COLORADO CENTER FOR Primary Care Innovation

Primary Care – Behavioral Health

Collaborative Guidelines

Dear Colleagues,

There are innumerable problems with the health care system and we are all struggling to provide the best care to our patients against a torrent of difficulties. The gaps in care are particularly critical in both the delivery and coordination of behavioral health care.

- Greater than 60% of patients seen in primary care have behavioral health issues.
- The vast majority of these issues are not addressed or treated.
- For those treated, primary care is not providing effective, evidence-based care.[1]
- Initial care for behavioral health conditions is primarily delivered by primary care.
- Behavioral health conditions lead to significantly higher morbidity and mortality.
- Mental health care is isolated and presents significant obstacles to patients.
- Two distinct medical cultures, medical and behavioral health, have evolved.

This Compact is designed to bridge these cultures in order to unify our efforts to successfully meet the challenges of mental illness. This Compact serves as a Rosetta Stone for collaboration between primary care and behavioral health. It defines integration and the core elements necessary to achieve collaborative care. It is not a model for integration or the process to integration. Each practice must choose their own path according to their capabilities, resources and community standards.

As change whirls around us, the core components of this Compact will hopefully provide the structure to create effective, working relationships that will lead us closer to the Triple Aim.

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Primary Care – Behavioral Health Collaborative Guidelines

I. Purpose

- *To provide optimal health care for all patients with physical or mental illness across all life stages.*

- *To create team care by providing a framework for better communication and safe transition of care between primary care and behavioral health care providers.*

- *To provide a definition for integrated behavioral health care and the relational elements with primary care.*

- *To encourage the proper selection of a model of integrated care according to the practice capabilities and increase awareness to operational barriers and challenges.*

II. Principles

- *Safe, effective and timely patient-centered care supported by credible evidence and research is the central goal.*

- *Effective communication between primary care and behavioral health care providers is key to providing optimal patient care and to eliminate the waste in and excess costs of the health care system. Information systems should share both medical and mental information between disciplines to facilitate shared care plans and seamless delivery of comprehensive care.*

- *Mutual respect is essential to building and sustaining a professional relationship and working collaboration. Effective partnerships require a commitment to change in order to overcome paradigmatic and cultural barriers of separate clinical systems.*

- *A high functioning system of health care provides patients with access to the 'right care at the right time in the right place'.*

    1. *Screening processes and registry tools designed for preemptive recognition of high-risk patients should identify patients for early intervention, assessment and treatment with the appropriate clinician in a team setting.*

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2. Periodic measurement of population-based parameters and treatment outcomes is essential to ensure quality care. Treatment is based on credible research evidence and guidelines.

III. Definitions

- *Primary Care Provider (PCP) – a generalist physician or other clinician whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients.*

- *Behavioral Health Provider (BHP) – a clinician with advanced, focused knowledge and skills who provides care for patients with mental or behavioral health problems.*

- *Consulting Psychiatrist (CP) – a medical doctor that specializes in psychiatry*

- *Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.*

- *Patient Goals – health goals determined by the patient after thorough discussion of the diagnosis, prognosis, treatment options, and expectations taking into consideration the patient's psychosocial and personal needs and values.*

- *Transition of Care – an event that occurs when the medical care of a patient is assumed by another medical provider or facility such as a consultation or hospitalization.*

- *Coordinated Care - BH providers and PCPs practice separately within their respective systems. Information regarding mutual patients is exchanged as needed, and collaboration is limited outside of the initial referral. (Blount 2003) http://www.ahrq.gov/research/collaborativecare/collab3fig1.htm*

- *Co-located Care - BH and PC providers (i.e., physicians, NPs) delivering care in same practice; describes where services are provided rather than being a specific service. However, co-location employs a referral process, which may begin as medical cases are transferred to BH. (Blount 2003) http://www.ahrq.gov/research/collaborativecare/collab3fig1.htm*

