Patient Centered Primary Care Home standards of care. The Integrated Behavioral Health Alliance standards were incorporated almost verbatim into Patient Centered Primary Care Home standard 3.C.3.

Integrated Behavioral Health Alliance Standards (2015)

1. Integrated behavioral health services are provided as part of routine care at the Primary Care Home including licensed Behavioral Health Clinician(s) delivering an array of services on-site. Behavioral Health Clinicians as defined in ORS 414.025.	Behavioral Health Clinicians provide(s) care at the Primary Care Home with a minimum staffing ratio of 1 Full-Time Equivalent (FTE) Behavioral Health Clinicians for every 6 FTE of Primary Care Physicians. For example, a Primary Care Home with 4 FTE Primary Care Physicians would need to have .67 FTE of a Behavioral Health Clinicians (approximately 26.5 hours /week). Note: Primary Care Home may utilize telehealth services to meet the staffing ratio as long as all other standards are met

Integrated Behavioral Health Alliance Standards (2015) (cont.)	
2. Integrated Behavioral Health Clinician provides a broad array of comprehensive evidence-based behavioral health services	Behavioral Health Clinicians services should be applicable to the Primary Care Home patient population served, including care for: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventive care, and ineffective patterns of health care utilization per OARS 414.025
3. Integrated Behavioral Health Clinician provides same-day open access behavioral health services	Same-day open access services are defined by the time in which the Behavioral Health Clinician does not have pre-scheduled appointments. The Behavioral Health Clinician is available in the clinic for a variety of activities including warm hand-offs, brief assessments and interventions for patients and families, consultations to Primary Care Physicians and other care team members, and participation in pre-visit planning and daily huddles. Same-day open access services are provided in real-time at the point of care when behavioral health issues are identified at the Primary Care Home. On average, at least half of a Behavioral Health Clinician's hours each week must be available for same-day open access services.
4. Primary Care Physicians, staff, and Behavioral Health Clinician utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients.	Primary Care Physicians, staff, and Behavioral Health Clinicians document clinically relevant patient information in the same medical record system and participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning and/or daily huddles.
5. Behavioral Health Clinician is an integrated part of the primary care team.	Primary Care Physicians, staff, and Behavioral Health Clinicians utilize shared physical space and the Behavioral Health Clinician participates in practice activities such as team meetings, daily huddles, pre-visit planning, and quality improvement projects
6. Primary Care Home utilizes a population-based approach to routinely deliver and coordinate integrated behavioral health services.	Primary Care Home utilizes data to track and manage the behavioral health needs of the entire clinic's patient population including screening, intervention and clinical outcomes, care coordination, and referrals. Patient Centered Primary Care Home utilizes written protocols for a stepped care approach to assess patients' level of need and coordinate transitions of care as indicated.
7. The integrated team includes psychiatric consultative resources.	Primary Care Home identifies the psychiatric care needs of their population, determines viable psychiatric consultation strategies and provider options, and develops a care model that includes these services. Examples may include routinely using the Oregon Psychiatric Access Line (OPAL), on-site psychiatric services, e-consults, telepsychiatry services, and/or the Collaborative Care Model.

Models of Care

Behavioral health integration does not always mean the same thing to different practices. Our hope is to align meaning across Oregon. Different models of care have different pros and cons. As clinics grow, they may find that having multiple care models in-house can be advantageous. For example, a Behavioral Health Clinician operates as a first line extension of the primary care team who sees patients briefly, triaging need. They may then act as an intermediary between the Primary Care Physician and a co-located specialty mental health or substance abuse clinician for patients who may need longer term support. The Behavioral Health Clinician may also provide support for on-site psychiatry by completing part of the psychiatry intake and determining whether the patient needs an appointment with the psychiatric provider or not. If a clinic will only have one model, having an integrated Behavioral Health Clinician is generally best for reaching a high number of patient concerns that present in primary care settings. This is commonly referred to as the Primary Care Behavioral Health model and is aligned with Oregon's Integrated Behavioral Health Alliance – Patient Centered Primary Care Home standards.

Summary of integrated care delivery models in primary care settings

	Co-located	Integrated Care	
Delivery Model	**Co-located specialty mental health/substance use/developmental**	**Psychiatric Collaborative Care Management/TEAM Care**	**Integrated Care Based on Integrated Behavioral Health Alliance Standards (a.k.a. Primary Care Behavioral Health)**
Key Features	Specialty interventions targeted to a small subset of higher-needs patients by referral from the Primary Care Physician.	Adds a behavioral health care manager and psychiatric consultant to primary care team to focus on patients with common conditions	Integrated behavioral health is a ROUTINE part of primary care. Behavioral health clinician is part of the primary care team and works alongside primary care physician to manage all patients.
Behavioral Health Clinician Key Functions	Via referral from Primary Care Physician, Behavioral Health Clinician treats patients with mental health and/or substance use disorders.	Utilizes a registry to focus on more intensive and active treatment for a subset of patients (condition-focused); strong "treat to target" approach	Behavioral Health Clinician provides a wide range of brief, short-term interventions for mental health, substance use, health behaviors, stress, lifestyle issues, developmental concerns, care plan adherence, etc.

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Summary of Integrated Care Delivery Models in Primary Care Settings (cont.)

	Co-located	Integrated Care	
Appointments and Population Reach	6–8 45–60-minute appointments per day.	Systematic follow-up with highly protocolized approach for patients on the registry; more intensive management via in-person and phone contacts	8–14 30-minute visits per day; at least 50% of Behavioral Health Clinician schedule open for same-day access and Primary Care Physician consultation. Immediate access to Behavioral Health Clinician for all patients when needs are identified.
Benefits	Reduced barriers and stigma, plus increased coordination.	Reduced barriers and stigma, increased coordination and outcome focused. Effective for a wide range of disorders, such as depression, and chronic medical conditions, i.e. diabetes. Lowers total cost of care.	Reduced barriers and stigma, plus increased coordination, increased prevention, and early intervention, and increased Primary Care Physician capacity. Focused on improving population health.
Challenges	Not population health focused; focused on highest need patients. Limited access and capacity (caseloads of 60–100 patients). Patients may have a long wait.	Behavioral health care managers have limited capacity and caseload may become full. Condition-focused approach. Steep learning curve to implement to fidelity.	Fee for Service reimbursement, Behavioral Health Clinician recruitment, and maintaining fidelity may be challenging.

- There are pros and cons to each model
- Selecting a Delivery Model to Implement

Selecting a Delivery Model to Implement

Co-located specialty Behavioral Health	Collaborative Care Management (CoCM)	Primary Care Behavioral Health/ Integrated Behaviora Health Alliance- Patient Centered Primary Care Home Standards
•On-site referral from Primary Care Physicians for ongoing therapy for patients w/ diagnosed mental health and substance use disorder conditions	•Intensive care management for patients with specific behavioral health conditions •Primary Care Physican support from a consulting psychiatrist/ Psychiatric Mental Health Nurse Practitioner •Registry management and treat-to-target approach	•Integrated team-based care for a broad range of patient concerns, including prevention and early intervention and behavioral medicine •Focus on same day warm hand-offs and other high-value services

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Preparing your practice for implementing Behavioral Health Integration

Behavioral Health Integration Program Considerations

Building an integrated care program requires intentionality and planning.

Readiness for Change	Payor & Financial Environment	Patient & Provider Needs
Is your clinic/ organization ready for change?	Payer environment What incentives & contract $$ is available to your clinic? -Patient Centered Primary Care Home -Value Based Payments	What do your patients, families, and primary care physicians need help with? What "problem" are you trying to solve? This helps determine which delivery model to implement.
	Payer metrics Which metrics can the behavioral health clinician help the clinic meet?	
	What is the plan for financial sustainability?	

Staffing	Recruitment & Retention	Quality Improvement
What staffing level and licensure is needed to adequately serve the patient population?	What is the plan for behavioral health clinician recruitment and retention?	How will the program & outcomes be monitored and evaluated?

Staffing Ratios

Patient Centered Behavioral Health/ Integrated Behavioral Health Alliance	Collaborative Care Management	Co-located specialty Mental Health/ Substance Use Disorder
Recommend minimum 1:6 Full-Time Equivalent Behavioral Health Clinician per Primary Care Physician	60-100 patients per 1.0 Full-Time Equivalent Behavioral Health Care Manager (but depends on patient complexity)	30-100 patients per 1.0 Behavioral Health Clinician Full-Time Equivalent

Unlicensed support staff (e.g., Behavioral Health Navigators, Care Coordinators/ Managers, Peer Support Specialists, etc.) are important in helping to augment the services of your licensed providers, especially for primary care behavioral health, as you want this person working at the top of their license (and not just fielding referral requests).

Choosing the Model(s) Your Clinic Needs

- Co-located specialty, collaborative care, and integrated care based on Integrated Behavioral Health Alliance standards are all valuable and complementary services. However, clinics often are unable to implement all three due to issues of start-up cost, space, or limited bandwidth for new workflows.

- The model that most clinics start with is integrated care (PCBH-IBHA standards). This is because Patient Centered Behavioral Health has the potential to reach the most patients at all levels of need. A Behavioral Health Clinician provides a primary care level of service: seeing and treating a wide breadth of physical and behavioral health needs, mitigating the need for specialty care. Their care of patients is generally short term, episodic, and based on treating the issue(s) of greatest concern to the patient. The expectation is that patients will come back when they have a new or worsening concern just as patients do with their Primary Care Physician.

Choosing Co-located Specialty

- Co-located specialty is an important model for clinics in several situations.
    - This includes clinics with a sizable number of patients requiring longer term and more intensive behavioral health support. It is difficult to manage the needs of a patient with severe and persistent mental illness in primary care without specialty care partnership.
    - Specialty behavioral health care and primary care rarely collaborate without a common space or opportunities for consultation and a shared chart. Getting records from specialty behavioral health, let alone getting in touch with a special behavioral health provider on the phone is often so burdensome that it does not happen.
    - Primary Care Physicians prescribing for patients with substance use disorders find that a scaffolding of specialty health for these patients is invaluable. This includes access to a chemical dependency counselor or support groups with a qualified professional.
    - Pediatric clinics commonly treat children with concerns for autism spectrum disorder, learning disabilities, and severe attention deficit hyperactivity disorder. Imbedded specialty developmental providers can ease this burden on patients and their families. Especially since pediatric and adolescent services are even more difficult to find in the community than services for adults.
    - Clinics with large geriatric populations also derive great benefit from having specialty behavioral health on site. This is in large part due to the very limited mental health options available to patients with traditional Medicare insurance. While older patients can also benefit greatly from seeing a Behavioral Health Clinician, many may be interested in establishing a longer-term therapeutic relationship as they cope with loss and life transitions.

Considerations of Co-located Specialty as Your Only Model

- Specialty behavioral health providers generally see 6-8 patients a day. They generally see their panel of patients weekly or biweekly. Their panel of patients is generally capped at 60 patients at a time. Patients often stay with these providers for a few months to over a year, resulting in few openings for new patients and long wait lists.
- Specialty behavioral health providers see patients for 45–50-minute visits with 10-15 minutes between their visits. This leaves limited time for consultation opportunities as they are almost always in session or documenting. Many specialty behavioral health providers are not “interruptible” during their visits.
- Specialty providers may have extra barriers to accessing their notes, making team-based care difficult (i.e., putting them “behind the glass” or even in a separate Electronic Health Record creating a sense that Primary Care Practitioners *should not* read the notes.)

Choosing Collaborative Care Management

- Choosing Collaborative Care Management includes support from both a behavioral health care manager and a psychiatric consultant.

- The behavioral health care manager provides intensive care management for patients who are often lost to care otherwise: those with psychotic spectrum disorders, bipolar disorder, intractable depression, or other forms of Severe and Persistent Mental Illness. They are also helpful for patients in the acute phases of psychiatric distress, such as in the case of a patient with marked and severe suicidal ideation or someone who has just experienced a debilitating psychiatric trauma.

- They utilize registries and are highly protocolized. Clear, defined treatment goals are routinely measured.

- Primary Care Physicians are supported by a consulting psychiatrist or psychiatric mental health nurse practitioner. The psychiatric provider does not see the patient directly but consults with the team. This approach helps spread the reach of limited psychiatry access.

- Registry management and a treat-to-target approach helps ensure patients get better.

Considerations of Collaborative Care Management as Your Only Model

- This model will only touch a small percentage of your patients. (However, the patients who this model supports are often the most expensive patients in the medical system)

- Patients are returned to full Primary Care Physician management after their target issue has been treated.

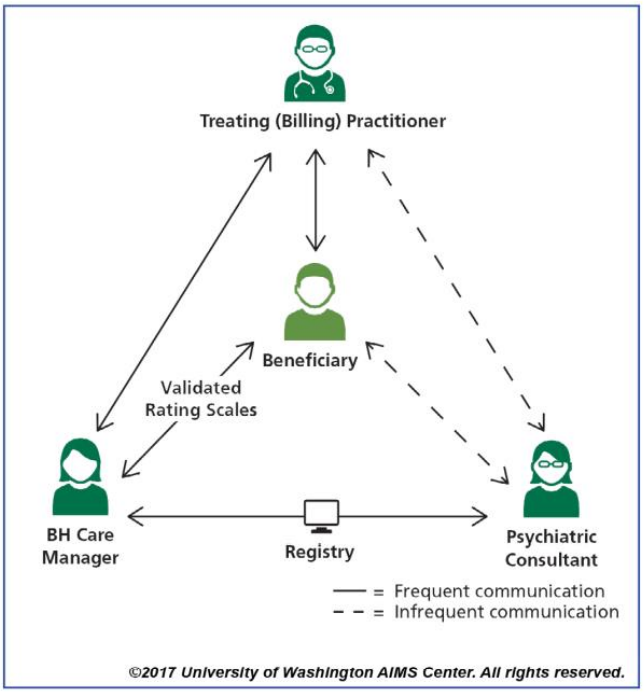
- Due the protocolized nature of this approach, there is less flexibility to adapt services to your individualized clinic's needs.

- This approach is the hardest of the three integrated approaches to implement to fidelity. It often takes the most time and infrastructure to support.

Helpful Resources:

- Practice Toolkit for Collaborative Care Management

Psychiatric Collaborative Care Services



What is Collaborative Care Management?
This figure is a model of behavioral health integration that enhances usual primary care by adding two key services to the primary care team, particularly patients whose conditions are not improving:

● Care management support for patients receiving behavioral health treatment

● Regular psychiatric inter-specialty consultation

● A team of three individuals deliver Collaborative Care Management: the Behavioral Health Care Manager, the Psychiatric Consultant, and the Treating (Billing) Practitioner

Behavioral Health Integration Services. (2022, Feb). *Medicare Learning Network.* Retrieved from Behavioral Health Integration Services (cms.gov)

Integrated Behavioral Health/ Primary Care Behavioral Health

The Behavioral Health Clinician is a routine part of care in the clinic and partners with Primary Care Physicians and patients to manage the entirety of the clinic's patient population.

- The Behavioral Health Clinician has no limits on how many patients they see and maintains at least 50% open access in their schedule for same day visits and consultations.
- The Behavioral Health Clinician is in a patient's care through consultations with the Primary Care Physician or care team.
- The Behavioral Health Clinician sees 8-14 patients a day for 30 minutes or less.
- Population health focused. Involvement in whole-clinic care reduces burden on Primary Care Physicians.

Considerations of Patient Centered Behavioral Health as Your Only Model

- Behavioral Health Clinicians do not have the capacity to see most patients for longer term care.
- In rural areas without specialty mental health access, Behavioral Health Clinicians will not be able to fully manage and treat the highest acuity patients without sacrificing their ability to care for your whole population.
- Behavioral health Clinicians cannot prescribe psychiatric medications.

Considerations of Patient Centered Behavioral Health as Your Only Model (cont.)

