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Abstract

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The trend towards integrated behavioral health and primary care services has been supported by the literature. To meet the growing demand for such services, one rural primary care clinic initiated and evaluated a pilot program increasing the number of behavioral health providers. One additional counselor was hired for six hours a week for twelve weeks. The aim of the evaluation was to determine if there was an increase in availability of services, improved communication about referred patients among providers, and increased satisfaction among patients. While outcomes were not statistically significant, positive changes were noted in all areas. The implementation was hampered by budgetary constraints, hiring freezes and space limitations. The evaluation of the pilot supports expansion of integrated services in the clinic.

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Introduction

Significance of the Problem

The topic of mental health problems in primary care has been well documented in the literature (Regier et al., 1993; deGruy, 1996; Blount, 1998; Strosahl, 1998; Bower & Sibbald, 2003; Tovian, 2009). In 1993, Reiger et al. identified primary care as the defacto mental health system in the United States. The authors identified that most people with mental health concerns sought services in the primary care setting. Estimates vary, but it has been identified that approximately 50% of all mental health services are provided in primary care (DHHR, 1999; AAFP, 2001; Henning, 2000; WHO, 2001; Lui et al., 2003; Kessler, 2009). One study found that 60% to 70% of patients presenting symptoms to their primary care provider have no diagnosable somatic disorder (Reiger et al., 1993). These are symptoms that have no biological basis and account for physical complaints such as chest pain, shortness of breath, fatigue, dizziness, insomnia, abdominal pain and numbness. The mental health problems identified in this paper include not only disorders that are diagnosable according to the DSM-IV, but also subthreshold problems such as stress, relationship difficulties, and financial hardships (deGruy, 1996). The care of patients with complex medical problems as well as mental health problems is challenging to providers. Providing care for such patients can lead to overutilization of medical services, increased costs, and poorer patient outcomes (Lefevre et al., 1999; Horn, 2003; Cummings, O'Donohue, & Cummings, 2009).

Over the past ten years there has been a gradual shift from the biomedical approach of providing health care to a biopsychosocial approach (Engel, 1977). George Engel's seminal article on the biopsychosocial model in *Science (1977)* introduced a more comprehensive model of disease, which included biological, psychological and social factors. Further, as Engel outlined, instituting a new model of care would decrease the limitations of the biomedical model and offer a new approach to understanding and treating various diseases within health. The biopsychosocial model was proposed as an alternative to the traditional biomedical approach that had been pervasive throughout medical history.

A movement in patient care delivery that is informed by the biopsychosocial model is integrated care. Integrated care is defined as a model of integrating mental health clinicians into primary care (Blount, 2003; Miller, Mendenhall & Malik, 2009). The terms integrated care and collaborative care have been used interchangeably throughout the literature, and will be used interchangeably in this manuscript as well. In 2002, the Report of the President's New Freedom Commission on Mental Health identified coordination between primary care and behavioral health as a major initiative (New Freedom Commission on Mental Health, 2002). Integrated mental and physical health care occurs when mental and general medical care providers work together to address both the physical and mental health needs of their patient (AHQR, 2008, p.9).

Although the biopsychosocial or integrated models of care appears to present a solution to service delivery, there are many barriers. Some barriers concerned the information or misinformation regarding mental health problems presented in primary care. These barriers implicated primary care providers, patients, and the system in which

care was received as the predominate source of the problems (WHO, 2001). Providers, lacking sufficient skills and training, often misidentified symptoms (Goldman, Brody, & Wise, 1998; Hodges, Inch, & Silver, 2001). Patients may inappropriately represent their symptoms or withhold information fearing disclosure of their mental health issues, which leads to further misdiagnoses. The system is not always accepting of patients with mental health problems because social stigma identifies them as different, demanding, and frightening (deGruy, 1996). Unfortunately, inadequate recognition and treatment of mental health problems in primary care can lead to worsening comorbidities, chronicity of mental health problems, and at the extreme, possible suicide (Klinkman, 2003; Tylee & Gandhi, 2005).

In 2000, the administration of Harpers Ferry Family Medicine, a rural health clinic, recognized the need for including behavioral health services in primary care. This was evident based upon the number of patients who were seen in the clinic with mental health related concerns. The trend toward integrated primary care behavioral health services was recognized and the service began in March, 2000. An advanced practice nurse (APRN) board certified in both adult mental health and family medicine was hired. An integrated or collaborative care model, in which a behavioral health provider was colocated in the clinic setting, or having shared office space and resources, was launched (Blount, 2003). Patients who would receive care were non-targeted with no psychiatric specific treatment modality identified. A non-targeted patient population refers to those patients who are diagnosed with a variety of mental health problems and are treated without a particular behavioral treatment strategy planned. For instance, a patient with anxiety may be taught relaxation exercises or hypnosis. However, this therapy plan would

not predetermined. The targeted patient population differs in that a patient with a specific problem such as anxiety would be admitted to a predesigned group teaching diaphragmatic breathing. Each intervention for behavioral health service was established based on patient history, clinical assessment, and self administered psychiatric inventories such as the Mood Disorder Questionnaire (Hirschfield, 2002) and/or the Patient Health Questionnaire- 9 (PHQ-9; Spitzer, Kroenke, & Williams, 1999). The interventions were conducted in a traditional mental health model allocating 30 or 45 minutes for each visit.

The integrated primary care behavioral health service has been successful since the inception. Visits have increased and have capped at 1500 adult patients seen yearly. The number of visits has doubled since 2001. However, with only one qualified behavioral health provider who has limited appointment times and a growing patient base, it has been deemed necessary to add additional providers to meet the needs of clinic patients. Patients are seen in a traditional mental health model which includes thirty or forty-five minute visits with the clinician. In addition, the service as an entity within the clinic lacks a formalized structure with policies.