- *Integrated Care - Tightly integrated on-site teamwork with a unified care plan. Often connotes organizational integration involving social & other services (Blount, 2003; Blount et al. 2007) and includes shared space and systems with regular communications, mostly unified rather than separate care plans, and largely shared culture and collaborative routines http://www.ahrq.gov/research/collaborativecare/collab3fig1.htm*

- *Integrated Primary Care - Combines medical & behavioral health services for the spectrum of problems that patients bring to primary medical care. Because most*

patients in primary care have a physical ailment affected by stress, problems maintaining healthy lifestyles, or a psychological disorder, it is clinically effective & cost-effective to make BHP part of primary care. Patients can feel that for any problem they bring, they have come to the right place. Teamwork of MH & medical providers is an embodiment of the biopsychosocial model. (Blount; www.integratedprimarycare.com)

- *Patient-Centered Medical Home (PCMH) – a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.*

- *Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration to create a care team working on behalf of the patient.*

IV. Types of Transitions of Care (as defined by the American College of Physicians)

- *Pre-consultation exchange – communication between the generalist and behavioral health care providers to:*

    1. *Answer a clinical question and/or determine the necessity of a formal consultation.*

    2. *Facilitate timely access and determine the urgency of referral to mental health care.*

    3. *Facilitate the diagnostic evaluation and initiation of treatment of the patient prior to a mental health care assessment.*

    4. *CP assists PCP in pharmacologic selection and management in the complex patient.*

- *Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCP after one or a few visits. The mental health care providers would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.*

- *Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient's health and social function, the mental health care provider/facility assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to*

community resources as outlined by the "Joint Principles" and meeting the requirements of a national PCMH recognition.

- *Co-management – where both primary care and behavioral health care providers actively contribute to the patient care for a medical or psychiatric condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.*
  - *Co-management with Shared management for the disease -- the behavioral health care provider shares long-term management with the primary care physician for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the PCMH/PCP and behavioral health care provider are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the BHP will provide expert advice, but will not manage the condition day to day.*
  - *Co-management with Principal Care for the Disease (Referral) – the BHP assumes responsibility for the long-term, comprehensive management of a patient's referred condition. The PCMH/PCP continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.*
  - *Co-management with Principal Care for the Patient (Consuming illness) – this is a subset of referral when for a limited time due to the nature and impact of the disease, the BHP becomes first contact for care until the crisis or treatment has stabilized or completed. The PCMH/PCP remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.*
- *Emergency care – medical or surgical care obtained on an urgent or emergent basis.*

V. The 4 Domains of Collaborative Care

- Review the 4 domains - transition of care, access, collaborative care management and patient communication - and determine which services you can provide.
- The Mutual Agreement section of the tables reflect the core elements of the PCMH and Medical Neighborhood and outline expectations from both primary care and behavioral health care providers.
- The *Expectations* section of the tables provides flexibility to choose which services can be provided depending on the nature of your practice and working arrangement with the PCP or behavioral health care provider.
- The **bolded elements** that are followed by an * in each of the domains require a verbal discussion to ensure understanding and agreement.

- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to specialty care, processes should be in place to determine the patient's overall needs and reintegrate further care with the PCMH, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary care to the patient.
- Each provider should agree to an open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- Optimally, this agreement should be reviewed every 2 years.

Transition of Care

Mutual Agreement

- Maintain accurate and up-to-date clinical records.
- When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD]
- **Ensure safe and timely transfer of care of a prepared patient*.**

Expectations

Primary Care	Behavioral Health Care
☐ PCP maintains complete and up-to-date and complete clinical records. ☐ Transfers information as outlined in Patient Transition Record in a timely fashion. ☐ Orders appropriate studies that would facilitate the specialty visit. ☐ Provides patient with specialist contact information and expected timeframe for appointment. ☐ Informs patient of need, purpose (specific question), expectations and goals of the BHP visit ☐ **Obtains confidentiality release from patient to discuss care with BHP in accordance with Federal and State privacy laws***. ☐ Ensures that patient/family in agreement with referral, type of referral and selection of specialist	☐ Appropriate staff determine and/or confirm insurance eligibility ☐ **Identifies a specific referral contact person to communicate with the PCMH/PCP*.** ☐ When PCP is uncertain of appropriate laboratory testing, advise PCP prior to the BHP/CP appointment regarding appropriate pre-referral work-up. ☐ Informs patient of need, purpose, expectations and goals of hospitalization or other transfers. ☐ Notifies referring provider of inappropriate referrals and explains rationale.