- Maintaining open access may be difficult when the only revenue stream for Behavioral health Clinicians is fee-for-service billing (Value-based payments and incentives for Patient Centered Primary Care Homes can offset these costs).

- Patient Centered Behavioral Health requires the most "buy in" from Primary Care Physicians as it truly requires team-based care. For Primary Care Physicians who have been in practice for many years and have a history of wanting full control over their patient's care, this can be difficult.

On-Site or Not (*Pick On-Site*)

- Integrated behavioral health care teams and services do not have to be present or delivered in the same physical location to meet the definition of integrated care[3].

- However, integrated behavioral health care teams and services often need to be delivered in the same physical location to have a fully successful program, meet Patient Centered Primary Care Home standards, and perhaps for value-based payment incentives.

- In primary care, even high need services are far less utilized when they are not on site and patients are unable to have a "warm hand-off" to the Behavioral Health Clinician.

- Most referrals are driven by consultation, or prior positive experiences with a Behavioral health Clinician seeing a patient.

- Referrals rarely keep up at the pace to keep a Behavioral health Clinicians program sustainable if Primary Care Physicians are not working side by side with the Behavioral health Clinicians.

- The most successful Behavioral health Clinicians are on site 100% of the time. This is because many in-depth consultations will not happen over the Electronic Health Records or by phone. Most of these will take on a different quality when they can occur in person.

- Additionally, there is a subset of patients who will not be able to fully access integrated behavioral health services remotely. These include young children, patients with special needs (such as those who are hearing impaired or have speech deficits), patients requiring interpreters (which can happen with telehealth, but is a significant barrier when emotionally laden content is being discussed), and for geriatric patients who may struggle with the technology. Additionally, many patients are profoundly isolated. Much of what makes Behavioral health Clinicians therapeutic is having the in-person connection.

[3]The Academy: Integrating Behavioral Health & Primary Care. (n.d.). *What Is Integrated Behavioral Health Care (IBHC)?* Agency for Healthcare Research and Quality. Retrieved from What Is Integrated Behavioral Health Care (IBHC)? | The Academy (ahrq.gov).

Prepare Your Practice for Implementation

- Behavioral Health Integration in Primary Care: Phases of Integration
- Starter Guide: School Based Health Center Integrated Behavioral Health
- Behavioral Health Integration Compendium
- Creating a Primary Care Workforce: Strategies for Leaders, Clinicians, and Nurses

Financial Sustainability

Can My Practice Afford to Implement Integrated Behavioral Health?

The number one barrier clinics face when deciding whether to implement integrated behavioral health is financial. Behavioral Health Clinicians receive lower reimbursement rates than Primary Care Physicians and have a narrower range of billable codes. A robust and integrated Behavioral health Clinicians also spends their time on non-billable but high-value activities such as consultations, same-day warm hand-offs, trainings, and care management/coordination. In a Fee-For-Service world, the idea of integrated behavioral health can feel dead upon arrival. Oregon recognizes these barriers to financial sustainability. As a result, the Oregon Health Authority (OHA), Coordinated Care Organizations and some private insurers may offer financial incentives to make integrated behavioral health financially sustainable. These include making integrated behavioral health an integral part of Patient-Centered Primary Care Home payments and value-based payments. Additionally, barriers to bill for Behavioral health Clinicians have lowered with expanded codes and increased options for telehealth.

Conceptualizing Financial Sustainability

- Integrated behavioral health is more about cost savings than revenue generation. Instead of thinking about a Behavioral health Clinician as akin to a Primary Care Physician regarding revenue, it is better to start from the premise that they are an integral team member providing high-value services that may not always be reimbursed under fee-for-service.

- In general, an adept Behavioral health Clinician will “break even” with billable encounters. However, keep in mind that the Behavioral health Clinician will be contributing towards your Oregon Health Authority Patient Centered Primary Care Home recognition standards as well as any value-based payment programs from payers.

- In addition, there are considerable cost offsets as well as intangibles that make integrated care make a lot more financial sense.

Cost Offsets

- Primary Care Physicians can see more patients/day when effectively utilizing the Behavioral Health Clinician, resulting in increased clinic revenue[1]

• Cost Offsets (cont.)

- Is your organization accountable for any total cost of care or shared savings metrics? If yes:
  - Use of health care services decreased by 16% for those receiving behavioral health treatment, while it increased by 12% for patients who were not treated for their behavioral health care needs[2]
  - Depression treatment in primary care for those with diabetes had $896 lower total healthcare costs over 24 months[3]
  - Depression treatment in primary care had $3,300 lower total healthcare cost over 48 months[4]
  - Annual medical expenses--chronic medical and behavioral health conditions combined -- cost 46% more than those with only a chronic medical condition[5]
  - Of the top five conditions driving overall health care costs (work related productivity + medical + pharmacy cost), depression is ranked number one[6]

1. Integrating Behavioral Health into Pediatric Primary Care: Implications for Provider Time and Cost. Natasha Gouge, PhD, Jodi Polaha, PhD, Rachel Rogers, MD, and Amy Harden, MD. Southern Medical Journal • Volume 109, Number 12, December 2016
2. Chiles JA, Lambert MJ, Hatch AH. The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review. Clinical Psychology: Science and Practice. 1999; 6:204-220.
3. Katon W, M. VK, Lin E, et al. Improving primary care treatment of depression among patients with diabetes mellitus: the design of the pathways study. General Hospital Psychiatry. 2003;25(3):158-168.
4. Unutzer J, Katon WJ, Fan MY, Schoenbaum MC, Lin EHB, Della Penna RD. Long-term cost effects of collaborative care for late-life depression. The American Journal of Managed Care. 2008;14(2):95-100.
5. Merikangas KR, Ames M, Cui L, et al. The Impact of Comorbidity of Mental and Physical Conditions on Role Disability in the US Adult Household Population. Arch Gen Psychiatry. October 1, 2007 2007;64(10):1180-1188.
6. Loeppke R, Taitel M, Haufle V, Parry T, Kessler RC, Jinnett K. Health and productivity as a business strategy: a multiemployer study. J Occup Environ Med. Apr 2009;51(4):411-428.

The Hidden Benefits

- Hiring a new Behavioral Health Clinician can be a leap of faith, particularly if your clinic setting has not previously had an imbedded Behavioral Health Clinician. Even having a co-located psychotherapist is vastly different than having a truly integrated team member. Thus, hiring a Behavioral Health Clinician to “break even” may seem like a lot of work for uncertain gain. The reason that an increasing number of clinics around the state have invested in growing integrated behavioral health has to do with the less tangible benefits. This includes:
  - Behavioral Health Clinicians support you and the rest of your care team.
  - Behavioral Health Clinicians improve patient satisfaction.
  - Behavioral Health Clinicians bring a fund of knowledge that improves the practices of the whole team.
  - Behavioral Health Clinicians reduced Primary Care Physician burnout and turnover.

Behavioral Health Clinicians Support of the Care Team

Behavioral Health Clinicians take an enormous amount of psychic weight off Primary Care Physicians. They are the time that Primary Care Physicians do not have. The Behavioral health Clinician will help the rest of the care team to understand and most effectively support the patients on your panel. They can spend time in crisis intervention or simply in listening to a patient's myriad needs and concerns. They have years of training in diagnosing and treating mental health issues, empowering Primary Care Physicians to make confident prescribing decisions. By being on the front lines to manage the most acute, complex, and frightening mental health issues, they create increased job satisfaction for the rest of the team. Behavioral health Clinicians not only help reduce Primary Care Physician burnout, but they play a key role in mitigating burden on your nursing staff. This is because they can get involved in triaging mental health crises and take over as appropriate. Additionally, nursing staff have the option of getting patients scheduled for same-day Behavioral health Clinician visits instead of being placed in the position of having to determine risk on their own or sending a patient to the emergency department (which is rarely the right call for a mental health crisis).

Behavioral Health Clinicians Improve Patient Satisfaction

- Most patients with behavioral health concerns do not have satisfactory access to behavioral health services. This is amplified in rural areas and for marginalized communities.

- Patients who have access to behavioral health services outside of your clinic may find these services to be sup-par. This is due to long wait times to get an initial appointment, long waits between appointments, and uncertain fit between the patient and the behavioral health provider.

- When we can get a patient into services quickly, we can often mitigate their worsening distress and lessened function. As a result, patients who can be seen earlier in their course (either of a mood episode, immediately following a crisis, or in the earlier stages of a new onset of an issue) often need less intensive treatment and experience less disability.

Behavioral Health Clinicians Know Helpful Things

- Behavioral Health Clinicians understand behavior and barriers to change. They can assess why a patient may be having trouble adhering to the plan of care discussed with the rest of the medical team. Is it health literacy? Is there a mismatch between the patient's values and the care team's goals? Is the patient struggling from another issue in their external or internal lives that is interfering with self-care? By determining *why* a patient may not be getting better, they can guide the Primary Care Physicians to meet a patient where they are at.

- Behavioral health Clinicians are trained to diagnose and treat mental health disorders. Often the main barrier for Primary Care Physicians in treating mental health disorders with medication is knowing what disorder the patient is suffering from. By being able to name what the patient is and is not struggling with, Primary Care Physicians can make informed decisions about treatment.

Behavioral Health Clinicians Know Helpful Things (cont.)

- Behavioral Health Clinicians can train the team on trauma informed care, improved self-care, communication, mindfulness, substance use, and help design workflows to reduce burnout.
- Behavioral Health Clinicians are skilled at boundary setting and this is important for all members of the care team. The Behavioral Health Clinician often helps the team set these necessary boundaries.

What Do Behavioral Health Clinicians Do?

- Everything. There is no bad referral to Behavioral Health Clinicians. A Behavioral Health Clinician should be willing and able to see patients of all ages with any presenting concern. Behavioral Health Clinicians need to have the range of a Primary Care Physician. They are trained to have enough knowledge of common health issues such as diabetes, heart disease, obesity, and chronic pain to be able to help patients develop goals to improve their health and reduce poor outcomes. For less common issues, Behavioral Health Clinicians are trained to collaborate and learn from the rest of the care team to help further the goals held by both the Primary Care Physician and patient.
- Every referral is of equal merit. A patient does not need to be in dire straits to benefit from integrated behavioral health. Any patient who seems like they might appreciate having someone listen and give them support/direction will get a lot of out behavioral health. Additionally, any patient where the care team feels stuck is also a good integrated behavioral health referral.

Behavioral Health Clinician as Clinician

- Behavioral Health Clinicians will see 8-10 scheduled patients a day on average.
    - Scheduled visits are generally bimonthly or less unless a patient is in active crisis.
    - Most patients are seen for short courses of treatment.
    - Patients may be seen longer term (often when their acuity is high and there are no other community options available to due to financial or geographic access issues)
- Behavioral Health Clinicians will see scheduled patients for 30-minute sessions.
- It is strongly recommended that at least 50% of the Behavioral Health Clinicians schedule is open access for same day visits, consultations, and warm hand-offs.
    - Same day visits occur when patients are otherwise in the clinic to see another member of their care team and express a need to speak to someone.
    - Consultations are brief, frequent, and happen in-person, over the Electronic Health Records, and by phone when both parties are not onside.
    - Warm hand-offs are generally 5 minutes or less when a Primary Care Physician introduces a patient in person to the Behavioral Health Clinician at the time of their office visit. They improve the chance that a patient will follow through on a scheduled appointment with the Behavioral Health Clinician.

What Do Behavioral Health Clinicians Treat?

- **Health Behaviors Impacting the Patient's Wellbeing**
    - This can be about lifestyle change regarding sleep, diet, exercise, socialization, or managing stressors. This also includes helping the patient reduce barriers to medication compliance and other elements of chronic disease management. They can help assess whether a patient is ready for a more significant intervention, such as bariatric surgery. They can also see families and couples when the family system is driving the unhealthy behaviors (such as in childhood obesity or smoking cessation when multiple family members are smokers)
- **All Mental Health Concerns**
    - This includes treatment of more treatment responsive conditions such as adjustment disorder, panic disorder, or physiological insomnia. It also includes mitigation of the worst outcomes of severe and persistent mental illness such as loss of jobs, housing, or supportive relationships that can come with untreated bipolar disorder or schizophrenia. Behavioral Health Clinicians are also trained to help patients struggling with personality disorders through direct intervention and helping the care team to maximize their support of these patients. Additionally, Behavioral Health Clinicians can help manage chronic suicidality, intractable depression, and obsessive-compulsive disorder among other concerns. They are particularly helpful for mental health concerns that are present almost exclusively in the medical environment such as somatization disorder, psychogenic seizures, or delusional parasitosis.
- **Developmental Concerns/Conditions**
    - Behavioral Health Clinicians can assess and treat attention deficit hyperactivity disorder. Additionally, they can be useful when patients fail a Modified Checklist for Autism in Toddlers (M-CHAT), with Ages and Stages Questionnaires (ASQs), or with toileting issues and sleep concerns. Behavioral Health Clinicians also assist with school-age children who experience learning disabilities, providing assessment, treatment, and care coordination.
- **Substance Use Disorders from harm reduction to cessation**
    - Behavioral Health Clinicians are trained to assess the level of need and to assist the patient with outside care if they are too complex to manage in the primary care environment, such as with referrals to detox and residential settings.

Behavioral Health Clinician as Consultant

- Not every patient wants to see a Behavioral Health Clinician. And not everyone needs to see a Behavioral Health Clinician. However, a Behavioral Health Clinician may still help improve that patient's care.
- When to use the Behavioral Health Clinician as a consultant:
    - The patient is already engaged with an outside mental health provider for the same issue you want the Behavioral Health Clinicians input on (i.e., the patient says that their therapist has diagnosed them with attention deficit hyperactivity disorder, can you read over the therapist's notes to see if you agree?)

Behavioral Health Clinician as Consultant (cont.)

- The patient refuses to see the Behavioral Health Clinician but you are having a hard time with their lack of progress, the way they interact with you or the rest of the care team, or a demand the patient has around certain medications or orders. In this case, you could present the case to the Behavioral Health Clinician, and they could help you plan on how to manage your interactions with the patient.
- Staff or providers have a strong reaction to a patient. They dread interacting with them or even feel fearful. The Behavioral Health Clinician can help your clinic produce a plan that prioritizes safety while balancing the needs of the clinic and the patient.

Behavioral Health Clinician as Trainer

- Behavioral Health Clinicians are professional communicators. Your Behavioral Health Clinician has the training and skill to manage individual encounters, group processes, and educational talks.
- Behavioral Health Clinicians can own any training in your clinic that has to do primarily with psychosocial issues. They can also partner with medical providers to train on the psychosocial complexities and health disparities related to chronic health conditions.
- Behavioral Health Clinicians have a unique role in improving trauma informed care in your practice. This can happen on both the micro level (leading case conferences) or the macro level (helping your front desk staff with language to deescalate belligerent patients).
- Behavioral Health Clinicians can have a central role in Balint Groups, Schwartz Rounds, and Morbidity and Mortality (M&M) discussions.

Is There Anything a Behavioral Health Clinician Does Not Do?

- A Behavioral Health Clinician should always find a way to coordinate and ease patient care when a request is made of them by the care team. However, this does not always come in the form of a visit with a patient. The Behavioral Health Clinician may quickly assess that what a patient needs is another member of the team, such as a case manager or clinical pharmacy, and offer to create the documentation in the chart to hand the patient over to this other provider.
- Behavioral health Clinicians cannot be every patient's long term mental health provider. If they were, they would not be addressing population-based care. 20% or fewer of the Behavioral Health Clinician's patients should be patients seen longer term.
- Behavioral Health Clinicians are not support staff. They need to be working at the top of their license as much as possible. As a result, it is important that they not "cold call" patients or manage scheduling requests or reminder calls.
- Behavioral Health Clinicians refer to specialists like Primary Care Physicians do: when an issue becomes too complex or requires a niche treatment modality. This includes issues like eating disorders, or assessments like a comprehensive neuropsychological evaluation, or treatment modalities such as neurofeedback or dialectical behavioral therapy.