One area of interest included in long term planning is certification for both mental health clinicians and for the formalized program. Clinician certification may be achieved through the Department of Family Medicine and Community Health of the University of Massachusetts Medical School. This certificate program will provide 36 hours of training specific to integration issues (Integrated Primary Care, 2009). The purpose of the program is to prepare mental health clinicians to work in primary care. Upon completion, the program provides a certificate to the learner. This program will be especially useful to

new mental health graduates who were trained in a traditional behavioral health model (Appendix A).

Program accreditation would be sought from the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF, under the Behavioral Health field categories, offers accreditation to a variety of mental health programs and facilities including integrated primary care /behavioral health programs (CARF, 2009). Accreditation has multiple benefits for a program. Accreditation assures that patients who seek care in an integrated primary care behavioral health program (PCBH) will receive care that meets the high standards set by the accrediting body. In addition, quality standards dictated by CARF will be continuously monitored (Appendix B). Funds for certification for clinicians and the program will be considered based on future budgets and a financially sound program. As a long term goal, these certifications would elevate the status of the program by meeting the required standards and assisting clinicians in keeping current with treatment options.

Therefore, this project will address a plan to expand already existing integrated primary care behavioral health services in this clinic. The proposal will also discuss the program structure, recruitment, hiring and credentialing of clinicians.

Theoretical Framework

The conceptual framework guiding this project will be Kurt Lewin's three step change theory. Lewin, a social scientist, believed an issue is held in balance by the interaction of two opposing sets of forces (Lewin, 1951). Forces seeking to change the system were labeled as driving forces, and those against the change, restraining forces.

Lewin believed that organizations are systems in which the present situation is not a static pattern but a dynamic balance of forces working in opposition (Lewin, 1951). In order for change to occur, the driving force must exceed the restraining force. This component of Lewin's theory is called force field analysis (Hershey, Blanchard, & Johnson, 1996).

Three key concepts have been identified in Lewin's theories that make planned change occur: unfreezing the status quo, moving to a new state, and refreezing the change to make it permanent (Hershey, Blanchard, & Johnson, 1996). In the unfreezing stage of this project, the problem identified is the lack of sufficient behavioral health services to meet the needs of the clinic population. The need for change will be communicated to the management of the clinic and also to various staff and providers. The APRN, in a continued effort to relay the need for change, will meet with the management to discuss the planned change. Information regarding increased demand for services, loss of referrals and revenue, and a plan for creative percentage fee for service pay for new hires will be presented and reviewed. This data will inform the change. Discomfort will arise from the unknown, particularly regarding the revenue generating potential of new hires and their ability to adjust their practice style to the primary care culture. Triage nurses will have concerns about the ability to schedule the new providers and billing staff will have concerns about credentialing and payments. These concerns have been discussed with regard to the current service by the staff when the service was initially started.

For planned change to successfully occur, it is important to unlock the status quo (Kassean & Jagoo, 2005). Consistent with Lewin's theory, a force field analysis will be completed (Appendix C). A timeline draft will be submitted to manage the change. This change process will be presented at a staff/ faculty meeting outlining the steps to be

taken. The timeline is a six week period in which the unfreezing would occur. This would include: program development, space, fee for service structure, billing, and credentialing.

The moving phase will occur after advertising for the position results in the hiring of the clinicians. The new hires will begin to provide services as referrals will be appropriately directed to them. An evaluation of the services will occur at six weeks after the inception of the expansion. Surveys will be given to patients regarding the availability of services and their satisfaction (Appendix H). Line and support staff will be encouraged to give feedback regarding the different aspects of the program. For instance, billing will provide feedback regarding pre-certification of insurances and collections since the hires will be multidisciplinary behavioral providers and not solely advanced practice psychiatric nurses. Also, feedback from faculty providers regarding the ease of referrals will be elicited.

In the refreezing phase of the capstone project, final change will be recognized at a staff /faculty meeting when the results of surveys and outcomes will be provided to the group. Additional feedback from the clinic administrator and program director will secure the new services. Staffing patterns for the clinicians would become permanent.

Lewin's concepts are adaptable and relate well to this capstone project. The change model provides a process by which services can be expanded in a structured, planned approach with positive outcomes.

Project Description

This project proposal grew from the success of an existing service. The service has produced positive clinical outcomes for patients and providers. With an increase in

demand for services and opportunities to increase services, the project will approach expansion as a planned change program. The program will have three specific objectives: (1) design and construct and integrated program; (2) hire additional behavioral health staff; and (3) secure certification for clinicians and the program.

Objective	Specifics	Measure	Action	Realistic	Timeline
1. To design and construct the program	Program Structure	Completed policies addressing no shows, late cancellation policy, assessed fees for n/s, medication refills, continuity of care	Gathering and adapting policies from other sources to provide guidelines to IBH program; identifying paneling and credentialing issues; site identified and remodeling begun	Yes	November 22, 2008
2. To interview and hire clinicians	Hire Clinicians	One part time clinician will be hired	Contract signed, background check complete, office complete, paneling and credentialing with insurance companies completed, patients being referred to provider; one chronic care group will begin; 2 walk-in /emergency appointments available per week; ½ day clinic day for consultations	Yes	February 9, 2009
3. To secure certification	Certification	Project manager will be certified as funds allow	Completion of certification course documented; Application packet from CARF will be requested as funds allow; voluntary certification available to new clinician(s) for 2010 program	Yes	January 2010