Additional agreements/edits: _____

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Access

Mutual Agreement

- **Be readily available for urgent help to both the physician and patient*.**
- **Provide adequate visit availability***.
- Be prepared to respond to urgencies.
- Offer reasonably convenient office facilities and hours of operation.
- Provide alternate back-up when unavailable for urgent matters.
- When available and clinically practical, provide a secure email option for communication with established patients and/or providers.

Expectations

Primary Care	Behavioral Health Care
☐ Communicate with patients who "no-show" to BHPs and address issues. ☐ **Determines reasonable time frame for BHP appointment*.** ☐ Establishes policy and protocol to facilitate direct communication by phone, email and in-person with the BHP and patient.	☐ Notifies PCP of first visit 'no-shows' or other actions that place patient in jeopardy. ☐ Schedule patient's first routine appointment with requested provider. ☐ Provides PCP with list of BHPs who agree to compact principles. ☐ Establishes policy and protocol to facilitate direct communication by phone, email and in-person with the PCP.

Additional agreements/edits: _____

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Collaborative Care Management

Mutual Agreement

- **Define responsibilities between PCP, BHP and patient and identify care team*.**
- **Define PCP and BHP scope of practice*.**
- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
- Maintain competency and skills within scope of work and standard of care.
- Give and accept respectful feedback when expectations, guidelines or standard of care are not met
- Openly discuss and agree on type of care that best fits the patient's needs.

Expectations

Primary Care	Behavioral Health Care
☐ Follows the principles of the Patient Centered Medical Home or Medical Home Index. ☐ **Manages the medical or behavioral problem to the extent of the PCP's scope of practice, abilities and skills***. ☐ Provides designated care coordinator to work with care team, as well as, the designated care manager. ☐ Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. ☐ Resumes care of patient as outlined by the BHP, assumes responsibility and incorporates care plan recommendations into the overall care of the patient. ☐ **Shares data with the BHP in timely manner including pertinent consultations or care plans from other care providers***.	☐ Reviews information sent by PCP and addresses provider and patient concerns. ☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. ☐ Confers with PCP before refers to secondary/tertiary specialists and, when appropriate, uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization. ☐ **Sends periodic written, electronic or verbal reports to PCP as outlined in the Transition of Care Record*.** ☐ Notifies the PCP office or designated personnel of major interventions, emergency care or hospitalizations. ☐ Prescribes pharmaceutical therapy in line with scope of license and insurance formulary with preference to generics, if appropriate to patient needs. ☐ Provides useful and necessary education/guidelines/protocols to PCP.

Additional agreements/edits: _____

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Patient Communication

Mutual Agreement

- Consider patient/family choices in care management, diagnostic testing and treatment plan.
- Provide to and obtain confidentiality release from patient according to community standards (see Transition of Care).
- Explores patient issues on quality of life in regards to their specific condition and shares this information with the care team.

Expectations

Primary Care	Behavioral Health Care
☐ Explains, clarifies, and secures mutual agreement with patient on recommended care plan. ☐ Assists patient in identifying their treatment goals. ☐ Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in their care team and participates with team. ☐ **Be available to discuss patient questions or concerns regarding the consultation or their care management***.	☐ Informs patient of diagnosis, prognosis and follow-up recommendations. ☐ Provides educational material and resources to patient when appropriate. ☐ Recommends appropriate follow-up with PCP. ☐ Be available to discuss patient questions or concerns regarding the consultation or their care management. ☐ **Participates with patient care team*.**

Additional agreements/edits: _____

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VI. Appendix

• PCP Patient Transition Record – Core elements – External Communication

1. Practice details – PCP, PCMH level, contact numbers (regular, emergency)

2. Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation and contact information including referral coordinator contact.