Getting Your Team Onboard

Primary Care: The "de facto" mental health system

- 1 in 5 adults have a mental health condition, but 56% of American adults do not receive treatment[1]
- >20% of children have a diagnosable mental health or substance use disorder and another 16% have impaired mental health functioning (=32%) BUT only 20% of those receive services in the specialty mental health system[2]
- 50 - 70% of primary care appointments are for problems stemming from psychosocial issues[3]

[1] Shaffer D, Fisher P, Dulcan MK, et al. *The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): description, acceptability, prevalence rates, and performance in MECA study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study.* J Am Academy Child Adolescent Psychiatry. 1996;35(7):865-877

[2] Burns BJ, Costello EJ, Angold A, et al. *Children's mental health service use across service sectors.* Health Aff (Millwood).1995;14(3):147-159

[3] Gatchel, R. J., & Oordt, M. S. (2003). *Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration.* American Psychological Association.

Embracing and Implementing Integrated Behavioral Health

- Once you have decided to bring in Primary Care Behavioral Health, co-located specialty, or a Collaborative Care Management program, it is critical to get your whole team on board.

- While most of your team members likely will think that it is a good enough idea to have behavioral health support imbedded, they may not know how to think about these new people and how they fit into your organization.

- Team members often carry some of the same reluctance about talking about and dealing with mental health that many of their patients do. Integrated behavioral health has only become a "thing" in the last decade or so not because it was not a good idea, but because many of us have a lot of strong feelings about mental illness and psychotherapy. This stigma has led to behavioral systems being partitioned out of mainstream systems and, in general, receiving poor reimbursement.

- It is important to remember this implicit bias as it is unlikely that everyone on your team will be excited and embracing of this huge culture change.

Most People Do Not Know What Behavioral Health Clinicians Do

- Most people, especially in rural communities with a dearth of services, have a very limited scope of personal experience with seeing a counselor, psychotherapist, or psychiatry provider.

- Even those that may have had first or secondhand experience with behavioral health treatment may have trouble imagining how a Behavioral Health Clinician could help all patients.

- This is partly by (previous) design as specialty behavioral health operates under the highest level of confidentiality. Thus, it can just seem like "talking" or only for people who are "crazy."

Most People Do Not Know What Behavioral Health Clinicians Do (cont.)

- Neither of these things are true, but it is up to your Behavioral Health Clinicians to be transparent about their work and teach your team about what goes on in sessions behind closed doors. This happens through frequent case consultations, well written and accessible chart notes, and speaking frankly about their patient care.

Allow Time for Your Behavioral Health Clinician to Meet with All Clinic Stakeholders

- Your Behavioral Health Clinician must create relationships with every member of your team. This helps them to demystify their work and allows everyone to see them as humans instead of as someone who does something secret, unknowable, and invading.
- Behavioral Health Clinicians should view a big part of their job as being accessible, friendly, and connected to various members of the care team. Part of the job is to be known, liked, and not intimidating. This is good generally for clinic relationships but is also important because patients who have trepidations about meeting with the Behavioral Health Clinician will feel less so if they see that other members of the care team think that the Behavioral Health Clinician is not scary.
- Allowing time for team members to meet with your Behavioral Health Clinician will also help establish their centrality in your clinic.

Primary Care Physicians and Behavioral Health Clinicians

- The Primary Care Physician is the Behavioral Health Clinician's #1 client.
- Many Primary Care Physicians are thrilled to have behavioral health support, but most do not know how to utilize a Behavioral Health Clinician without scaffolding. Additionally, they need repeated reinforcement that integrated behavioral health services are worthwhile and helpful.
- It is the Behavioral Health Clinician's job to teach Primary Care Physicians what they do. However, it is important to have at least one Primary Care Physician who acts as a Behavioral Health Clinician champion, taking the "risk" of referring patients early on to the Behavioral Health Clinician in order to let the Behavioral Health Clinician prove their skill.
- Only with repeated positive experiences of seeing their patients get better and their work burdens lessen will many Primary Care Physicians refer to a Behavioral Health Clinician without hesitation.
- Some Primary Care Physicians worry that they are providing lesser care to their patients if they are not the one to address all the patient's concerns. It is important to remind Primary Care Physicians that:
    - Behavioral Health Clinicians are mental health and behavior change experts. Their services will help reduce the patient's distress expeditiously allowing more "room" for the Primary Care Physician to work on the patient's other chronic health conditions.

Primary Care Physicians and Behavioral Health Clinicians (cont.)

- Behavioral Health Clinicians are an extension of Primary Care Physician care. They work with the patient on the referral reason provided by the Primary Care Physician and are there to help the patient with the goals that the Primary Care Physician has identified as paramount. The Primary Care Physician is the Behavioral Health Clinician's #1 client.

Encouraging Primary Care Physicians with Reluctance to Engage in Team-Based Care

- Primary Care Physicians may struggle to ever embrace "sharing the care" of their patients.
- While it is the Behavioral Health Clinicians job to win over the Primary Care Physician, the Behavioral Health Clinician may need some help.
- Strategies that can work:
  - Have your Behavioral Health Clinician do a joint clinic with your Primary Care Physician during a half day (or video precept if your clinic has the technology). The Behavioral Health Clinician can provide feedback to the Primary Care Physician after each visit about the patients seen and how the Behavioral Health Clinician may be helpful.
  - Have clinic leadership encourage the Primary Care Physician to utilize the Behavioral Health Clinician for the toughest cases - the patients on behavioral agreements or the patient the Primary Care Physician most wants to get off their panel. The Behavioral Health Clinician will likely be able to make headway with these patients in a way that the Primary Care Physician could not, perhaps impressing their utility upon the Primary Care Physician.
- Have your Behavioral Health Clinician be a non-negotiable part of a clinic workflow. This can be that they automatically see patients with a Patient Health Questionnaire- 9 (PHQ-9) score of 10 or higher or they see every patient prescribed a stimulant medication. These forced encounters with a Primary Care Physician patient often help to show off the Behavioral Health Clinicians skills – and make team-based care the standard of care at your practice.

Behavioral Health Clinicians, Nurses, Medical Assistants, and Administrative Support

- Behavioral Health Clinicians have a role to play with each role in your clinic.
- For staff triaging patient need, or those who are first to see when a patient is in distress, knowing that they can go to the Behavioral Health Clinician for help improves their work lives.
- Front desk staff may get help from Behavioral Health Clinicians re: language to use with an escalated patient, or even request help from a Behavioral Health Clinician to de-escalate a tense situation.
- Medical assistants may come get a Behavioral Health Clinician when a patient is panicking or tearful. They may also give a heads up to the medical provider that it would be prudent to involve the Behavioral Health Clinician.
- Registered Nurses may get a triage call from a suicidal or psychiatrically complex patient. They can ask for the Behavioral Health Clinician to support them in coming up with a care plan.

Behavioral Health Clinicians and Clinic Management

- Clinic management must champion Behavioral Health Clinicians through understanding their work, their potential positive impact on clinic culture, and how the Behavioral Health Clinician is (at worst) a neutral clinic cost.

- Clinic management should spend time to work with the Behavioral Health Clinician on optimizing workflows for schedules, billing, and referrals so that the Behavioral Health Clinician knows who to go to for various issues.

Hiring a Behavioral Health Clinician

Who To Hire

- Consider your unique clinic.
  - Patient population
  - Geographical region
  - What do your Primary Care Physicians and patients require for buy in?
- Licensure and supervision requirements
  - What is your budget?
  - Are you looking to stop at one Behavioral Health Clinician or to grow a larger program?
- Hiring for longevity versus creating a program that is more transitional.
- When an applicant states that they have integrated Behavioral Health Clinician experience, this means a range of things. To see if the Behavioral Health Clinician work they did is in line with the models we have found to be most successful, we recommend having them take a screener from the Center for Integrated Healthcare.

Universal Characteristics of a Good Behavioral Health Clinician

- **Flexibility**
  - A core part of training for mental health professionals is the "frame." This is about the scaffolding of exact timing, place, and privacy in traditional mental health environments. Your Behavioral Health Clinician must be comfortable with letting the frame go.
- **Adaptability**
  - Every day is new and unexpected for a Behavioral Health Clinician. You never know who will be placed on your schedule, what crisis you will navigate, what situation requires your attention. Most patients are unknown to the Behavioral Health Clinician. The only constant is the clinic and team members.

Universal Characteristics of a Good Behavioral Health Clinician (cont.)

- **Someone willing and able to work at a fast pace (the pace of primary care)**
  - Behavioral Health Clinicians directly interact with 2-3x the number of patients that most providers in specialty mental health will. This includes office visits and warm hand-offs.
  - The person you hire must be willing to move fast for the common good. Services should be provided in the shortest amount of time possible to provide good care. Similar to Primary Care Physicians, Behavioral Health Clinicians must do more with less time.
- **Someone who can simultaneously hold their own, while having appropriate deference to medical providers and other team members**
  - Your Behavioral Health Clinician must be able to command a room, quickly winning over patients and impressing care team members.
  - Yet, they must know the limits of their license and competency. They must speak frequently and openly to all parties about their scope so that everyone is clear that the Behavioral Health Clinician is never making the call on issues such as medications or non-psychiatric diagnoses.

Your Unique Clinic

- The success of integrated behavioral health rises and falls on the Behavioral Health Clinician's "fit" in your clinic. Regardless of how successful a Behavioral Health Clinician may have been at a previous clinic or how impressive they look on paper, their fit in *your* clinic is paramount.
  - Behavioral Health Clinicians often have variable success depending on how well they connect to Primary Care Physicians and other care team members. Everyone must find them both likeable and competent. Otherwise, the Behavioral Health Clinician will fail to fully reach your population.
  - Your Behavioral Health Clinician must be able to speak the language of your providers and patients alike. While a Behavioral Health Clinician does not need to be from a similar community to the one your practice operates in, they do need to be able to "code switch." For example, a Behavioral Health Clinician from a big city operating in a rural practice must be curious, thoughtful, and able to shift their language to better relate to your patients' needs and concerns.
  - If the Behavioral Health Clinician seems unapproachable to you, they will be even more unapproachable to your patients. Regardless of how skilled they are or how much you like them once you can ultimately connect to them.

Equally Qualified Candidates. Who do you choose?

- When judging whether to prioritize competency or likeability between two equally qualified candidates, weigh competency more highly.
  - Likeability gets the Behavioral Health Clinician in the door; competency keeps referrals and patient successes going in perpetuity.

  - The Behavioral Health Clinician you can trust to provide deep and wide-ranging care, expanding the expertise your clinic has to offer, will have the greatest influence in your clinic.

- License/education matters
  - The license your Behavioral Health Clinician has will determine what you can bill for. For instance, only Doctor of Philosophy in Psychology or a Doctor of Psychology (PhD/PsyD) or Licensed Clinical Social Worker (LCSW) candidates can currently bill for Medicare services.

  - Having a Behavioral Health Clinician who has strong skill in diagnostic clarification should be prioritized over those who do not.
    - While a background in integrated behavioral health matters, strong therapeutic and crisis skills matter more.
      - Likely, your Behavioral Health Clinician will often need to be operating independently and seeing a wide range of patients. They must have the skill to know how to help the vast majority of patients without extensive consultation.

    - There are many different modalities of psychotherapy. While certain orientations may be a more organic fit for integrated behavioral health (such as Cognitive Behavioral Therapy or Acceptance and Commitment Therapy), it matters more that your Behavioral Health Clinician has a professional identity and clinical depth.

Licensure and Titles

Pre-Licensed Professionals

- Licensed Professional Counselors (LPC) Associates, Marriage and Family Therapists (MFT) Associates, Clinical Social Worker (CSW) Associates, and Psychologist Residents are all in their last year of training before receiving their licenses. While they are still early in their behavioral health careers, they should have at least two prior years of counseling or psychotherapy experience. Psychologist residents have 4 prior years of psychotherapy training.

- Additionally, integrated behavioral health is now taught in graduate school programs in more comprehensive ways than at any time in the past. Thus, these trainees are likely to have some prior integrated behavioral health experience and coursework.

- These individuals still require supervision from a licensed professional in their chosen field. This supervision is licensure dependent, and generally requires 2 or more hours of supervision time weekly. If your agency does not have a licensed professional who can provide this supervision, expect to pay between $100-$200/hour for this supervision.

- Insurance companies are beginning to allow these individuals to bill for their services, but this is far from universal.

- In general, associates and psychologist residents are compensated at a rate of 50-66% the rate of a licensed professional.

- Associates and residents are less likely to have the gravitas and skill to win over skeptical patients and Primary Care Physicians. This improves with maturity and time, but is a meaningful consideration if you have concerns about clinic buy in.

Integrated Behavioral Health Training in Your Clinic (Master's Level and Doctoral Students)

- Many clinics find that having master's level and doctoral level students is a significant added benefit.

- This would involve having your licensed Behavioral Health Clinician provide supervision to these students. This supervision is usually 1-2 hours a week (individual supervision + group supervision with the Behavioral Health Clinician and two or more students).

- Behavioral Health Clinicians often experience greater job satisfaction when they are involved in training students.

- Clinics are happy to have expanded integrated behavioral health and psychotherapy services in house.

- Because students neither bill nor require compensation, they are a cost neutral way to provide behavioral health support to patients who could not otherwise afford this care.

Training and Titles Defined

- **PhD in Psychology**- Psychology Doctorate with research focus. Minimum of 4 years of schooling + 1 year of internship + 1 year of residency.

- **PsyD- Psychology** Doctorate with a clinical focus. Minimum of 4 years of schooling + 1 year of internship + 1 year of residency.

- **LCSW-** Licensed Clinical Social Worker. Two-year master's degree program + 3500 hours of supervised clinical social work experience (takes 2 or more years to complete).

- **LMFT-** Licensed Marriage and Family Therapist. Two-year master's degree program +2400 hours of supervised clinical work experience (up to 400 hours can be pre-degree). Specialty in working with couples and families.

- **LPC-** Licensed professional counselor. Masters in counseling (MA or MS). Two-year master's degree program +2400 hours of supervised clinical work experience (up to 400 hours can be pre-degree).

- **QMHP**- Qualified Mental Health Professional. THIS IS NOT A TERM OF LICENSURE and only is recognized by organizations that operate under a Certificate of Approval (COA) under the Oregon Health Authority. Typically, only in specialty behavioral health organizations. An individual who has at least a masters-level education and training in psychiatry, psychology, counseling, social work, or psychiatric nursing, and is currently licensed by the State of Oregon to deliver those mental health services he or she has undertaken to provide.

- **QMHA**- Qualified Mental Health Associate. THIS IS NOT A TERM OF LICENSURE and only is recognized by organizations that operate under a Certificate of Approval (COA) under the Oregon Health Authority. Typically, only in specialty behavioral health organizations. With enough experience, this is a credential that can be achieved without a bachelor's degree.

- **CADC I, CADC II, or CADC III.** Certified Alcohol and Drug Counselor. As a standalone degree, this individual will not be able to bill for services. This is a helpful **additional** certification for a Behavioral Health Clinician.

The Psychiatry and Collaborative Care Management Workforce

Psychiatrist – A physician who went to medical school and also completed a residency program specializing in psychiatry.

Psychiatric Nurse Practitioner – A certified advanced practice nurse who provides medical services to the mental health needs of individuals, families, and groups.

Psychiatric Physician Assistants - Specializes in psychiatric/mental health and provides mental health services under the supervision of a psychiatrist.

Workforce Behavioral Health Clinicians (Co-located or Integrated Behavioral Health)

- **Clinical Psychologists** make diagnoses and provide treatment and therapy. Sometimes they can prescribe medications, but this is currently not allowed in Oregon.
- **Clinical Social Workers** make diagnoses and provide counseling and therapy, case management, and advocacy.
- **Case Management Social Workers** provide case management and help locate treatment services and other services to support recovery and healthy living.
- **Counselors** make diagnoses and provide counseling. They help with improving life skills and relationships.