The expansion project acknowledges the value of integrated primary care behavioral health services and recognizes that it is state of the art treatment for behavioral health problems (Blount, 1998; Strosahl, 1998; Robinson & Reiter, 2007). The program is also congruent with the clinic's newly adopted concept of "medical home". The medical home concept gained attention from the "2002 Future of Family Medicine" project initiated by seven national family medicine organizations (Kahn, 2004). The patient centered care model or access model refers to a patient's ability to secure appropriate and preferred medical assistance where and when it is needed (Berry, Selders, & Wilder, 2003). The guiding principles of the Patient Centered Medical Home (PCMH) are having a personal physician who directs the medical practice, providing a whole person orientation with integrated, coordinated care, quality and safety, technology and enhanced access to care (Graham, 2007). Integrated primary care behavioral health enriches and supports the medical home concept (Patterson, Phillips, Bazemore, Dodoo, Zhang, & Green, 2008). Patients often comment on how smoothly a referral was made and what a convenience it is to receive mental health services within the primary care setting.

In keeping with the mission of Harpers Ferry Family Medicine and the Eastern Division of West Virginia University, the integrated behavioral health primary care program expansion will address the needs of patients, faculty, residents, medical students, and the community at large by providing high caliber care and excellent opportunities for learning. Expanding services will provide enhanced educational opportunities for family practice residents and other health sciences center students who may rotate through the clinic by incorporating the mental health care of patients within their primary care

experiences. Teaching will occur through didactic education and real time interactions with patients in concert with the behavioral health professionals. In addition, at Harpers Ferry Family Medicine, there is a commitment to change in order to achieve excellence. New and innovative ways to serve patients are being explored within the context of the medical home concept. A Sunrise Sick Call Clinic, a webpage for patients, and email to providers from patients, are ways that patient satisfaction and the acceptance of the medical home have been promoted. Accessibility is a hallmark of the medical home and the ability for patients to see a behavioral health provider in their primary care facility is an important aspect of that care (Arvantes, 2008; Patterson et al., 2008).

Literature Review

The integration of primary care and behavioral or mental health care is a trend in patient care delivery that has grown over the last fifteen years. Integrated care is a model of delivery that emphasizes the connection of the mind and body and has been defined by several leaders in the field (Blount, 1998; Strosahl, 1998; Robinson & Reiter, 2007). In the seminal work of George Engel (1977), medicine as it had been practiced was denounced. In addition, there was a declaration that this disconnected approach to care was inadequate to meet the complex needs of patients. This denunciation, and Engel's biopsychosocial model of care, paved the way for what we now identify as integrated primary care or integrated behavioral health care. Blount (1998) believes that by connecting physical and mental health care in a primary care setting, the body mind split is avoided. He further asserts that integrated primary care "is the structural realization of the biopsychosocial model that Engel advocated so broadly in family medicine" (p.2).

Models of integrated and collaborative care between primary care and behavioral health have received numerous endorsements (AAFP, 1999; DHHR, 1999; WHO, 2001; SAMHSA, 2004).

While the field has grown and more information emerges, there are concerns about the continued preference for the biomedical model of care. Blount (1998) questions why "when the evidence appears to be so compelling, but has not been compelling enough" to change the paradigm completely (p.122). However, there is little high level evidence specifically demonstrating the efficacy of integrated care (AHRQ, 2008). Early literature discussed a collaborative care model while other authors described an integrated system. These terms have caused confusion in that each describes a different relationship within the medical and behavioral health systems (Blount, 2003). Doherty, McDaniel, & Baird (1996) described dimensions of care between systems and define levels of collaboration. Further elucidation is provided by Blount (2003) who categorized the relationships between the providers, the relationships of service to populations, and specificity of services provided. In this paper, the terms "collaborative" and "integrated" have been used interchangeably.

Within existing research, response to integrated care has been positive but limited. In a randomized control trial (RCT) by Unutzer et al. (2002), a collaborative intervention program for late life depression was studied. This large study included eighteen primary care clinics in five states with six hundred fifty participants in both the control group and the intervention group. The outcome revealed decreased depression for the treatment group as well as increased quality of life. The authors do admit biases within the study which may have favorably affected the study. Notification to the referring physician

when a patient meeting the study criteria was assigned to usual care was identified as a flaw. The authors surmise that this notification impacted treatment favorably in that the intervention may not have occurred in usual care (Unutzer, et al, 2002). Another limitation included reliance on self reports of medical conditions and on medication use.

Katon, Roy-Byrne, Russo, & Crowley (2002) conducted a RCT in which one hundred fifteen primary care patients with panic disorder were assigned to a collaborative care intervention. This intervention included systematic patient education and two visits by a consulting psychiatrist. Telephone assessments were performed at three, six, nine, and twelve months. The results of the study indicated that the patients who received the intervention had more anxiety free days. The study further demonstrated lower costs with greater effectiveness. The authors note several limitations that may have affected the study. Failure to consider the effect of anxiety from a broader perspective such as employment (lost days and productivity) and on earning potential and marital stability was discussed (Katon et al., 2002). Additionally, patients' time off from work to attend physician visits in the study, travel time to and from the clinic, waiting time in the clinic, and time with the physician were not considered. With adjusted calculations for both employed and unemployed patients, an additional cost savings per patient was associated with the collaborative care intervention.

An effectiveness study using survey data compared integrated mental health care with enhanced referral care. The study, "The Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E)", compared integrated behavioral health care versus enhanced referral care in primary care settings across the United States. Of the one hundred twenty seven clinicians who were surveyed, most preferred the

integrated model for most of the mental health care (Gallo et al., 2004). Additionally, the respondents affirmed that communication between primary care clinicians and behavioral health clinicians was superior in collaborative care versus referral care. One limitation of this study was that the data was elicited via survey and may not be generalized to all clinicians. Another limitation was the small sample size.