3. Diagnosis – ICD-10 code

4. Query/Request – a clear clinical reason for patient transfer and anticipated goals of care and interventions.

5. Clinical Data --

   - Medical and surgical history including:
     - Past psychiatric history
   - Family history of psychiatric illness
   - Social history to include:
     - History of substance abuse and mental trauma
   - Medication
     - Current
     - Previous psychiatric medications
   - Allergy/contraindication list
   - Relevant notes
   - Pertinent labs and diagnostics tests
   - Patient cognitive status
   - Caregiver status
   - List of other providers

6. Type of transition of care.
   - Consultation
   - Co-management
     - Principal care
     - Consuming illness
     - Shared care
   - Specialty Medical Home Network (complete transition of care to specialist practice)

7. Visit status -- routine, urgent, emergent (specify time frame).

8. Communication and follow-up preference – phone, letter, fax or e-mail

• PCP Patient Transition Record – Core elements – Internal Communication

1. Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation and contact information including referral coordinator contact.

2. Diagnosis -- ICD-10 code

3. Query/Request – a clear clinical reason for patient transfer and anticipated goals of care and interventions.

4. Clinical Data --

- Social history to include:
  - History of substance abuse and mental trauma
- Patient cognitive status

5. Type of transition of care.

- Consultation
- Co-management
  - Principal care
  - Consuming illness
  - Shared care
- Specialty Medical Home Network (complete transition of care to specialist practice)

6. Visit status -- routine, urgent, emergent (specify time frame).

7. Communication and follow-up preference – phone, letter, fax or e-mail

- ## BHP Patient Transition Record –Core Elements (Initial)

1. Practice details – Clinician name, contact numbers (regular, emergency)
2. Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation.
3. Communication preference – phone, letter, fax or e-mail
4. Diagnoses (ICD-10 codes)
5. Recommendations – communicate opinion and recommendations for further diagnostic testing/imaging, additional referrals and/or treatment. Develop an evidence-based care plan with responsibilities and expectations of the BHP and primary care physician that clearly outline:
    1. **A-** ssessment:
       New/changed primary and secondary diagnoses with ICD 9/10 codes, controlled vs. uncontrolled.
    2. **D-** ecision-making:
       Supportive evidence and logic for diagnosis, differential diagnosis and rationale for medication treatment or cognitive therapies.
    3. **A-** dvice to patient and patient goals:
       Summarize information, patient education and community resources provided to patient. Specify patient goals and methods to activate/engage patient in their care.
    4. **P-** lan:
       Recommended treatment plan and expectations with timeline of future tests or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
    5. **T-** ask List:
       Outline next steps in treatment and who is responsible for each task; specify when does patient return to the PCP.
6. Follow-up status – Specify time frame for next appointment to PCP and BHP. Define collaborative relationship and individual responsibilities.
    1. Consultation
    2. Co-management
        - Principal care
        - Shared care
        - Consuming illness
    3. Specialty Medical Home Network (complete transition of care to mental health practice)

BHP Patient Transition Record -- Core elements (Follow-up)