Workforce (Peer Support and Chemical Dependency)

- **Peer Specialists/Recovery Coaches** are people who have experienced mental, or substance use disorders and are in recovery. They can teach you about the health system, provide emotional and social support, and help your recovery. Peers often receive training and certification.
- **Substance/Addiction Counselors** advise people who have alcohol or other substance use disorders. They provide treatment and support to help in your recovery.

What Kind of Behavioral Health Clinician Does my Practice Need?

- **PhDs and PsyDs**
  - More training in diagnosis, treatment, and assessment than other providers. They are also more expensive. Some practices find that it is helpful to have a be introduce their Behavioral Health Clinician as ”Dr. X” as Primary Care Physicians and patients sometimes find comfort in this title. They can bill all insurance types.
- **Licensed Clinical Social Workers (LCSWs)**
  - Extensive training and skill with care coordination and understanding systems. May have less comfort with diagnosis. They can bill all insurance types.
- **Licensed Marriage and Family Therapists (LMFTs)**
  - Expertise in family systems and generally are very comfortable working with children of all ages. Currently cannot bill for Medicare.
- **Licensed Professional Counselors (LPCs)**
  - Wide ranging experiences, very program and individual dependent. Currently cannot bill for Medicare.

Certificate of Approval Exceptions

- Primary care clinics providing integrated behavioral health care do not need to operate under a Certificate of Approval (COA) from the Oregon Health Authority (OHA) if they are utilizing licensed Behavioral Health Clinicians or Behavioral Health Clinicians working towards licensure under a board-approved supervisory contract (i.e. board-registered associates and psychologist residents). The COA designation, which was designed for specialty behavioral health organizations that serve Medicaid patients with serious mental illness or substance abuse conditions, provides the structure and ability to have unlicensed staff provide behavioral health services under the supervision of a licensed professional and receive reimbursement for those services. However, there is an enormous administrative burden to operate under a COA and this is generally not a sustainable route for integrated behavioral health programs.

- In Oregon, board-registered associates and psychologist residents are classified as Behavioral Health Clinicians and their services are billable under Medicaid and some commercial plans.

Oregon Administrative Rules

- Chapter 309 of the Oregon Health Authority (OHA) sets out the Oregon Administrative Rules (OARS) for Medicaid behavioral health services.

- Definitions of Licensed and Pre-Licensed (board registered associates and psychologist residents):
  - Licensed Psychologist
  - Psychology Resident/Psychology Post-Doc
  - Licensed Professional Counselor
  - Licensed Marriage and Family Therapist
  - Licensed Professional Counselor Associate and MFT Associate
  - Licensed Clinical Social Worker
  - Certified Social Worker Associate

Recruitment

How to Attract a Good Behavioral Health Clinician

- Behavioral Health Clinicians are generally value-driven individuals who are looking to make a difference in the lives of patients and communities. Speaking to the culture of your clinic and the community you reside in makes a difference.

- Behavioral Health Clinicians are looking for work/life balance, strong support, and sustainable duties. The set-up of an integrated behavioral health program facilitates this as 50% of their time will be open access (allowing for consultation, care coordination, and warm hand-offs), team-based care, and lack of on-call responsibilities make Behavioral Health Clinician positions attractive. Highlighting these features in a job description will go a long way.

- Behavioral Health Clinicians want to be valued for their years of training and experience. Remember, that many have years of training that approaches or matches that of Advanced Practice Providers and Physicians. They are billing providers who add expertise and depth to your care team experience. Differentiating them from "case workers" in your job description and your interview process is critical.

Salary and Benefit Expectations for Behavioral Health Clinicians

- Your benefit packages should mirror the benefits of your Primary Care Physicians (equal Paid-Time-Off, continuing education support, and bonuses).

- Salary and benefit expectations for pre-licensed and licensed Behavioral Health Clinicians (Behavioral Health Clinicians) have increased due to a growing appreciation for their contribution to primary care as well as due to a low supply of qualified candidates. Behavioral Health Clinicians make more on average than their counterparts in other organizational behavioral health positions due to the high demands of the position.

- Expect to offer benefits in addition to health insurance, paid time off, and retirement. Benefits should include loan repayment options, payment of licensure (or supervision) fees, designated days off for licensure or prelicensure activities (such as attending conferences or preparing for a licensure exam) and paying for continuing education courses.

- Remember that Associates and Psychology Residents have lower salary requirements, and that this is time limited as all should gain licensure within 1-3 years of working in your practice. Additionally, these individuals require supervision. Anticipate an additional $500-$1500 a month in costs if you do not have an internal licensed professional to provide your pre-licensed Behavioral Health Clinician with supervision (remember that this internal person must have the same license that the Behavioral Health Clinician is seeking).

Suggested Salary by Licensure

- **Current as of January 2022. Expect marked inflation over time given the competitive nature of this market.**

- Professional Counselor (PC) Associates, Marriage and Family Therapy (MFT) Associates, Clinical Social Worker (CSW) Associates, and Psychologist Residents: Starting at $50,000/year + paid supervision. To secure a psychologist resident, consider paying as much as $70,000 a year.

- Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs): Starting at $70,000/year, as much as $90,000 a year for a seasoned clinician.

- Licensed Clinical Social Workers (LCSWs): Starting at $80,000/year. Anticipate paying $100,000/year for a seasoned clinician.

- Doctor of Psychology (PsyDs/PhDs): Starting at $105,000/year. Up to $130,000/year for a seasoned clinician.

- *Note that you may be able to offer a reduced salary with generous loan repayment options. PsyDs often carry $200k or more in student debt. PhDs who have gone to funded programs generally carry about half of that. Debt is variable for master's level providers, but many commonly carry 50k or more.

Training

Training your Behavioral Health Clinician

Many will not have extensive prior experience in the integrated behavioral health model. Those that do may still need scaffolding and guidance.

On Site Training for Behavioral Health Clinician

- You may have attracted a strong candidate with limited or no experience in integrated behavioral health. You want to make sure that this Behavioral Health Clinician is trained in integrated behavioral health model so that they provide the most comprehensive care for your patient population.
- Behavioral Health Clinicians benefit from a mix of didactic and in vivo training experiences.
- The most powerful training comes through mentorship. We highly recommend that Behavioral Health Clinicians be given the opportunity to learn and consult with other Behavioral Health Clinicians in your broader organization or community. This typically means protected time for formal and informal meetings. When your organization is small, this is harder to accomplish. However, numerous opportunities exist throughout Oregon and nationally.

Virtual Training for Behavioral Health Clinicians

- There are myriad online and community training resources. Many are low quality. Some are an important foundation for a new Behavioral Health Clinician. Others are helpful references.
    - If your Behavioral Health Clinician does not have a strong foundation in integrated behavioral health, we recommend investing in a certification course as they are being onboarded. While many programs are available, we have had a universally positive experience with the University of Massachussets IBH training modules
    - For comradery and support, we recommend that Behavioral Health Clinicians have access to peer groups. Some Coordinated Care Organizations have networks of Behavioral Health Clinicians who connect with each other. The Oregon Primary Care Association (OPCA) also offers a robust opportunity for training and connection. OPCA Peer Groups
    - Your Behavioral Health Clinician will also have many questions that come up along the way about issues such as billing, coding, and integrated behavioral health treatment for specific conditions. We recommend the following online resources:
        - High Quality Resource Links from Integrated Behavioral Health Partners
        - Resources from American Psychological Association
        - YouTube Videos created by Neftali Serrano, PsyD, who is now in charge of the Collaborative Family Healthcare Association Primarycareshrink

Additionally, we recommend investing in a Collaborative Family Healthcare Association membership for your Behavioral Health Clinician. They have a robust and active listserv that will respond to all questions that your practice has about integrated behavioral health.

High Quality Continuing Education Experiences

- Collaborative Family Healthcare Association Conference and the Integrated Care Conference
- Harvard Medical School and Affiliates
- Mayo Clinic School of Continuous Professional Development
- Annual Conferences offered by the Oregon licensure board your Behavioral Health Clinician is licensed under may provide good opportunities for networking.
- PESI is a comprehensive catalogue of online and in person conferences. Many, but not all, are of high quality.

Coaching and Technical Assistance

- Many practices find that hiring experts to help train their Behavioral Health Clinicians and their clinics in this model of care is a worthwhile investment. Coaching and technical assistance may include support with choosing the right hire, building referrals and workflows, billing and coding, or Electronic Health Records support. Two primary groups in Oregon provide coaching and technical assistance for integrated behavioral health and Patient Centered Primary Care Homes. They include:
    - Integrated Behavioral Health and Patient Centered Primary Care Home Program Development and Technical Assistance:
        - Creach Consulting Group
    - Medication Assisted Treatment (MAT)/ substance use disorder (SUD): MAT/SUD Program Development and Technical Assistance:
        - Synergy Health Consulting
- Additionally, we recommend a national group, Primary Care Development Corporation, who are based in New York and California.

OPCA Oregon Primary Care Association

CC GROUP Creach Consulting Group

Primary Care Behavioral Health Scheduling

Example of Schedule Template for Primary Care Behavioral Health

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 AM	Open Access	Open Access	Open Access	Open Access	Case Conference
8:30 AM	Scheduled	Scheduled	Scheduled	Scheduled	
9:00 AM	Open Access	Open Access	Open Access	Open Access	Open Access
9:30 AM	Scheduled	Scheduled	Scheduled	Scheduled	Scheduled
10:00 AM	Open Access	Open Access	Open Access	Open Access	Open Access
10:30AM	Scheduled	Scheduled	Scheduled	Scheduled	Scheduled
11:00 AM	Open Access	Open Access	Open Access	Open Access	Open Access
11:30 AM	Scheduled	Scheduled	Scheduled	Scheduled	Scheduled
12:00 PM	Lunch	Lunch	Lunch	Lunch	Lunch
1:00 PM	Provider Meeting	Open Access	Open Access	Open Access	Open Access
1:30PM		Scheduled	Scheduled	Scheduled	Scheduled
2:00PM	Open Access	Open Access	Open Access	Open Access	Open Access
2:30PM	Scheduled	Scheduled	Scheduled	Scheduled	Scheduled
3:00PM	Open Access	Open Access	Open Access	Open Access	Open Access
3:30PM	Scheduled	Scheduled	Scheduled	Scheduled	Scheduled
4:00PM	Open Access	Open Access	Behavioral Health Clinician Meeting	Open Access	Open Access
4:30PM	Scheduled	Scheduled		Admin	Admin

Primary Care Behavioral Health Schedule Template Explained

- A Behavioral Health Clinician's schedule has 50% or more of their schedule available for warm hand-offs, same day scheduling, consultation, care coordination, and training. Behavioral Health Clinicians may also use this time for documentation/inbox management. However, they are expected to prioritize clinical activities and to be available to pivot whenever needed.

- The other 50% is for pre-scheduled appointments. Behavioral Health Clinicians will generally try to maintain availability for these appointments so that no one must wait more than 2-3 weeks to schedule a non-urgent appointment (which would be scheduled in a same day slot).

- Behavioral Health Clinicians are most successful when they have a "seat at the table" with Primary Care Physicians. Additionally, greater face time with the team ensures a better referral stream. Thus, it is recommended would have them attend meetings attended by Primary Care Physicians.

Example Schedule for Co-located Specialty Care

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 AM	Case Conference	Intake	Patient	Patient	Patient
9:00 AM	Patient		Patient	Patient	Patient
		Intake			
10:00 AM	Patient		Patient	Patient	Patient
11:00 AM	Patient	Patient	Patient	Patient	Patient
12:00 PM	Lunch	Lunch	Lunch	Lunch	Lunch
1:00 PM	Patient	Patient	Patient	Patient	Provider Meeting
2:00 PM	Admin	Admin	Admin	Admin	Admin
3:00 PM	Patient	Patient	Patient	Patient	Patient
4:00 PM	Patient	Patient	Behavioral Health Clinician Meeting	Patient	Patient

Co-located Schedule Template Explained

- Co-located specialty mental health will generally see patients for a therapeutic hour (45-50 minutes).
- Many will also schedule 90-minute-long intakes. Once full, they will generally not be able to see more than 1-2 new patients a week, sometimes they will not see any new patients for weeks or more.
- Their schedules should be blocked to participate in meetings that allow them to participate in all-clinic or provider discussions.
- Anticipate that they will require at least one hour a day of blocked administrative time as their documentation is often more time-intensive than their primary care behavioral health colleagues.
- Many specialty mental health providers do not concurrently document. Many have more involved assessments than their primary care behavioral health colleagues.
- Generally, time is not built into their schedule for frequent or organic consultation with the rest of the care team.
- Anticipate that they will see 6-8 patients a day.

Collaborative Care Management Schedule

- Your psychiatric consultant and behavioral health care manager do not have set schedules. They will co-manage a small panel of patients along with the patient's Primary Care Physician and the psychiatric provider will work directly with the Primary Care Physician and behavioral health care manager to make evidenced based, targeted, treatment recommendations.
    - For example, the psychiatric consultant may meet with each Primary Care Physician and the behavioral health care manager for 1 hour/week and provide consultation on-site or via telehealth. The psychiatric consultant may also be available for e-Consults throughout the week.

Treatment course for Primary Care Behavioral Health

One Visit or Many

- While integrated behavioral health is often talked about as a short-term model of care, where patients are seen no more than 6 or 8 visits, it helps to conceptualize why this is and how it benefits clinics.
- It is helpful to think about the Behavioral Health Clinician as seeing patients in a similar fashion to a Primary Care Physician.

Primary Care Physician	Behavioral Health Clinician
Some patients may only need to come in for preventative care or when a straightforward problem arises (an upper respiratory infection, seasonal allergies)	Straightforward issues for a Behavioral Health Clinician include grief, diagnostic clarification, stress or adjustment issues, or care coordination (often with a school or outside mental health provider)
Others benefit from more regular care, particularly to address chronic health issues. These patients may be seen more frequently during the initiation of a new treatment, such as an insulin start, and then q3 months once they are stable.	Will also see a patient more frequently after diagnosis with a chronic condition, to assist with getting through a crisis, when quitting smoking or drinking alcohol. Only to see them less frequently after early stabilization has been achieved.
Other patients do a lot better (staying out of the emergency department, adhering to their treatment regimens) when they are seen frequently.	The Behavioral Health Clinician can see the patients who get on the Primary Care Physicians. schedule all the time (for issues big and small) every two weeks and act as a relieve valve for the Primary Care Physicians. limited availability and the support staff's ability to manage the patient over the phone.

One to Two Visits on Average

- Most patients are seen for only one or two visits. This is for myriad reasons.
    - Patients may have a discrete issue that can be ameliorated with limited intervention.
    - Patients need help seeking specialty care in the community and the Behavioral Health Clinician acts as a referral source.
    - Patients need diagnostic clarification either to inform their Primary Care Physician's choices or for their own knowledge.

One to Two Visits on Average (cont.)

- Patients may drop out of care because their lives are chaotic or because they are feeling somewhat better and no longer feel integrated behavioral health care is a priority.
- Patients may not be ready to engage in change for any number of reasons, but still benefit from knowing who they can contact when they do become ready.

Episodes of Care

- Like with their Primary Care Physicians, patients may see a behavioral health patient 1-6 times for a discrete issue and then not return to care again for months or years in order to address a different or recurring concern.
- Behavioral Health Clinicians do not "terminate" with patients in the way that specialty mental health providers do. They may bring an episode of care to a close, for example after helping a patient reduce insomnia, but patients remain welcome to reschedule later.
- Behavioral Health Clinicians often see patients during different phases of their lives. Just as in primary care, a Behavioral Health Clinician may see the same patient for enuresis as a preschooler, for an attention deficit hyperactivity disorder evaluation when that child is in elementary school, bullying in middle school, and test anxiety in high school.