Further support of an integrated model of care is described in a survey study by Farrar et al. (2001). This report described satisfaction surveys developed and sent to family physicians, psychiatrists, and counselors. Each questionnaire was specifically tailored to the respective discipline and each asked questions pertinent to patient and provider satisfaction. Results for all three groups indicated a high level of satisfaction with the integrated model. Generalization to other practice groups in this study was a limitation. Another limitation was that the survey data may sometimes be skewed in that respondents may wish to be seen in a positive way and may be reluctant to give negative answers.

A comprehensive review of more than sixty case studies was compiled by Blount (2003). In his review, the author reported that overall positive outcomes resulted from integrated care. The review portrays positive outcomes in: treatment effectiveness, satisfaction among patients, physicians, and behavioral health clinicians, and cost effectiveness. Blount (2003) states that the location and the service provided should be specified in order to adequately assess the outcomes. The distinction among coordinated, co-located, and integrated services assists in a clear understanding of the processes. Blount (2003) further clarifies the differences between targeted and non-targeted services to provide the reader with insight into the populations served. The author also defines

treatment modalities that clarify intervention approaches used in integrated programs. The author reminds the reader that the information as a whole is confusing and the literature can be cumbersome.

A systematic analysis of the literature related to better practices in collaborative mental health care in primary care was conducted by Craven & Bland (2006). The study revealed that there is a body of literature emerging on collaborative practice. Clinical implications included: collaboration is most successful when built on existing clinical relationships, enhanced collaboration should be paired with disorder-specific treatment guidelines, and skill transfer in collaborative relationships requires service restructuring in support of behavioral change (Craven & Bland, 2006). The authors admit that because the numbers of studies are small and there is variation in the study methodologies, the analysis is limited.

This literature review discussed integrated primary care and the historical antecedents offered by George Engel. Existing research reviewed for this paper included two randomized controlled studies, two survey studies, a comprehensive literature review, and a systematic analysis. Although randomized control studies offer the highest level of evidence, both authors admitted flaws in the research that may have positively affected the outcome. The survey studies, which are considered less reliable, also supported the effectiveness of integrated care. The comprehensive review is also supportive of integrated care; details different aspects of care; and addresses location of services, populations served, and clinical effectiveness. The systematic analysis documents the emerging evidence for collaboration with positive clinical implications and supports higher levels of evidence.

Focused research into the area of integrated care is warranted. With a better understanding of the relationships among providers and service to populations and specificity of services provided, this research will be made possible.

Program Objectives

The main program objective is the evaluation of the expansion of behavioral health services in a rural primary care clinic. The measurement of this expansion is the implementation of this program with written polices in place and clinicians hired. The total time for the program expansion is estimated to be four months based on the ability to hire part time contractual clinicians who are willing to work on a percentage of fees for service basis.

The first objective involves writing policies and procedures for the program. This task is estimated to take approximately six weeks. This will entail formulating and organizing the integrated primary care policies with already existing clinic polices. Included in this is the exploration of human resource information for the purpose of hiring a mental health clinician. This would also include: insurance paneling, credentialing, and development of contractual information to be presented to the new hires. Additionally, space would be identified and remodeling would begin to accommodate the new providers. The evaluation would include the completed policies and patient admission packet, a plan for contractual services, and finished work space.

The second objective is estimated to take six weeks. This would include: advertising, interviewing, and hiring one or two clinicians for the positions at the site. Again, the time lag may be a result of identifying clinicians who would agree to work

under a contractual work assignment. Once hired, the clinicians will be oriented and assigned to a schedule. The amount of time worked will be based on the demand for services. New services will be explored. For example, a chronic care group may be added to the schedule of brief intervention visits. Onsite consultations in the clinic with the residents will be available one half day per week. Evaluation of this phase would include: clinicians hired with signed contracts, completed orientation, and assignment of offices with full schedules. Onsite consultations will begin within the same time period and will reflect advancement towards diversifying services within the program.

The third and final objective, certification and credentialing, is a longer term goal. The certification process for the project manager has been discussed and some funds were allocated. However, budget reductions within the clinic system have compromised the ability to complete this objective as initially scheduled. Therefore, this objective will not be included in the evaluation process

Marketing Plan

The key stake holders in the project expansion are Dr. C. Mitch Jacques, Dean, West Virginia University, Eastern Division, Dr. K.C. Nau, Program Chair of Family Medicine, West Virginia University, Eastern Division and Aaron Henry, MBA, Administrator, Harpers Ferry Family Medicine, faculty providers, residents, support staff, and patients. A stake holder is a person or group having an interest in the success of an enterprise, business or movement (Morehead, 2006). Each stake holder has a different interest but is an important link in the process. For instance, Dr. Jacques, Dr. Nau and Mr. Henry are not only concerned with quality patient care, but also the financial feasibility,

cost /benefit, and sustainability of the project. The faculty providers and residents are concerned with quality care but also with an expeditious referral process. The support staff members are interested in having more available appointments in which to schedule the patients, and the patients want quality, an expeditious service that is conveniently located within the primary care office setting.

A SWOT analysis is a facet of a marketing strategy and an essential part of strategic planning. A SWOT analysis is a process used in projects or business that can facilitate discussions on the strengths, weaknesses, opportunities and threats to the organizational processes (McClouskey & Cusick, 2001). The SWOT analysis provides a roadmap to the organization. The SWOT analysis for this proposed project is described in the following paragraph.