2. Practice details – Specialist name, contact numbers
3. Patient demographics -- Patient name, DOB, PCP designation.
4. Clinical Data –interval history and pertinent exam, current medication and allergies list, new labs and diagnostic tests.
5. Diagnoses (ICD-10 codes)
    1. Current or new/changed primary diagnoses
    2. Current or new secondary diagnoses.
6. Care Plan Recommendations using ADAPT format –
    1. Communicate opinion and recommendations for diagnosis, further diagnostic testing/imaging, additional referrals and/or treatment.
    2. Develop an evidence-based care plan that clearly specifies responsibilities and expectations of the BHP and primary care physician:
        1. Advise on medication changes, refills and monitoring responsibility as appropriate to license.
        2. Recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
        3. Community or medical resources obtained or needed such as Home Health, Social Services, Physical Therapy, etc.
        4. Patient goals –
            - Outline education and consultation provided to patient on psychiatric condition and management. Summarize their desired outcome/needs/goals/expectations and understanding.
    3. Specify Follow-up status –
        1. Specify Transition of care status – Consultation, Co-management (shared care, principle care, consuming illness).
        2. Specify preference for bi-directional communication (phone, letter, fax or e-mail) – how does BHP prefer to send information to PCP and how does BHP want to be contacted by PCP.
        3. Specify time frame for next appointment to PCP
        4. Specify time frame for next appointment to specialist.

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Appendix A

Common Barriers and Challenges to Integrated Care

Barrier	Problems	Solutions
Language	Differences in jargon lead to uncertainty in goals, responsibilities and relationships (e.g. patient vs. client)	• **Compact Definitions**
Communication	• Lack of bidirectional information exchange and shared care plan • Barriers to speak with the PCP • Barriers to speak with the BHP	• **Compact Principles, Domains and Transition Care Record** • Set up policies and protocols to facilitate contacts.
Time constraints	• PCPs have high volume, unpredictable schedules with little control of type or number of problems to address. Tend to allow interruptions.	• **Compact Domain**- Access
	• BHPs provide comprehensive and intense sessions. Tend not to allow interruptions.	
Access and Availability	• PCPs accustomed to frequent interruptions during patient visit. Access variable.	• **Compact Domain** - Access
	• BHPs have structured schedules allowing for	

	little interruption. Access limited.	
Identification of Behavioral Health needs	• 31% of individuals qualify for a mental health diagnosis within a 12-month period (Kessler 2005). • Only 50% of patients with mental disorders actively seek care (Regier 1993). • 50% of mental health care is delivered by PCPs (Regier 1993).	• Implement screening protocols • Use registries for population management (screening, prevention, chronic disease)
Knowledge base	• PCPs have variable training and expertise in mental health issues that may limit ability to screen, assess and treat. • BHPs have different skill sets and/or specialties that may not be appropriate for all referrals.	• **Compact Domain** – Care Management • Identify gaps in knowledge • BHP suggests articles, studies, reviews and resource links to PCP • BHP expands skills to provide quick assessment to expedite referral, when indicated
Utilizing effective care	Evidence-based treatment guidelines are not consistently followed.	• **Compact Domain** – Care Management • Agree on evidence-based guidelines to implement in practice.
Understanding scope of care	• PCPs provide comprehensive care and offer a wide range of services depending on their interest and training. • BHPs have different training and backgrounds and skills may be more focused depending on their interest and capabilities.	• **Compact Domain** – Care Management • Provide BHP with information on PCMH and PCPs scope of care • Provide PCP with scope, experience and limits of practice according to training level. Improve skills to be first contact evaluator in order to

		direct patients to appropriate clinicians.
Models of care	• PCPs are accustomed to treating multiple problems in episodic care and provide first contact to access health care. • BHPs are accustomed to continuous care of a defined, single problem	• Choose one of the many models of behavioral health integration that best suits the capacity and resources of the primary care practice.
Difference in patient expectations	• PCP patients often expect immediate results for all issues. • BHP patients often expect confidentiality.	• **Compact Domain** – Transition of Care • Develop a care plan and negotiate an appropriate actionable timeframe. • Clarify what information is to be shared.
Failures in self-management of the illness	• Decreased adherence to treatment and poor clinical outcomes.	• **Compact Domain** – Patient Communication • Engage BHPs in care of patients with chronic disease. • Engage PCPs to treat physical problems of patients with mental illness. • Engage care managers into the interdisciplinary care teams.
Privacy regulations	• Lack of release form impedes communication between providers.	• Provide patient with release form and discuss privacy rights at time of initial referral.