Retention

How to Value Your Behavioral Health Clinicians Enough that they Stick Around

- Compensation and incentives modeling retention practices for Primary Care Physicians in perpetuity. Often, a health system will leave out Behavioral Health Clinicians while other providers may see greater performance incentives, retirement matching, or even short-term disability coverage. If these practices are uneven, Behavioral Health Clinicians will feel this acutely are likely to be driven to other settings that value them as fellow providers.

- Say thank you. Behavioral Health Clinicians will be seeing the highest acuity patients you have, back-to-back (to-back). Acknowledgement of this and appreciation (generally with words) goes a long way.

- Offer autonomy. If a Behavioral Health Clinician is meeting their productivity numbers, support them in making clinical judgments around how to structure their time in a way that best works for your clinic (so long as they are meeting the open access criteria).

- Recognize that they have a fund of knowledge that no one else in the clinic does. Behavioral Health Clinicians should be empowered to work to the top of their license. This includes them adding psychiatric diagnoses to the problem list or having their input valued when a case is fraught with complex ethical decisions.

- Offer them a seat at the table. Behavioral Health Clinicians are billing providers, not support staff. While they may never make as much money as their Primary Care Physician counterparts, they can be offered the opportunity to build their reputations and presence in the clinic to reflect their integral role on the care team.

Support your Behavioral Health Clinicians when they are asked to therapize clinic team members

- Support your Behavioral Health Clinician in declining to engage in providing mental health services to colleagues. They must empathically decline to engage to avoid burnout.

- Behavioral Health Clinicians can refer colleagues to a professional upon request but cannot be that professional.

- Behavioral Health Clinicians need to commiserate just as much as any other colleague. It is important that their relationships with team members are basically reciprocal.

Integrated Behavioral Health for Special Populations

Primary Care Behavioral Health Clinicians See Everyone

- Your Behavioral Health Clinicians will see most of your patients in the short term. However, these short-term interventions can still be highly impactful for patients needing a higher or more specialized level of care.

  - These populations include, but are not limited to:
    - Severe and persistent mental illness
    - Eating Disorders
    - Substance Use Disorders
    - Developmental Concerns
    - Obsessive Compulsive Disorder
    - Severe Anxiety
    - Treatment Resistant Depression
    - Patients in acute crisis requiring intensive support/partial hospitalization/hospitalization
    - Patients desiring bariatric surgery
    - Support for gender affirming care including surgery and hormone replacement therapy
    - Patients suffering from borderline personality disorder
    - Domestic Violence (both victims and perpetrators)

What do Behavioral Health Clinicians do for these Populations?

- **Severe and Persistent Mental Illness** - Behavioral Health Clinicians can act as the link between Primary Care Physician and community mental health. They can see these patients every 3 months to assure that they are engaging with their community mental health provider and to assess for stability, supporting patients and care teams as needed when a patient decompensates or otherwise requires additional support.

- **Eating disorders**- Behavioral Health Clinicians can help to assess level of need for these patients, assist with implementing in-clinic procedures including taking blind weights, encouraging Primary Care Physicians to regularly collect appropriate labs and vitals (orthostatic hypotension, electrocardiogram), supporting the patient in developing a less disordered relationship to food/exercise. They can help get patients into higher levels of care when needed, which is next to impossible for these patients without dogged advocacy (due to an enormous shortage of beds and patients generally being less worried about their issues than everyone else is).

- **Substance Use Disorders**- Behavioral Health Clinicians can help patients at various stages of change with motivational interviewing to help them move to a place of action. Additionally, they can help Primary Care Physicians assess the level of risk and provide the behavioral support if a Primary Care Physician initiates an outpatient detox regimen for a patient. Behavioral Health Clinicians can also help patients and families assess levels of need and recommend appropriate levels of care.

What do Behavioral Health Clinicians do for these populations? (cont.)

- **Developmental/Learning/Behavioral Concerns:** Behavioral Health Clinicians can help assess concern when patients are not meeting early milestones i.e., with gross motor, fine motor, speech, or social delays and help families get connected to early intervention services through the county and prompt referrals to developmental pediatrics as needed. Behavioral Health Clinicians diagnose attention deficit hyperactivity disorder and prompt schools to test for mathematics, reading, and writing disorders. Behavioral Health Clinicians can help families advocate for 504 plans, Individualized Education Plans, and consult with school counselors and teachers.

- **Obsessive Compulsive Disorder:** Obsessive Compulsive Disorder is often missed in a primary care setting unless a family member or other concerned person prompts the Primary Care Physician to this concern. Behavioral Health Clinicians are skilled at assessing these issues, which are often secretive and shameful for patients. While specialized treatment is often needed for Obsessive Compulsive Disorder, Behavioral Health Clinicians can prompt Primary Care Physicians to start medication regimens and help patients disclose the extent of their disabled functioning resulting from this debilitating problem.

- **Severe Anxiety:** Behavioral Health Clinicians can work on short protocols with patients to help reduce the severity of these symptoms while bridging them to care. They can also prompt Primary Care Physicians to prescribe based upon the patients most distressing symptoms and help guide what pain control management meds may be most appropriate for the patient.

- **Treatment resistant depression:** Behavioral Health Clinicians can take a very good history from patients to have a better understanding of whether their depression is truly intractable or if the patient has not had full therapeutic trials of prior therapies or medications. They can assist Primary Care Physicians in consulting with psychiatry for medication assistance. Additionally, they can help instill hope in patients while guiding them appropriately to interventional psychiatry (for Transcranial Magnetic Stimulation Therapy, esketamine, or ketamine), Electroconvulsive Therapy (ECT) clinics, or to other modalities to provide hope and relief.

- **Patients in acute crisis:** Psychiatric hospitalization worsens outcomes for all but a tiny subset of those in severe and acute distress[1]. Behavioral Health Clinicians can help assist patients and their support with safety planning and directly admitting them into intensive outpatient or partial hospitalization programs as needed.

- **Patients interested in bariatric surgery** are required to have behavioral health involvement and to have lost a certain amount of weight through diet and exercise before a surgeon will agree to operate (often 10% of their body weight). The Behavioral Health Clinician can help the patient begin this journey and assess how ready they may be for the rigors of the post-surgery recovery and dietary limitations.

What do Behavioral Health Clinicians do for these populations? (cont.)

- **Patients accessing gender affirming care:** Outside of urban areas these patients have very limited access to behavioral health support. Hormone replacement therapy is a primary care intervention. Primary Care Physicians often appreciate having a Behavioral Health Clinician assessment for gender dysphoria and to provide support for these patients, who have a markedly higher level of psychiatric distress than the general populations. Behavioral Health Clinicians can also provide surgery letters for these patients (any behavioral health professional with a master's degree or higher).

- **Borderline Personality Disorder:** Patients with Borderline Personality Disorder are often the most difficult for primary care settings to manage. Behavioral Health Clinicians can help the care team set therapeutic boundaries and scaffolding for these patients, support these patients through trauma informed care and evidenced based interventions, and connect these patients to dialectical behavioral therapy or mentalization based therapy.

- **Domestic Violence (victims):** Behavioral Health Clinicians can help patients connect to domestic violence community supports, provide supportive treatment to families, and engage these individuals with case management support.

- **Domestic Violence (perpetrators):** Behavioral Health Clinicians can help patients get connected to anger management services and encourage engagement in court-mandated treatments.

[1.] Qin P, Nordentoft M. *Suicide Risk in Relation to Psychiatric Hospitalization: Evidence Based on Longitudinal Registers. Arch Gen Psychiatry.* 2005;62(4):427–432. doi:10.1001/archpsyc.62.4.427

Documentation

Documentation for Primary Care Behavioral Health, Collaborative Care Management, and Co-located Psychotherapy

- Behavioral Health Clinicians should concurrently document their encounters.
- Behavioral Health Clinicians write their notes in the same chart as the rest of the care team. These notes are not "protected" any more than any other chart note.
- Notes are written with a sensitivity towards the Primary Care Physician as the primary reader.
- Just like with all other documentation in the Electronic Health Record, patients can read the Behavioral Health Clinician's notes.
- Notes should avoid psychotherapy jargon and are often based around plans and goals that have been co-created with the patient.
- Intake documentation is generally only slightly longer than follow up notes.
- Behavioral Health Clinicians do not write clinical reports for intakes, periodic reviews, or discharges. Thus, every note looks roughly the same.
- Notes are rarely time intensive for the experienced Behavioral Health Clinician.

Collaborative Care Management

- Notes are written by the behavioral health care manager, the consulting psychiatric provider, and the Primary Care Physician.
- See examples here
- The behavioral health care manager note mirrors a psychotherapy intake in co-located care. It is long, time intensive, and highly detailed around pertinent mental health, psychotropic medication history, and risk assessment.
- The psychiatric consultant's note is shorter. References that the psychiatrist/psychologist nurse practitioner/psychiatric nurse practitioner has not seen the patient directly but gathered the information from the collaborative care management care coordinator. Very brief assessment followed by plan for medication initiation and non-pharmaceutical interventions.
- The Primary Care Physician is the one who initiates contact with the Collaborative Care Management team through their documentation and writes the prescriptions as suggested by the team. They will drop appropriate documentation elements into existing office visit notes or telephone encounters as appropriate.

Co-located Psychotherapy

- Documentation is asynchronous from medical visit.
- Longer intake documentation with emphasis on getting a full developmental and psychiatric history.
- Follow-up documentation is often shorter, and at times very brief.
- Documentation written with a sensitivity towards protecting patient privacy, especially from those auditing charts (like insurers).
- Clinicians may keep their own additional notes as they formulate issues that omit from charting.
- Notes may be written in a separate Electronic Health Record or kept "behind the glass" where an extra password and justification for reading the note is required before viewing.
- Notes are generally not routed to Primary Care Physicians or other care team members.
- Intake documentation, periodic reviews, and discharge/termination summaries are time intensive and require ample administrative time.
- Note: while co-located notes are often siloed, this is far less than in cases where the specialty care is off site. Numerous benefits still exist for having a co-located specialty mental health provider in house.
- Documentation burden will be highest on co-located specialty mental health (especially in organizations operating under a Certificate of Approval) and on the behavioral health care manager in the Collaborative Care Management model. Their notes most closely mirror documentation in specialty mental health settings and can be easily translated into other settings that may often ask for these notes (other specialty mental health care providers). These notes are highly detailed, but often less easy to interpret for those outside of the specialty mental health world.
- Documentation burden should be the lowest on integrated Behavioral Health Clinicians and psychiatric consultants. Their notes should be pithy, readable, and pragmatic. They are usually not substantial enough to count as a "psychiatric evaluation" as may be required for a patient's social security application or court ordered evaluation.
- The learning curve is higher for Behavioral Health Clinicians to learn how to document in ways that are helpful to the rest of the care team and written without mental health jargon.

Documentation Examples

- Center for Integrated Care
- University of Montana
- APA divisions
- SOAP notes
- SOAP notes video

Elements of a Behavioral Health Clinician Note

1. Type of service (Behavioral Health Office Visit Note)

2. Time spent with the patient (should be exact to the minute)

3. Modality you saw the patient in (in person, video, by phone)

4. Documentation of informed consent being completed at this visit or previous visit

5. Which Primary Care Physician referred to your patient and what the referral reason was.

6. Visit diagnosis (what you are seeing them for today)

7. Assessment. How can others understand the patient's struggles and experience? Interventions used and the patient response to these interventions (can be incorporated into the assessment. Diagnosis and justification for diagnosis if you are the first one making it.

8. Plan (includes when they will be following up with you and goals of care)

9. Subjective**.** This is the narrative about the patient. What are they talking about in session? Be very detailed about medication and medical treatment compliance as well as risk, substance use, and physical symptoms.

10. Objective (Mental Status Exam)

11. Risk (or note that risk has been denied) which can be included in your mental status examination (MSE).

12. Your name and title should be somewhere on the note (likely auto-populated) as this shows that you are qualified to provide the service.

13. Justification for why the patient needs the service. This comes across in the distress they report in the subjective, your assessment of their needs in the assessment section, and your plan where you note when you will be seeing them again.

Interventions, Conditions Treated, and Scope

Behavioral Health Clinicians Provide Whole Person Care

- Generally, when patients feel empowered in one area of their life, this can helpfully translate into other areas of positive change.
- Thus, a patient referred for fatigue, may identify an early goal with their Behavioral Health Clinician of asking for more help from family members, engaging in energizing activities, or taking time for themselves: not just finding ways to get more sleep (which will also be addressed).
- Lifestyle interventions are central to what Behavioral Health Clinicians do. Improved sleep, diet, exercise, socialization, and hydration are all core to bettering patient health. Helping patients to set boundaries in other parts of their lives is also key.

Behavioral Health Clinicians Scope of Practice

- Behavioral Health Clinicians are experts on psychiatric assessment, diagnosis, and treatment. However, their job is much bigger than that.
- It can be an uncomfortable shift for clinics (and Behavioral Health Clinicians) new to this model to figure out what is within the Behavioral Health Clinicians scope as health and behavior change for ALL MEDICAL conditions are core to the work.
- Your Behavioral Health Clinician must learn and know about most common medical conditions to the degree that they can support the rest of the care team. This will mean that they are familiar with what constitutes a normal vital sign from a concerning or urgent one.
- This will also mean that Behavioral Health Clinicians are familiar with hemoglobin A1c's, the risks associated with increasing body mass index (BMIs), and signs and symptoms of a very concerning medical presentations ("the worst headache someone has ever had" or "chest pain radiating down my left arm").
- It may feel inappropriate for Behavioral Health Clinicians to hold even baseline medical knowledge.
- However, it is necessary that they know enough to partner with the care team on the patient's needs, especially when a patient is in danger.
- This is because our patients often feel like they have "come to the right place" by the time they are seeing anyone on the care team, regardless of training background or licensure and they often will give the Behavioral Health Clinician information that needs to be heard by their Primary Care Physician.

Behavioral Health Clinician Scope of Practice (cont.)

- Your Behavioral Health Clinician must be knowledgeable and astute enough to grab a clinic Registered Nurse or Primary Care Physician during a visit. You want to have someone who has good enough instincts to ask questions and, in non-urgent situations, augment the medical provider's plan for the patient with well thought out and researched advice:
    - "I know that Dr. Smith's first goal around weight loss is to support people in getting under a Body Mass Index (BMI) of 40 as we see worsened health outcomes when you are above this range. For you, that gives us an attainable goal of 10 pounds over the next 6 months, as we also know that if you lose the weight too fast it will be hard for you to maintain that progress."
    - "With the concussion with loss of consciousness that you just suffered a few days ago, I am sure that Dr. Patterson would be in support of our clinic providing you with a work accommodation to not be looking at your computer screen 8 hours a day. I will loop back with her to get you a note to provide for your job."
    - "You are sharing with me that you always forget your mid-day dose of your medication. Let me speak to your Primary Care Physician about whether there may be another way to dispense your medication (with an extended-release formulation) so that you are covered for the whole day.
    - Or your Behavioral Health Clinician may identify that a patient with severe nightmares may be a candidate for an alpha blocker but knows that a Primary Care Physician will want to have blood pressure reading on the patient in order to make this determination. Your Behavioral Health Clinician can ask a medical assistant to take the patient's blood pressure so that a Primary Care Physician can make an informed decision about whether this is a prudent idea.

Do and Don'ts of Behavioral Health Clinician's Practice

- Behavioral Health Clinicians should **never** provide medical directives.
- Behavioral Health Clinicians should **always** support the medical directives of the Primary Care Physician.
- Behavioral Health Clinicians should **never** provide medication advice to a patient.
- Behavioral Health Clinicians should know enough about psychotropic medications to prompt a Primary Care Physician to consider the choices they are making.
    - "I noticed that your patient is tolerating their Selective serotonin reuptake inhibitors (SSRIs), but not yet getting benefit after four weeks of treatment. They are open to going up on the med and would like to touch base with you further on whether this is appropriate."