Strengths are identified as internal attributes that are helpful in achieving the objectives (Hazelbaker & Hall, 2006). In the proposed project, these include: administrative support, history of providing primary care behavioral health service, experienced project manager, and creative budgeting. Weaknesses in an organization are defined as those internal conditions that are harmful to achieving the objective of the organization (Hazelbaker & Hall, 2006). Identified weaknesses in the system that could impact the proposed project are: the lack of acceptance of other mental health providers' services due to unfamiliarity with providers other than the Advanced Practice Nurse by the staff, credentialing and billing issues, improper scheduling, and inappropriate referrals. Opportunities are external conditions that are useful in achieving the objective of the organization (Hazelbaker & Hall, 2006). Such opportunities include: increased demand for service, increasing patient population at Harpers Ferry Family Medicine and

the recent trend toward the medical home model. Lastly, threats are external conditions that are harmful to achieving the objectives of the organization (Hazelbaker & Hall, 2006). Threats considered in this proposal include: inability to hire clinicians due to part time status and billing/reimbursement issues, which would impact the financial feasibility of the program. Understanding these conditions will provide for better management of the project.

Project Design

This project is an evaluation of the impact of expansion of behavioral health services in a primary care setting. This project will involve a descriptive, longitudinal design to evaluate the expansion of services and stake holder satisfaction with the project. Surveys specifically designed to gather the information will be used. According to Polit & Beck (2008), "a survey is designed to obtain information about the prevalence, distribution, and interrelations of variables with a population" (p.323). A survey is a systematic, standardized way to collect data. Surveys are uniform in that the same questions are posed to all respondents. In a survey, family physicians, psychiatrists and mental health counselors working in primary care were polled on their satisfaction with a collaborative care model vs. usual care. High levels of satisfaction were recorded with family physicians expressing increased comfort in handling mental health problems and were satisfied with the benefits to their patients (Farrar, Kates, Crustolo, & Niklaoul, 2001).

The survey instruments that will be used are modeled after examples that have been offered in a toolkit for primary care behavioral health integration services and

available for replication (Canadian Collaborative Mental Health Initiative, 2006). Not intended for research, validity and reliability have not been established for these instruments. Measurement on a Likert scale with 1 = high and 7 = low, will address issues of concern that present the most difficulty for faculty, providers, and staff. These concerns will include: accessibly, communication, and satisfaction.

To gather information about satisfaction with the expansion of services in this rural primary care clinic, written surveys will be distributed to the faculty and support staff in this project prior to the expansion and six weeks after the expansion to the faculty and support staff in this project. These surveys will be distributed to stake holders at the same point in time; thus gathering information from a cross section of stake holders (Melnyk & Fineout-Overhold, 2005). Written surveys will be distributed to the faculty providers, who are primary care providers, during a faculty meeting (Appendix F). The surveys will be distributed by the program manager. Responses will remain anonymous and placed in a collection box in the program manager's office after the meeting. Surveys allow for quick responses and have minimal costs. The distribution of the surveys by the project manager will reinforce the importance of the surveys to the development of the new service.

Follow up surveys will be administered to patients after they have participated in the proposed service (Appendix H). Another written survey will be administered to the support and triage staff (Appendix G). It is their job to field calls from potential patients requesting appointments. In addition, the triage staff must deal with patients who request emergency visits when there are no mental health appointments available. Because of their direct communications with patients, these staff members are important stake

holders. A way to best instruct the support and triage staff and obtain evaluation information from them would be to have a noon meeting and provide lunch. This would assure that respondents are educated on the survey and reinforce the program goals. These surveys would be administered within a one week window of the faculty surveys so that the process would be completed by November 29, 2008.

All data collected before program implementation will be discussed with the faculty and staff within the next month as the plans for the program unfolds. The approximate time line would be December 22, 2008. Questions will be answered at both the faculty meeting and a support staff meeting regarding the results and the proposed program. Timelines for phase one as previously described will be six weeks. Therefore, program construction and policy will be underway from November 22, 2008 until January 6, 2008.

The post implementation survey will be administered approximately six weeks after the inception of the expansion services being provided to patients. These surveys will be distributed to both faculty and support staff. Evaluative information will be shared with the survey participants in a timely manner using the previous meeting sites.

The goal of the survey is to evaluate the providers' needs for expanded services and measure their current satisfaction with the current service within the clinic. The survey will serve as a pretest within the project. These surveys will be distributed and collected at the November faculty meeting.

Resources

Resources needed for this project are minimal. Policies and procedures will be gathered from integration resources and merged with existing University Health Associates polices. These policies will address clinic specific issues mentioned previously such as no show and late cancellations policies. All the resources needed for this phase of the project are in place and included in budget operations, such as binders, paper, and technical support.

Personnel requirements will involve meeting time with the administrator to discuss: contractual information, percentage of fees collected, patient no show rates, and late cancellations policies. These are issues that have challenged the program but have been overlooked. It is unacceptable to have these programmatic problems when clinicians are paid only for patients that they have seen. Brief meetings times will be also needed with billing staff, human resource, and clerical support staff. Because the service is already operational, these meetings dealing with the new program would require no extra time or cost because regular meetings with these personnel are routinely scheduled.

Equipment

Technology, space and furniture are items that must be purchased for the new clinicians. A computer and furniture for the newly hired clinician's office has been estimated in the budget. Shared space will be available in the facility for additional clinicians as the clinic expansion is completed. Minimal renovation will be required for the space.