Do and Don'ts of Behavioral Health Clinician Practice (cont.)

- "Your patient does not have major depressive disorder; their depression is 2/2 Post Traumatic Stress Disorder (PTSD). My understanding is that higher doses of their medication are often needed to address these symptoms. Would you like me to get them scheduled with you to discuss this further?"
- "Your patient disclosed some concerning recent substance use history with hypnotic medications and alcohol. It makes me wonder about their repeated requests for benzodiazepines and Lunesta with you and I do see that they recently filled a small prescription of zolpidem that was prescribed from urgent care. I shared with them that I would speak to you about all of this. How would you like to handle follow up?"

Behavioral Health Clinicians can act as Conduits for the Rest of the Medical Team

- A Primary Care Physician can give a directive to a patient through the Behavioral Health Clinician. For example, a Primary Care Physician can share with the Behavioral Health Clinician that they read a patient's message and want to wait on ordering imaging until the patient has completed physical therapy. Or they can tell the Behavioral Health Clinician to let the patient know that their labs were reassuring. Behavioral Health Clinicians can provide patients with information similar to how a medical assistant would: they do not dispense medical advice but can be utilized to reduce the number of 'touches' a patient has in your clinic.
- Behavioral Health Clinicians can pay attention to the patient's chart when they are in clinic and get a provider if the patient is due for an important lab, missed a call for the care team, or no showed a recent visit where the provider was planning on getting a data for the urine drug screen (UDS), orthostatic vitals, or even update their insurance information.

Behavioral Health Clinicians are Trained to Treat a Myriad of Health Issues

- Smoking Cessation
- Harm Reduction (often around substance use disorders)
- Treatment adherence (taking medications as prescribed or following other directives from Primary Care Physicians). This is helpful for patients with conditions like uncontrolled diabetes or asthma.
- Pain management.
- Weight loss, improving eating habits, and increasing exercise.
- Coming to terms with terminal or debilitating illnesses.
- Insomnia.
- Improving distress tolerance (when a patient has a troubling or partially disabling condition).

Behavioral Health Clinicians Specialize in Ambiguity

- Patients often have symptoms without known etiology.
- Some will never have a conclusive diagnosis, or they will receive a diagnosis of exclusion.
- These patients are often the hardest for Primary Care Physicians to manage because they want both "answers" and a "fix" when neither may be available.
- Behavioral Health Clinicians help patients tolerate ambiguity and rediscover what control they may have in their lives.
- Additionally, they help the patient focus on lifestyle interventions that may reduce how central their symptoms are in their life.

Behavioral Health Clinicians and Mental Health Issues

- Depression, anxiety, stress, trauma, and adjustment are the "bread and butter" of Behavioral Health Clinician practice.
- Behavioral Health Clinicians can identify attention deficit and hyperactivity disorder and are an important first step for patients with learning disabilities, autism spectrum issues, and other developmental delays.
- Behavioral Health Clinicians are also skilled at diagnosing more severe mental illness such as schizophrenia or bipolar I disorder.
- They can diagnose less common presentations such as Obsessive Compulsive Disorder or cyclothymic disorder.
- Behavioral Health Clinicians are well versed in supporting patients and care teams in managing personality disorders. Not only can they provide some initial treatment for these patients, but they can help the care team create therapeutic boundaries and appropriate expectations.

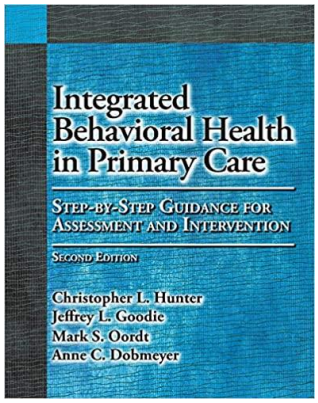
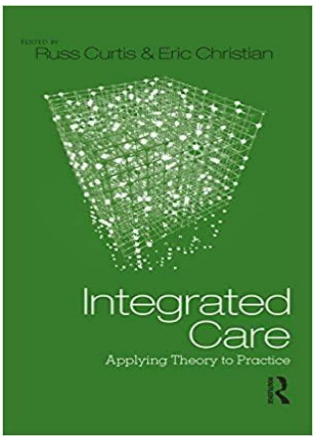
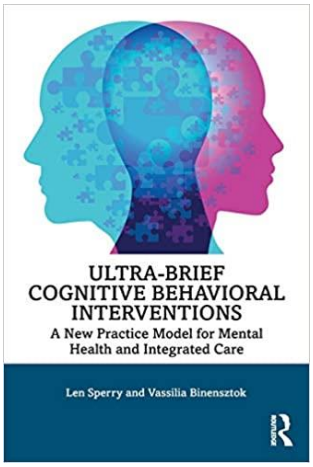
Intervention Types

- Behavioral Health Clinicians are skilled at motivational interviewing, supportive techniques, cognitive restructuring, and manualized treatments.

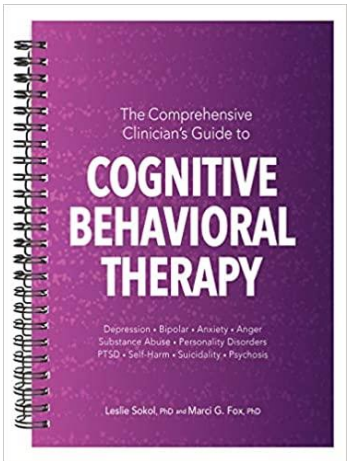
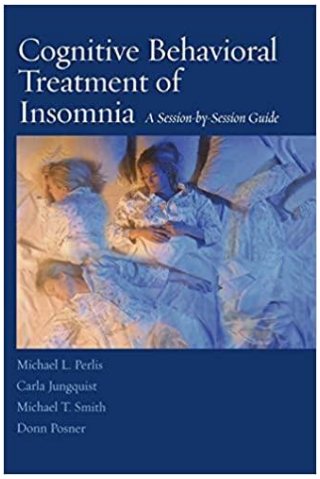
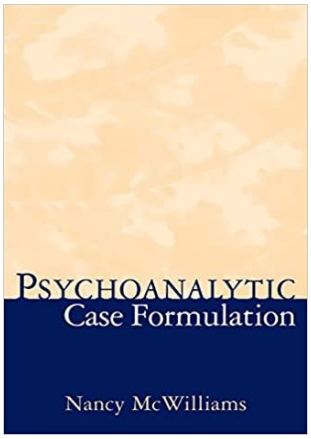
- Interventions that focus on evidenced based mental health treatment modalities (cognitive behavioral therapy, mindfulness-based treatments, acceptance and commitment therapy, behavioral therapy, relational therapy such as supportive psychotherapy or interpersonal psychotherapy). Note that most interventions can be well adapted to shorter term treatment, including psychodynamic psychotherapy.

- Your Behavioral Health Clinician will generally identify with a certain school of thought (therapeutic orientation) from their training. It is not important what orientation they have, only that they have a deeply rooted way of thinking about patients *and* that they are willing to be flexible in their approach to patient care.

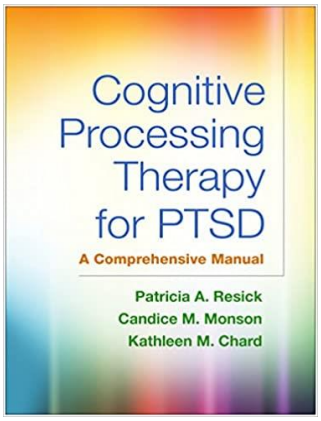
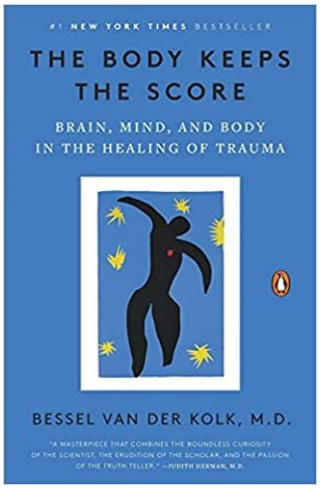
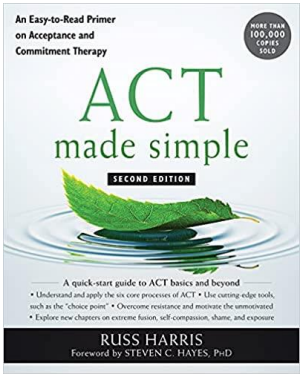
Helpful Intervention Guides

	**Integrated Behavioral Health in Primary Care: Step-By-Step Guidance for Assessment and Intervention** by Christopher L. Hunter (Author), Dr. Jeffrey L. Goodie PhD (Author), Mark S. Oordt (Author), Anne C. Dobmeyer PhD ABPP (Author)
	**Integrated Care** by Russ Curtis (Editor), Eric Christian (Editor)
	**Ultra-Brief Cognitive Behavioral Interventions: A New Practice Model for Mental Health and Integrated Care** by Len Sperry (Author), Vassilia Binensztok (Author)

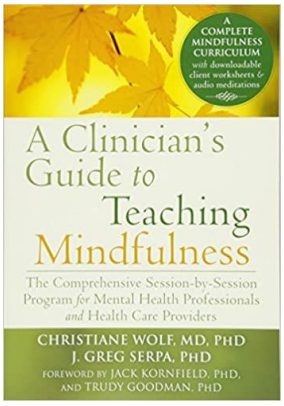
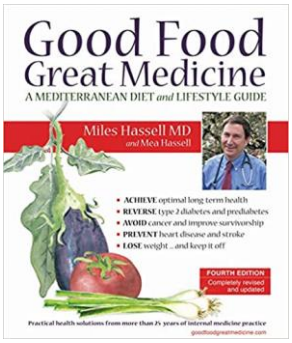
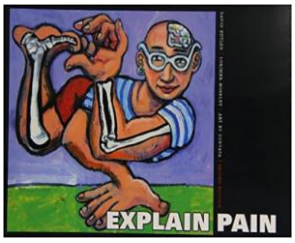
Helpful Intervention Guides (cont.)

	**The Comprehensive Clinician's Guide to Cognitive Behavioral Therapy** by Leslie Sokol (Author), Marci Fox (Author)
	**Cognitive Behavioral Treatment of Insomnia: A Session-by-Session Guide** by Michael L. Perlis (Author), Carla Jungquist (Author), Michael T. Smith (Author), Donn Posner (Author)
	**Psychoanalytic Case Formulation** by Nancy McWilliams (Author)

Helpful Intervention Guides (cont.)

	**Cognitive Processing Therapy for PTSD: A Comprehensive Manual** by Patricia A. Resick (Author), Candice M. Monson (Author), Kathleen M. Chard (Author)
	**The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma** by Bessel van der Kolk M.D. (Author)
	**ACT Made Simple: An Easy-To-Read Primer on Acceptance and Commitment Therapy** by Dr. Russ Harris (Author), Steven C. Hayes PhD (Foreword)

Helpful Intervention Guides (cont.)

	**Clinician's Guide to Teaching Mindfulness** by Christiane Wolf (Author)
	**Good Food, Great Medicine: A Mediterranean Diet and Lifestyle Guide** by Miles Hassell MD (Author), Mea Hassell (Author)
	**Explain Pain** by David Butler; Lorimer Moseley (Author)

Billing and Coding

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Behavioral Health Clinicians Must Bill

- Some practices find the prospect of billing for behavioral health so convoluted or different than traditional medical billing that they default to not billing at all.
- While relative value units for Behavioral Health Clinicians work are less substantial than visits of equal commitment by Primary Care Physicians, the relative value units do add up.
- Even the most valuable team player will struggle with maintaining relevance without a way to monetize their services.
- The key is to understand how to bill correctly.
- Behavioral Health Clinicians must be adept at billing for their services, helping ensure financial sustainability and longevity in your clinic.

General Billing and Coding Principles

- Visits are coded in two different ways depending upon what diagnosis is primary.
- Every visit (beyond 16 minutes) will be billed with either **psychotherapy codes** (primarily 90832 and 90834) or **health and behavior codes** (primarily 96156 and 96158). These are your base codes for everything taking 16 minutes or more.
- If the primary diagnosis is a **mental health issue** (F codes in the ICD 10/ 290-319 in the ICD-9), your Behavioral Health Clinician will bill for **psychotherapy codes.** These included 90791, 90832, 90834, and 90836.
- If the primary diagnosis is for **any other issue**, your Behavioral Health Clinician will bill **health and behavior codes** (HBAI). These are 96156-96171.

General Billing and Coding Principles (cont.)

- If a visit is for both a mental health and a medical issue, the most focused area of the session will determine how the visit is billed.

- Intake (90791)/Initial Assessment (96156) visits are not time based but require a higher burden of documentation than follow up visits that use time-based codes.

    - A 90791 requires a comprehensive clinical interview with clinical history, which is hard to achieve in 30 minutes. When you have had a first encounter without a complete mental health and family history, use 90832 instead of 90791.

- Other codes, such as crisis intervention (90839) require a minimum of 30 minutes of intervention time. You must be able to substantiate that a patient is in a situation with considerable risk and need for imminent intervention.

- You can use interactive complexity code (90785) with psychotherapy codes, but not with crisis codes. See related interactive complexity link.

- Some add-on codes can increase relative value units (and thus billing). These include Screening for Brief Intervention and Referral to Treatment (SBIRT) and smoking and tobacco counseling. Codes: 99406-99409.

- Other codes do not increase relative value units but may be meaningful to show what you are doing (for the purposes of pulling data later or proving the value of integrated behavioral health in your clinic). These include developmental screeners for children and brief emotional screening, such as a Patient Health Questionaire-9 (PHQ-9). Codes 96110, 96127.

- Choosing whether to use psychotherapy codes versus health and behavior codes is about what problem is primary. Often you are addressing both, so both your clinical judgment and your documentation must reflect which you believe is primary. You do this by marking a primary diagnosis in the note, emphasizing this diagnosis in your assessment, and generally having this be the “meat” of your subjective section. If it is truly an even split between health and behavior change and mental health (which is rare), it is reasonable to emphasize the mental health coding. Your primary diagnosis does not have to be consistent with the referral reason. However, there should be some explanation of why, for instance, focusing on the patient’s depression became more prominent than exploring their diabetes (especially if this is why they were referred to you).

- All other psychotherapy (90832, 90834, and 90836) and Health Behavior Assessment and Intervention visits (96158-96171) are time based.

- In general, warm hand-offs that are “meet and greets”, consultations, and charting are not billable.

- Care coordination of 20 minutes or greater may be billable (see 99484).

General Billing and Coding Principles (cont.)

- Smoking cessation and alcohol use reduction may be billable and can be added onto a psychotherapy or Health Behavior Assessment and Intervention visit.
- Using screeners for developmental issues (in children) or brief emotional screeners for adults may not be billable but can be coded for tracking purposes.
- Crisis visits (must be at least 30 minutes long) have higher relative value units.
- Interactive complexity codes (for a high intensity visit) can be added to a psychotherapy visit (see 90785). They cannot be added to a crisis visit.
- Family interventions (with and without the patient present) are typically billable for Health Behavior Assessment and Intervention visits. Coverage is variable for family interventions for a primary psychiatric issue.

Coding 101		
Always	**Added Relative Value Units**	**Added for data, no Relative Value Units**
Psychotherapy (90832, 90834)	Screening, Brief Intervention, & Referral to Treatment; SBIRT (99408 and 99409)	Developmental Screening (96610)
Health Behavior Assessment and Intervention (96156, 96158, etc…)	Tobacco Cessation (99406 and 99407)	Behavioral Health Screening (96127)

Billing for Collaborative Care Management

- Note that collaborative care management codes include time for the Primary Care Physician, behavioral health care manager, and the psychiatric consultant. Helpful tables and explanation.
- G2214 30 minutes in ANY month of collaborative care management services.
- 99492 First 70 minutes in first calendar month of collaborative care management services.
- 99493 First 60 minutes in any subsequent calendar month of collaborative care management services.
- 99494 Each additional 30 minutes in any calendar month of collaborative care management services.
- G Codes for Federally Qualified Health Centers / Rural Health Centers Practices:
  - G0512 Minimum 70 min initial month and 60 min subsequent months of collaborative care management services.
  - G0511 20 or more minutes/month of General Care Management, including activities previously billed as Chronic Care Management (99490 or 99487).
- Another helpful resource

Coding

Integrated Behavioral Health Coding Summary

Integrated Behavioral Health Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
Add-On Collaborative Care Management (Any month) (Current Procedural Terminology, CPT code 99494)	Each additional 30 minutes per calendar month	13 minutes
Integrated Behavioral Health Initiating Visit (Annual Wellness Visit, Initial Preventative Physical Examination, Transitional Care Management, or other qualifying Evaluation and Management Visits)[+]	n/a	Usual work for the visit code
Collaborative Care Management First Month (CPT code 99492)	70 minutes per calendar month	30 minutes
Collaborative Care Management Subsequent Months** (CPT code 99493)	60 minutes per calendar month	26 minutes
General Behavioral Health Integration (CPT code 99494)	At least 20 minutes per calendar month	15 minutes
Initial or subsequent psychiatric Collaborative Care Management (Healthcare Common Procedure Coding System, HCPCS Code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

** Collaborative Care Management is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no Collaborative Care Management for 6 consecutive months)

[+]Annual Wellness Visit, Initial Preventative Physical Examination, Transitional Care Management services.

Insurance Coverage

- Mental health parity, despite being law, is not yet a reliable reality.
- How well insurers will reimburse your Behavioral Health Clinician's claims is variable and often hard to gauge ahead of submitting a charge.
- Medicare covers Behavioral Health Clinician and Collaborative Care Management services for Licensed Clinical Social Workers (LCSWs), Doctor of Psychology (PhDs, PsyDs), and psychiatric providers (Medical Doctors, Doctors of Osteopathic Medicine, Physicians Assistants, and Nurse Practitioners).
- Some insurers continue to "carve out" coverage for mental health issues, despite this practice being identified as a systemic barrier to integrated care.
- Some private insurers treat behavioral health services in the same way they do other specialty care, possibly resulting in large out of pocket expenses for patients.
- Encouraging patients to check with their insurers is paramount if they are concerned about being charged for Behavioral Health Clinician services.

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Track Your Billable Encounters over a 3-month period (to understand what is being reimbursed or not)

	Insurer 1	Insurer 2	Insurer 3	Insurer 4	Insurer 4
99406					
99484					
90832					
90834					
90839					
96156					
96158					

Screening

Behavioral Health Clinician Screeners

- Behavioral Health Clinicians use numerous screeners to get a baseline on a patient's struggles as well as to assess progress (or decline) over time.
- Behavioral Health Clinicians are trained to use screeners as tools to guide treatment, not to rely on them for diagnosis.
- Many screeners are good at capturing distress and less reliable at capturing a diagnosis. However, they are still useful tools and a skilled Behavioral Health Clinician will be able to appreciate what it means when a patient endorses every screener in a pan-positive way, whereas other patients may under-report their issues.
- Tools such as the Mood Disorder Questionnaire are great for ruling out bipolar disorder (if negative), but far less reliable at ruling it in.
- Patient Health Questionaire-9's (PHQ-9s) are likewise a good tool for capturing depressive symptoms, but do not provide confirmation of a major depressive disorder diagnosis.

Links to Common Screening Tools

Depression and Suicidality

- Depression Screening/PHQ-9
- Adolescent Depression Screener/PHQ-A
- Geriatric Depression/GDS (Short Form)
- Columbia-Suicide Severity Rating Scale/ C-SSRS

Bipolar Disorder

- Mood Disorder Questionnaire (for ruling out bipolar d/o)/MDQ

Anxiety and Trauma

- Generalized Anxiety Disorder Screening/GAD-7
- Post Traumatic Stress Disorder/ PTSD/PCL-5
- Adverse Childhood Experiences/ACE Questionnaire

Links to Common Screening Tools (cont.)

Attention Deficit Hyperactivity Disorder (ADHD)

- Vanderbilt Attention Deficit and Hyperactivity Disorder (in childhood)
- Adult ADHD Self Report Scale/ASRS v1.1
- Wender Utah Rating Scale (for Adult ADHD) WURS
- Weiss Functional Impairment Rating Scale (for Adult ADHD) WFIRS-S

Cognitive Screeners for MCI and Dementia

- Montreal Cognitive Assessment/MoCA
- St Louis University Mental Status/ SLUMS

Access and Referrals

- Your Behavioral Health Clinician will play a critical role in determining both level of care and specificity of care for your patients. Many behavioral issues can be handled in-house, at least to the point of immediate stabilization and assessment. However, unlike other primary care services, your Behavioral Health Clinicians' job is to assess the needs of your patients and to determine when (and with what speed) they should be evaluated by a specialist. Also, much like the role of Primary Care Physician, your Behavioral Health Clinician will bridge the patient until they are fully connected with other services. Behavioral Health Clinicians will often also schedule infrequent follow-up or check-ins with patients to assure that they remain appropriately engaged with specialty care.

- Your Behavioral Health Clinician will try and treat as many patients as they can, triaging need and assessing for readiness/ability to benefit from treatment while balancing having open access in their schedule.

- This tension must be managed expertly. We recommend that Behavioral Health Clinicians have open access every day for crisis care. Additionally, they must have access to scheduled follow-up visits within 2-3 weeks.

Triaging Need

- Many patients benefit from just one integrated behavioral health visit. Behavioral Health Clinicians will work to establish rapport and create goals with patients as quickly as possible. They will then leave follow up "open" if the patient does not have a clear need for continued care.

- Most other patients need only a short course of care, 1-6 visits. For these patients, Behavioral Health Clinicians will generally schedule follow up visits every 2-4 weeks.

- A small number of patients need more frequent or intensive services to bridge them to longer term care or get them through a crisis.

Crisis Care

An appointment analogy might be your patient with hyperemesis gravidarum. You may see this patient every other day in your clinic to give them fluids, optimize their antiemetics while they are at the height of their struggles, and help them implement behavior changes to reduce their distress. You may send them to urgent care or the emergency room for management if they cannot go through the weekend without care, but you only make this choice after exhausting primary care options. Your Behavioral Health Clinician will follow a similar strategy with a severely and actively suicidal patient who is at high risk but denies imminent intent. They may see this patient 2 or even 3 times a week, create a comprehensive safety plan, and attempt to get them through the crisis without a hospital visit. If necessary, they may refer them to an intensive outpatient program and will also provide them with crisis line information for after-hours needs.

Referrals to Specialty Care

Certain mental health conditions require ongoing support (in perpetuity) and others require specialized targeted treatment.

The first situation falls into the category of how primary care may approach other complex chronic illnesses, such as having endocrinology follow patients with Type I diabetes or infectious disease follow patients with Human Immunodeficiency Virus (HIV). Patients with severe and persistent illnesses such as schizophrenia or bipolar I disorder generally need this level of care.

Patients who require specialized, targeted treatment include patients with obsessive compulsive disorder (OCD), treatment resistant depression (who may benefit from Transcranial Magnetic Stimulation, electroconvulsive/shock therapy, or esketamine), or patients with Post Traumatic Stress Disorder (PTSD) who may benefit from cognitive processing therapy or neurofeedback. These patients will benefit from treatment that generally lasts months, not years, and results in a marked reduction of symptoms.

There is a final category of patient who really benefits from long-term psychotherapy. For some, having an ongoing therapist that they see weekly, or biweekly is part of self-care. This can be especially pertinent for patients struggling with relational issues, complex trauma, and attachment issues.

Resources Your Behavioral Health Clinician and You Can Access

There is an enormous shortage of mental health providers of all kinds. The most extreme shortage is among psychiatry providers. This is further exacerbated for pediatric populations and in rural areas. Your clinic may not have the resources for an imbedded psychiatry provider or to start a Collaborative Care Management program. Oregon Health and Science University's (OHSU) psychiatric access line (OPAL) for children, adolescents, and adults (OPAL-K and OPAL-A) is an invaluable resource in Oregon. With the benefit of good diagnosis from your Behavioral Health Clinician and the advice from an OPAL psychiatrist, many Primary Care Physicians feel empowered to prescribe and manage complex presentations.

Databases for Finding Psychotherapists and Prescribers

- Your Behavioral Health Clinicians or behavioral health navigator can help patients find long term treatment options through online databases including:
    - Psychologytoday.com
    - Portlandtherapycenter.com
    - Insurance Company Websites

- It is worth having your Behavioral Health Clinician do an intake to determine need and help a patient figure out who the right fit might be for them for ongoing treatment.

- With wide adoption of telehealth, your patient can be seen by any provider licensed in Oregon, regardless of their location. Many intensive programs (such as dialectical behavior therapy or an intensive outpatient program) are being held over secure video platforms.

Oregon Health Plan Databases for Specialty Behavioral Health

- CareOregon
- IHN
- PacificSource
- Eastern Oregon
- Trillium
- Jackson Care Connect
- Advanced Health
- Cascade Health Alliance
- Allcare Health
- Umpqua Health
- Yamhill Community Care
- Columbia Pacific

Understanding Specialty Mental Health Care in the Community

- Mental health parity, while law, does not yet exist. Specialty mental health services operate with different rules than any other kind of medical service our patients can access in our communities. Appropriately navigating these systems, which are largely disjointed and broken, takes advocacy, persistence, and considerable literacy.

- The options available to your patients may be limited and their quality may not be reliable. However, specialty mental health services still serve an important role, and the goal is to utilize the existing resources to the extent they can be accessed and to continue to press for more.

- Specialty/outside mental health is divided into community mental health clinics, private practices, and group practices. What your patient can access is determined first by their insurance coverage and second by their presenting issue (and the severity of this issue).

Private Practitioners, Group Practices, and Community Mental Health Clinics

- Counselors and psychotherapists in private practice may take private insurance or be self-pay. It is important to understand that reimbursement for private practitioners from insurance companies is often low while the documentation/auditing requirements are high. Thus, many private practitioners opt out of taking some (or all) insurance because it is not sustainable. Providers may see patients on a sliding scale, however. Note that those that state that they take Oregon Health Plan (OHP) only do so with prior authorization, which will be explained in further depth below. Anticipate variable quality of care and care coordination with these individuals. Behavioral Health Clinicians (and/or referral coordinators) should try to develop relationships with these providers when possible, in order to improve the quality of referrals made from your clinic.

Private Practitioners, Group Practices, and Community Mental Health Clinics (cont.)

- Most group practices take health insurance, but often do not take all insurance. These practices may have a formal referral partnership with your clinic if your Behavioral Health Clinicians have developed a relationship. Some group practices also support trainees who bill less or take a limited number of Oregon Health Plan patients and patients referred in the late summer are most likely to get a spot as this is when their training year begins.

- Patients with Oregon Health Plan/Medicaid may have limited options for mental health and substance abuse care. See the links to your Coordinated Care Organization above for your listed community mental health clinics. Your patient can self-refer to a community mental health clinic but may benefit from having a care team member at your clinic set up the intake appointment. Patients may experience long wait times, infrequent care, frequent turnover of counseling staff, and very long waits to access psychiatry (6-9 months is not uncommon).

- Remember, a release of information is not required for care coordination purposes unless you are communicating with a substance abuse treatment facility that is subject to title 42 of the Code of Federal Regulations (CFR). Nonetheless, some providers and outside entities such as schools, may still request an Release of Information.

Intensive Services and Specialized Specialty Care

- Patients with the Oregon Health Plan will be able to access emergency services (emergency department and hospitalization) for a psychiatric crisis just like any patient with private insurance.

- However, this is often not the case for partial hospitalization, intensive outpatient, or any level of services beyond basic outpatient. See exceptions below regarding substance use treatment. Patients require a treatment authorization request, which your Behavioral Health Clinician can assist with. This is a form, accompanied by a psychiatric evaluation, showing that the level of care is warranted.

- Services such as dialectical behavioral therapy (often utilized for borderline personality disorder) or eating disorder treatment also generally require a treatment authorization request. However, your Coordinated Care Organization may have less restrictive rules and your Behavioral Health Clinician is encouraged to call the specialty provider they plan to refer the patient to, in order to learn whether a treatment authorization request is required.

Substance Use Care

- There may be fewer barriers to getting into substance use disorder care, but it is still not easy. Patients who require detox and have the Oregon Health Plan will often have to wait in line to be served, which is a high barrier for care. Patients who require residential treatment can access this treatment more quickly for substance use disorder services than for psychiatric issues but must need this level of care to qualify. Anticipate that your patient may have to travel far distances if you are in a rural community and may need to ultimately go out of state. This is especially the case with adolescents.

Substance Use Care (cont.)

- Substance use disorder care is kept at an even higher level of confidentiality than other mental health services. Thus, getting a release of information is needed that you can help manage the patient's care after discharge.

- Due to the shortage of Substance use disorder care, having providers who provide medication assisted treatment (MAT) is paramount. Your Behavioral Health Clinician can help you create a robust MAT program by providing substance abuse intakes/ American Society of Addition Medicine (ASAM) or chemical dependency support groups.

Reporting, Metrics, and Quality Improvement

Reporting and Metrics

- Your clinic should develop a robust dashboard to measure the success and outcomes of your integrated care program. Examples to consider include:
    - # of billable encounters a Behavioral Health Clinician has each day.
    - # of Behavioral Health Clinicians' encounters that were warm hand-offs or scheduled same day.
    - Population Reach: The number of unique patients seen by your Behavioral Health Clinician is divided by the number of unique patients seen in your primary care clinic. This includes billable and non-billable encounters (warm hand-offs, brief interventions).
    - # of patients your Behavioral Health Clinician is reaching with certain high-risk conditions (i.e., patients with an A1C over 9, patients who are smoking, patients with a positive screening, brief intervention and referral to treatment (SBIRT), patients with attention deficit hyperactivity disorder, or patients with a chronic pain disorder.
    - Demonstrating that your Behavioral Health Clinician has 50% or more of their schedule open for activities outside of pre-scheduled appointments (i.e., consultations, participating in clinic huddles, warm hand-offs, and quality improvement activities).
    - Depression remission or reduction (e.g., 50% reduction in Patient Health Questionaire-9/PHQ-9 score).
    - The ratio of full-time equivalent between your Behavioral Health Clinician and Primary Care Physicians. Integrated Behavioral Health Alliance standards call for a minimum of 1:6 ratio.

Quality Improvement

- Your Behavioral Health Clinician should always seek to make their services more targeted, helpful, and clinic centered.
- Your Behavioral Health Clinician, with support from your clinic, is strongly encouraged to examine ways that they can better tailor their care to your unique population.
- The Primary Care Behavioral Health model is an important framework that helps to delineate traditional mental health services (which serve very few) from an integrated and dynamic team-based care model. However, there is room for your Behavioral Health Clinician to experiment with optimizing their patient and whole team care. Championing these efforts will result in a happier Behavioral Health Clinician and a more enduring integrated behavioral health program in your clinic.

Appendix A – Resource Links

Integration Resources

- A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers
- Oral Health, Mental Health, and Substance Use Treatment: A Framework for Increased Coordination and Integration

Substance Use Resources

- Enhancing Motivation for Change in Substance Use Disorder Treatment
- Best Practices in Primary Care – Tips For Treating Alcohol Use Disorder
- Quick Guide for Clinicians – A Guide to Substance Abuse Services for Primary Care Clinicians.