Budget and financial plan

The gross revenue projected for the project is based on two staff clinicians. To ensure an adequate patient flow, clinician hours will be phased in over the course of twelve weeks. During the initial four weeks, one clinician will work one day or eight hours a week increasing in week five to sixteen hours per week. Beginning in week nine, a second clinician will be added for an additional eight hours of services for a total of twenty-hour hours per week. In week twelve and forward, the two clinicians will provide a total of thirty-two hours of service per week. The budget is based on the clinicians each working forty-eight weeks with the assumption that each clinician will take the equivalent of four weeks of vacation a year. Because patients will miss appointments for a variety of reasons and the staff will not be productive during these sessions, the revenue has been reduced by 12%. This would include patient “no shows”. Since most patients will have some third party insurance coverage, the gross revenue has been reduced to an estimated average insurance payment of $83 per session based on current collectables. The resulting net patient revenue is the total operating revenue for the program since there will be no other sources of income.

The largest operating expense is the monies paid to the contract clinicians who will be providing the counseling services. Clinicians will be paid 60% of patient revenue for fees collected. Other significant expenses include a standard 10% surcharge on collections for University Health Associates (UHA) support operations and the standard 10% surcharge on collections for Dean’s Support. The Dean has waived the Dean’s surcharge for the first six months to ease the cash flow deficit during this period. Other expenses include a 7% charge on projected receivables to cover clerical costs and the

estimated actual costs for rent and utilities. Five hundred dollars is budgeted for miscellaneous expenses and this line item provides some cushion for unexpected expenses. Built into the expense budget are the 0.6% West Virginia provider tax and an estimated bad debt expense of 5%. Bad debt expense covers the loss of revenue when patient revenue is not collected such as when prior authorization for services is not obtained or co-pays are not collected. It should be noted that most of these expenses (clinician payments, UHA and Dean's surcharges, clerical costs, provider tax, and bad debt expense) vary with the operating revenue. Thus, if the program fails to meet its revenue targets, these expenses will proportionally decrease. In the same way, these expenses will increase if the program exceeds its revenue projections.

Start up expenses include additional furniture and a computer for the clinicians with an estimated total cost of $2000.00. There is also staff recruitment expenses estimated at $500.00. Included in this estimate are advertising fees for two local papers at approximately $250.00. An additional cost of $150.00 is estimated for lunch and travel during the recruitment process. Another $50.00 is budgeted for supplies needed for recruitment such as folders, binders, and paper. Payment for staff orientation will be drawn from miscellaneous costs since the clinicians are paid on a fee for service basis. Therefore, it will be important to have a precise schedule on orientation day, which would include mandatory in services, paperwork, and medical issues such as TB testing. The first year's annual budget projects $98,165 in operating revenue with $91,693 in expenses for a projected gain of $6,472. However from a cash flow perspective the program will have a loss of $1093 during the first six months due to the lag in insurance payments for services (see cash budget). At the end of the first year, cash flow is

projected to be a positive $1,175. In year two, the projected gain is $5,907 on revenues of $112,189. If only the start up expenses are considered, the return on investment (Gain from Investment – Cost of Investment divided by the Costs of the Investment) would be positive (6,472 - 2500)/2500) = 1.59). However, this does not consider the existing resources such as office space, which could be allocated to alternative projects (Appendix D).

Key site support

In discussions with K.C. Nau, MD, Program Director of Family Medicine and Vice Dean of the Eastern Division, and Aaron Henry, MBA, Administrator of Harpers Ferry Family Medicine and Vice President of Finance of the Eastern Division, verbal support for this project has been ongoing. This is based on the Program Director's ongoing support of mental health services in the clinic and the commitment to provide primary care/ behavioral health integration. The creative percentage of fees collected contractual agreement with the clinicians also provides a risk free financial opportunity for the clinic.

Clinic faculty and support staff is also eager for a structured program and for more behavioral health staff to provide services. Because there has been exponential growth in the clinic population and more primary care providers, the need is clear. A letter of support for the project has been given by Mitch Jacques, MD, Dean of West Virginia University's Eastern Division (Appendix E).

Evaluation Plan

Evaluation of the program would be completed based on the objectives previously discussed in this paper. The first objective is program construction and policy. Several measurements will be used. In order to measure satisfaction with the service by the faculty and staff, surveys will be administered by the project manager (Appendices G, H). One survey will be completed prior to the hiring of new clinicians and the start up of new structured program. The follow-up survey will be administered six weeks after the clinicians start. Additionally, satisfaction surveys given to patients will be distributed as they experience the new program (Appendix H). Independent *t* tests will be used for statistical analysis (Melynk & Fineout-Overhold, 2005). Other evaluative mechanisms of this objective will be the completion of the policies and a patient admission packet. Policies will address the internal and external referral process, late cancellations and no show, and safety and reporting circumstances related to: harm, safety contracts, emergency resources, and dismissal from the practice due to nonattendance or noncompliance with treatment.

Objective two addresses the clinician and performance. Evaluative measures that will be reviewed will be the amount of time dedicated to patient treatment booked on the providers' schedules and achievement of productivity standards. These measures are now being maintained in the new EPIC system and are easily retrievable for review. These benchmarks will be set by the clinic. In general, a clinician should have a less than 12 % patient no show rate and maintain a 90% booked schedule. A chart review process monitoring aspects of the behavioral health intervention will also be put into place with appropriate feedback to clinicians. This is a new process for the clinic and standards will

be set based on CARF accreditation standards. Currently, this evaluative process is measured for the APRN by family practice standards. However, since the new clinicians will only provide mental health services, the format and indicators will change. Some quality indicators may include: elements of the evaluation, diagnostic criteria, and the completeness of the chart. Built into the evaluation processes will be frequent and timely feedback to administration and new clinicians. This will be done through monthly reports. In the past, these reports were difficult to access and often inaccurate. The new system wide computer system provides easy access. Frequent communication during the start up phase is essential for the viability of the program and in assisting the new clinicians in adapting and understanding the new environment.