Trauma Informed Care Resources

- Trauma-Informed Care in Behavioral Health Services (ohsu.edu)

Pandemic Resources

- Building Resilience Among Physical and Behavioral Healthcare Providers During a Global Health Pandemic Mental
- COVID-19 And Mental Health: A Growing Crisis

Appendix B – 2021 OPCA BHI Billing Assessment

Oregon Primary Care Association Behavioral Health Integration Billing and Reimbursement Experiences Project

Project Background

The Oregon Primary Care Association (OPCA) regularly convenes the Behavioral Health Leaders Peer Group from Federally Qualified Health Centers (FQHC) across Oregon. The group reports significant variance in integrated behavioral health billing and reimbursement practices by Coordinated Care Organizations (CCO).

In response to these anecdotal reports, OPCA contracted with Creach Consulting, LLC to better understand and document the range of behavioral health billing and reimbursement experiences for community health centers (CHC) across the state. This report strives to understand and highlight how CCO payment practices impact integrated care delivery models, financial sustainability, and patient care.

A total of six CHCs representing different CCO regions participated in the project. Creach Consulting, LLC developed a survey to gather specific billing and coding information and conducted semi-structured interviews with staff at each CHC.

Participating Federally Qualified Health Centers:

- Aviva Health
  CCO: Umpqua Health Alliance
- Klamath Health Partnership
  CCO: Cascade Health Alliance
- One Community Health
  CCO: PacificSource Columbia Gorge
- Outside In
  CCO: HealthShare/ CareOregon
- Waterfall Community Health Center
  CCO: Advanced Health
- Winding Waters Clinic
  CCO: Eastern Oregon

As confirmed by this project, we found significant variation in both behavioral health delivery models and billing and reimbursement experiences across the CHCs. The lack of a standard payment approach across CCOs results in a tenuous financial situation and inconsistent access to integrated behavioral health services for patients and families. Further, there is concern that some CCOs may be taking advantage of Oregon Health Authority's (OHA) approach to paying CHCs to save money in their own global budgets.

Key Takeaways

- Oregon's CCO model, which supports local innovation and control, has distinct benefits but also leads to significant variation in payment practices and access to integrated care.
- Most of the CHCs interviewed reported that the OHA "wrap" payment is providing all or a significant amount of funding for behavioral health services, representing cost-shifting from the CCOs back to the state.
- Financial sustainability for integrated behavioral health requires both CHCs and CCOs to be intentional about their vision, program design, and billing and reimbursement strategy.

Recommended Actions

1. To improve access to evidence-based fidelity integrated care models and standardize billing practices, the Oregon Primary Care Association (OPCA) should consider engaging subject matter experts to provide technical assistance and training to community health centers.
2. With coordinated care organizations (CCOs) now required to move more reimbursement into value-based payment approaches, it may be appropriate to reconsider the Alternative Payment and Advanced Care Model (APCM) and prospective payment system (PPS) payments, including assessing the impacts of cost-shifting from CCOs back to the Oregon Health Authority (OHA).
3. OPCA could play an important role in engaging OHA and CCOs to advocate for sustainable payment approaches to support integrated behavioral health at CHCs.

Relationships Between Community Health Centers, CCOs, and Community Mental Health Programs

The six community health centers (CHCs) that participated in this project reported a wide range of experiences with their local CCOs. CHCs that reported positive relationships with their CCO also reported less restrictive and more supportive CCO behavioral health reimbursement practices. They also reported more frequent interactions with the local CCO staff specifically related to integrated behavioral health, indicating that intentionality is a key component for supporting integrated care.

Some CHCs signaled they would like to see more collaboration and communication from their local CCO to support behavioral health integration, while others reported working very closely with their CCO and feeling very supported.

When it comes to relationships with local Community Mental Health Programs (CMHP), significant variation was also reported. Some CHCs reported positive, cooperative, and non-competitive relationships with local CMHPs. Other CHCs reported a more complicated relationship with no incentive to work together and felt the clear message they are given is to "stay in their lane." A more competitive relationship may emerge when CCOs restrict the amount of funding allocated to behavioral health care, resulting in CMHPs viewing CCO reimbursement for integrated behavioral health care as reducing their own budget. The new version of CCO contracts ("CCO 2.0") was intended to remedy this situation by disallowing CCOs from setting a limit for behavioral health services within their global budget[1]. However, it is unclear if CCOs are in compliance with this requirement and in some regions a competitive relationship persists.

Regardless of a cooperative or more complicated relationship with their local CMHPs, all six CHCs consistently reported frustration with long wait times when referring patients to specialty behavioral health services, particularly for psychiatry.

[1] CCO Contract Effective Oct. 1, 2019, Exhibit M, 2.a. "Contractor shall not set a limit for Behavioral Health services within the Global Budget."

Behavioral Health Billing and Coordinated Care Organizations (CCOs) Payment Practices

Community Health Centers (CHCs) in Oregon receive Medicaid payments from their local CCO and directly from the Oregon Health Authority (OHA). CHCs receive a Prospective Payment System (PPS) rate from OHA and may also participate in Oregon's Alternative Payment Methodology (APM) Program or Alternative Payment and Advanced Care Model (APCM). These programs pay health centers a prospective per-member-per-month (PMPM) payment for Medicaid members who are not enrolled in managed care through a local CCO and for Care STEPs (Services that Engage Patients). The Care STEPs are high-value, patient-centered services that may not result in an otherwise billable encounter to the CCO.

Currently, services provided for mental health or substance abuse as the primary diagnosis are carved out of the APCM program and are reimbursed by the local CCO and by OHA via the PPS payment. This means that when a mental health or substance abuse service is rendered for a CCO member, the CHC bills the patient's CCO and will receive reimbursement for those services. However, if the amount received from the CCO is less than the PPS rate, OHA will pay the CHC additional money to make up the difference so the total reimbursement will equal the PPS rate. This is commonly referred to as a "wrap around" payment and includes services provided by all licensed clinicians including primary care providers and behavioral health clinicians (BHC).

During interviews with participating CHCs, the "wrap" payment from OHA was mentioned frequently as the sole reason why integrated behavioral health services were financially possible. There is concern that some CCOs may be taking advantage of this system by under-paying for behavioral health services to save money in their own global budget, knowing that OHA will provide the "wrap" payment to CHCs. With CCOs now required to move more reimbursement into value-based payment approaches, it may be appropriate to reconsider the APCM and PPS payments and evaluate the extent of cost-shifting from CCOs back to OHA.

Regardless of the APCM and PPS payments, CCO reimbursement remains a critical factor for creating financially sustainable integrated care at health centers. However, the interviews for this project revealed significant variation both in CHC billing practices and CCO reimbursement approaches. These differences result in vastly different experiences for patients and families in terms of the amount and type of behavioral health services available to them.

Contracting Structure

Winding Waters CHC reported that their local CCO, Eastern Oregon CCO, delegates the behavioral health benefit to a separate organization, GOBHI, resulting in the CHC having to hold two separate contracts – one for "physical" health with the CCO and one for "mental" health with the delegated entity (GOBHI). The practice of "carving out" or delegating the behavioral health benefit to a separate organization is well-known to result in fragmentation and increased administrative burden. In fact, in response to stakeholder feedback during CCO 2.0 policy development, OHA now requires CCOs to maintain responsibility for behavioral health services[2]. Oregon's Primary Care Payment Reform Collaborative also developed consensus recommendations to support effective behavioral health integration and explicitly calls for the elimination of behavioral health carve-out practices by health plans3. However, given OHA's lack of oversight and enforcement to-date, it appears this practice persists.

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[2] CCO Contract Effective Oct. 1, 2019, Exhibit M, Section 1.a

[3] Oregon's Primary Care Transformation Initiative, 2018 Progress Report. https://www.oregon.gov/oha/HPA/dsi-tc/SB231%20Meeting%20Docs/PCPRC2018Report-1.28.19.pdf

In the Portland metropolitan area, HealthShare Coordinated Care Organization (CCO) delegates Medicaid insurance benefits to several different health plans. Under this structure, the health center Outside In must execute separate Medicaid contracts with each of these delegated entities including CareOregon, Oregon Health and Sciences University (OHSU), and Providence. In addition, Outside In also contracts with Trillium CCO. This arrangement creates administrative complexity and fragmented reimbursement for their Medicaid patients. It was reported that one of the HealthShare delegates, Providence, was utilizing the carve-out Optum to manage behavioral health benefits but that as of January 1, 2021 it was eliminated and Outside In was, at the time, unsure how to bill for behavioral health services. Another particularly troubling aspect reported by Outside In is the narrow specialty behavioral health provider networks to refer to when patients need a higher level of care, which is another result of the fragmented contracting structure. However, given that approximately 50% of Outside In's Medicaid patients are CareOregon members, the billing and reimbursement information provided for this report pertains primarily to CareOregon.

Klamath Health Partnership community health center (CHC) reported that Cascade Health Alliance CCO will not currently contract with the clinic for behavioral health services and that "all the dollars go to the Community Mental Health Program (CMHP)." They reported that their integrated behavioral health clinicians (BHCs) are credentialed with the CCO but not included in contract. The result is that when the CCO determines more behavioral health services are needed they will reimburse the community health center, but then payment will stop and there is no guarantee the of reimbursement from the CCO, thus, Klamath Health Partnership relies on the "wrap" payment from Oregon Health Authority (OHA).

Several of the CHCs interviewed also have specialty behavioral health programs that operate under a Certificate of Approval (COA) from OHA. The COA allows organizations to receive facility-based funding for their unlicensed behavioral health staff who are not otherwise working toward licensure under a board-approved supervisory contract. However, given the significant administrative burden of COA program requirements and the shift toward Value Based Payments (VBPs), the benefits of continued participation in this program are unclear.

CCO Payment Approaches

The interviews and survey data highlight a wide array of behavioral health payment approaches by CCOs ranging from fee-for-service (FFS) only to full and partial capitation to FFS plus a prospective per-member-per-month (PMPM) linked to quality and outcomes.

All six CHCs reported to receive PMPM payments linked to their Patient-Centered Primary Care Home (PCPCH) tier level (which is required by OHA), but only One Community Health CHC reported that their CCO, PacificSource, had a specific value-based payment (VBP) program to support behavioral health integration. Under the PacificSource VBP program, a PMPM payment on top of FFS reimbursement is available for meeting the PCPCH and Integrated Behavioral Health Alliance standards, providing same-day open access services, reporting metrics, and maintaining a benchmark for "population reach" of integrated care.

Aviva Health CHC mentioned that Umpqua Health Alliance CCO will be offering new "Value Based Care Quality Incentive and Behavioral Health Access and Health Equity Awareness programs" and they were reviewing the agreement for possible participation.

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[4] Integrated Behavioral Health Alliance http://www.pcpci.org/integrated-behavioral-health-alliance

Two community health centers (CHCs), Waterfall and Winding Waters, reported that integrated behavioral health services are fully capitated by their coordinated care organization (CCO), but that the payment was low such that the Oregon Health Authority (OHA) "wrap" payment provides most of the financial reimbursement for integrated care. One CHC expressed concern that their CCO is "getting off the hook by not paying for behavioral health services that they should be."

Billing Codes and Reimbursement

As part of this project, participating CHCs completed a survey regarding billing and reimbursement for a wide array of behavioral health services. The survey was completed by certified billing/coding professional and/or revenue professionals at each CHC. Appendix A provides a summary of the CHC's experience with the most frequently used billing codes.

The survey results demonstrate a range of different codes that CHCs may be using based on the type of behavioral health services provided, reimbursement policy of their local CCO, and organizational knowledge of Current Procedural Terminology (CPT) coding. Two of the six CHCs, Waterfall CHC and Winding Waters, are not receiving Fee-for-Service (FFS) reimbursement for integrated behavioral health because the services are paid via a capitated rate. Winding Waters expressed dissatisfaction with the capitated prospective per-member-per-month (PMPM) rate paid by Eastern Oregon CCO's delegated carve-out, GOBHI, insisting that it does not cover the cost of providing those services to patients and families. Waterfall CHC reported that the clinic is fully capitated for all primary care services but that the rate paid for behavioral health "is a small amount and most of the funding comes from the wrap payment from OHA."

It appears that while most CCOs are technically covering a variety of behavioral health clinician (BHC) CPT codes, some CHCs experience denials, bundling, and low capitation rates which make financial sustainability difficult. For example, Outside In reported that in 2020 half of the claims submitted to CareOregon for behavioral health services were denied. Aviva Health reported that behavioral health screening and assessment tools administered by integrated BHCs are denied when billed with psychotherapy and psychiatric diagnostic evaluation codes. In fact, most of the CHCs interviewed reported that the OHA "wrap" payment is providing all or a significant amount of funding for behavioral health services, representing cost-shifting from the CCOs back to the state.

One Community Health also noted a lack of sustainable reimbursement for Certified Alcohol and Drug Counselors (CADCs), and for integrated behavioral health at their school-based health center.

The variation in billing and reimbursement practices suggests the need for a more consistent approach across CHCs and CCOs. For example, in 2018 the Oregon Primary Care Payment Reform Collaborative produced a list of CPT codes that all health plans should reimburse to sustainably support integrated care[5]. However, not all CHCs are utilizing those codes and so it is unclear if CCOs are reimbursing them or if the capitated rates are intended to cover each type of service.

[5] Oregon's Primary Care Transformation Initiative, 2018 Progress Report. Page 34
https://www.oregon.gov/oha/HPA/dsi-tc/SB231%20Meeting%20Docs/PCPRC2018Report-1.28.19.pdf

Other Challenges

In addition to integrated care financial sustainability challenges, the six community health centers (CHCs) interviewed for this project reported several other obstacles to providing whole-person care including:

- High burden of health-related social needs that necessitate adding Traditional Health Workers such as Peer Support Specialists and Community Health Workers, especially to address health equity for BIPOC (Black, Indigenous, People of Color) patients and families
- Recruiting enough qualified behavioral health clinicians (BHCs) to meet the demand
- Dearth of child and adolescent psychiatry and specialty therapy options
- Long wait times for specialty behavioral health and staffing instability and turnover at community mental health programs (CMHPs)
- Lack of reimbursement and available staff for providing behavioral health case/care management services
- High prevalence of trauma in patients and families
- Delays with health plan BHC credentialing
- Lack of physical space to accommodate growing care teams
- Given the ongoing pandemic, providers and staff are fatigued and need more resilience-building strategies

Conclusion

- In 2020, Mental Health America ranked Oregon overall 50/51 when considering access to care and prevalence of behavioral health conditions[6]. Primary care continues to be the "de facto" mental health system[7], with only about 20% of those in need accessing care in a specialty behavioral health setting. Behavioral health integration improves access, decreases primary care provider burnout, and produces better health outcomes and patient experience. However, many community health centers in Oregon are shouldering an enormous burden without sustainable funding to address the high prevalence of behavioral health concerns presenting in their clinics.
- This project identified significant variation across coordinated care organizations (CCOs) in their payment approaches and uncovered concerns about CCOs shifting the cost of behavioral health care back to the state. Further, while Oregon's Alternative Payment and Advanced Care Model (APCM) program is intended to cover important care steps that may not result in a billable encounter, with CCOs required to rapidly implement more Value Based Pay (VBP) approaches, it may be prudent to reconsider the APCM and Prospective Payment System (PPS) programs in this context.
- Lastly, we also found significant variation in the behavioral health delivery models and Current Procedural Terminology (CPT) codes utilized by CHCs. This indicates a need for technical assistance and training to standardize their approach and ensure that patients and families across Oregon have consistent access to high quality and financially sustainable whole person care at community health centers.

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[6]The State of Mental Health in America 2020
https://mhanational.org/sites/default/files/State%20of%20Mental%20Health%20in%20America%20-%202020.pdf
[7]Primary Care is the De Facto Mental Health System. Rodger Kessler and Dale Stafford.
https://link.springer.com/chapter/10.1007/978-0-387-76894-6_2