The final objective, certification, will be delayed indefinably due to a budget shortfall and fiscal constraints. The initial plan was that there would be two measurements. The first completed measurement was certification of the project manager. The completed certification course would be conducted through the University of Massachusetts, Department of Family Medicine and Community Health Certificate Program. This is a 36 hour didactic and interactive training course conducted in six, full day workshops given one Friday a month for six months. The completion of the program by the project manager will be measurable as will the request for the program certification packet from CARF.

Evaluation

The program evaluation was based on the specific objectives outlined in the proposal. The aim of the first objective was to provide structure to the integrated primary

care behavioral health program through policies and procedures specific to the service. These policies, which are contained in forms that patients sign at registration, provide both patients and staff with guidelines for the management of unique situations that are related to integrated services such as disclosure, informed consent and safety. The policies were written for patients seen only in the Harpers Ferry Family Medicine integrated primary care behavioral health program and associated clinics where such services may be delivered. Specifically, the policies included counseling policies, privacy policies, informed consent for medication treatment, informed consent for release of information, patient intake form – self information sheet, and telephone appointment reminder consent (Appendices I, J, K, L, M, N).

Prior to submission for approval, the policies were researched from a variety of sources including other practices and WVUH/Chestnut Ridge Hospital outpatient services. Standard forms from behavioral health manuals were also considered (Wiger, 1999; Zuckerman, 2003). Additionally, polices and practices informally used in the program were formalized. For instance, the counseling polices discussed with patients on their first visit by the clinician were now in a written format allowing for clarity between patient and provider.

The target date for the completion and approval of the policies was November, 2008. Approval did not occur until approximately March, 2009. There was a significant delay particularly relevant to the no show policy because, while this was a policy approved for Chestnut Ridge Hospital outpatient service, it had never been approved for a primary care site. All policies were finally approved by corporate compliance but have

yet to be implemented due to university and system wide priorities that were superseded by the implementation of, and transition to, the new computer system.

Another aim addressed in objective one was the initiation of human resource activities which would prepare for the hiring of the clinician as proposed in the expansion. The objective specified that activities such as paneling and credentialing for insurance purposes, and establishing a contractual fee for a service pay scale would be completed as an evaluative measure. The debate and confusion over the status of clinician's position resulted in extraordinary delays and a significant change in the evaluation process. The inability to hire a contractual employee for the position voided the evaluative processes which had been proposed. Since the clinician would be hired as a part time salaried employee who would not bill for services, no contractual fee schedule, or insurance paneling and credentialing activities were necessary.

The final measure of objective one was the allocation of completed space in which the clinician could see patients. It had been estimated that space would be identified and modified to meet the needs of a behavioral health clinician seeing patients. However, due to faculty and full time staff changes, there was no space available at Harpers Ferry Family Medicine. Space was assigned at a satellite women's health clinic associated with the main clinic which is part of the clinic system. The total time estimated for this objective to be completed was six weeks. However, the space allocation took four months to complete.

The evaluation process based on objective two was even more complex and addressed the hiring of the clinician. The position of mental health clinician was advertised in the local newspaper and drew only a few applicants (Appendices O, P). A

master's prepared social worker (MSW) working on licensure as a Licensed Independent Clinical Social Worker (LICSW) responded to the ad (Appendix, Q). The clinician was hired for six hours per week for twelve weeks. The clinician was paid $32.50 per hour which included FICA tax @ 7.65%. The clinician worked only eleven weeks because of a personal situation that caused an absence for one week .The total salary for the eleven week period was $2,145.00. During the eleven weeks, the clinician was in the clinic for six hours per day. There were a total of sixty counseling appointments available with six hours of unproductive time being used for orientation, computer based learning, and a didactic presentation to the resident staff. Of the sixty available appointments, forty - three [72%] appointments were booked. This is a lesser percentage than was projected in the initial proposal at which time 90% booked appointments was projected. However, this decrease in booked appointments could be attributed to the change in venue for the clinician and lack of shared office space at the main clinic office. Additionally, of the forty three appointments booked, six patients (7%) did not come for their appointment, and seven patients cancelled appointments. Based on an estimated rate of $83.00 per visit for thirty completed visits, the clinician could have earned $2490, slightly above salary. These calculations did not consider what level of payments that payors would approve. However, the computations suggest that a behavioral health clinician could be self supporting.

Pre and post implementation surveys completed by providers, staff, and patients were collected and analyzed as discussed in objective two. The surveys for the providers and staff groups contained five questions and were measured on a seven point Likert scale. The scale weight was 1 = high to 7= low. The analysis of faculty and staff

responses included perceptions of accessibility of services prior to and after the interventions (Appendices F, G). The surveys for the patient group contained eight questions and were measured on a five point Likert scale. The weight of the scale was 1 = high to 5 = low. Patient responses included perceptions of satisfaction pre and post implementation (Appendix H). Prior to data analysis, the level of significance was set at $p < 0.05$. Independent *t*- tests were conducted with each group. When no statistically significant differences were found using this statistic, a Cohen's *d* test was used. While statistical significance is certainly important, it is not necessarily the most important consideration in evaluation research. Effect size is a simple way of quantifying the size of the difference between two groups (Ender, 2003). The difference between the each group was measured by the pre and post tests. Effect size has a particular value in quantifying the effectiveness of a particular intervention which in this project was the clinician (Coe, 2002). Cohen's *d* evaluates the effect size when comparing two group means, computed by subtracting one mean from the other and dividing by the pooled standard deviation called the standardized mean difference (Polit & Beck, 2008, p.749). Effect size is important to establish when a study has limited statistical power (Becker, 2000).

Analyses of accessibility by *t* test in the provider group resulted in $p = .466$, which was not statistically significant. A Cohen's *d*, measuring the mean difference in accessibility resulted in $d = .30$. According to Polit and Beck (2008), when no prior research exists, researchers may estimate the effect size or the magnitude of the effect which can be small, medium, or large (p. 604). A *d* of .30 is a small effect. Analyses of communication by *t* test in the provider group resulted in $p = .356$, which was also not statistically significant. However, the effect size as measured by a Cohen's *d* resulted in *d*

=.41. This also indicated a small effect. Although indicating only a small effect size, both tests revealed a positive change. Although not statistically significant as indicated in Table 1, the changes indicate an improvement in the perceptions of the providers. These improvements indicated that providers' perceptions about both accessibility and communication were improved between the pre and post test and indicated that the intervention was effective.

Table 1. Provider Groups

Question	Pretest Mean (sd)	Posttest Mean (sd)
1. Access to treatment	4.35 (1.63)	3.27 (2.04)
2. Access to emergency mental health care	5.07 (1.70)	4.5 (2.27)
3. Timely communication w/MH providers	3.57 (1.72)	2.81 (1.84)
4. Status updates on mental health referrals	4.42 (1.84)	3.36 (2.32)
5. Opportunities for case discussions mental health providers	3.21 (1.81)	3.09 (1.62)

Patients' responses revealed little change with a $p = .101$. A ceiling effect, or cluster of high scores, was noted with this group. This means that the measurement cannot take on a value higher than some limit or ceiling which is imposed by the phenomenon being measured (SMARTPsych, 2009). As a result there is a lack of variability. In the patient surveys, the scores were rated at the high end of the scale. This lack of variance impaired the investigator's ability to measure the true means.

Table 2. Patient Groups

Question	Pretest Mean (sd)	Posttest Mean Mean (sd)
1. How long did you wait for appt	1.45 (1.07)	1.0 (0)
2. How much have you been helped with mental health problem?	1.45 (0.65)	1.11 (0.31)
3. Knowledge, competence of provider	1.09 (0.28)	1.11 (0.31)
4. Courtesy, respect, of provider	1.09 (0.28)	1.11 (0.31)
5. Visit overall	1.0 (0.42)	1.11 (0.31)
6. Amount of wait time for 1st appt	1.81 (1.11)	1.0 (0)
7. Seeing a counselor in your Dr's office?	1.09 (0.28)	1.33 (0.99)
8. Mental health treatment overall?	1.27 (0.44)	1.11 (0.33)

Staff perception of accessibility of the services resulted in $p = .109$, which was not statistically significant. A Cohen's *d*, measuring the mean difference resulted, $d = .71$ indicating a modest effect size and improvement in the findings. Staff perception of communication from pretest to posttest declined, $p = .124$. This value was nonsignificant. A Cohen d test resulted in $d = .70$ also indicating a modest effect size. While staff perception of accessibility of services did improve, staff perception of communication about the service did decline. The fact that this occurred is not surprising based on the confusion related to the clinician's availability and assigned site. Staff, unsure of the clinician's work hours and duty station, found it necessary to make frequent calls to the satellite office to verify these issues. Additionally the referral process, once hoped to be conducted with ease, became cumbersome for the staff. It became a multistep process involving several staff personal at two different offices. Unfortunately, as with the total process, by the end of the twelve week period, the staff understood the flow, but the pilot test for the service was then over.

Table 3. Staff Groups

Question	Pretest Mean (sd)	Posttest Mean (sd)
1. Access to MH appts for adults in practice	5.2 (0.4)	4.0 (2.0)
2. Access to emergency MH for adults in the practice	6.4 (0.8)	5.18 (1.69)
3. Access to MH appts for adults in community	5.7 (1.1)	4.90 (2.15)
4. Positive comments about counseling in practice	1.4 (0.8)	2.72 (1.48)
5. Difficulty dealing with patients who are diagnosed w/ MH problems	3.2 (1.6)	3.45 (1.55)

Additional qualitative data was gathered and revealed positive comments about the intervention. One provider wrote:

> ML called twice to discuss concerns she had regarding my patient. I appreciated this and it made me feel like I was better able to care for my patient because of it. Also it was very nice that the patients I referred for behavioral health were seen in a more timely manner during the time when ML was here. A lot of patients don't come in until they are in crisis or almost in crisis. It is often very frustrating when we have to tell them they have to wait six weeks when they need the care today.

The third and final objective dealt with the completion of certification of both clinicians and the integrated program. While this was and is a lofty goal, the previously discussed financial that barriers exist prohibit either process from occurring at this time that have been elucidated in this paper.

Discussion

Proposal Modifications

The pilot program, the Evaluation of the Expansion of Behavioral Heath Series in a Primary Care Clinic, was launched in a very different format than was originally proposed. The final capstone project submitted in December 2008 was scheduled to be completed by April 2009. However, the timeline was not achieved because there were

many barriers and obstacles that were introduced. The project was significantly delayed and the program was greatly modified due to budgetary constraints, a hiring freeze, and space limitations. Clinical, philosophical, financial and organizational barriers continue to hamper integration as described in the literature (Gunn & Blount, 2009; Robinson & Strosahl, 2009).

The first objective of the proposal was to formalize the program structure. Policies and documents which were previously lacking were written. These policies included: privacy policies, informed consents for treatment and medications, patient self information forms, counseling policies, and adult assessment forms. Although the forms were accepted and approved by the university compliance office, implementation never occurred (Appendices I, J, K, L M, N). Unfortunately, the planned implementation coincided with the clinic's transition to Merlin, the electronic medical record system within the university. The technical change process was a significant burden for the support staff and, in particular, the front desk staff that are responsible for obtaining patient signatures for consent. Adding new forms to an already cumbersome process would significantly slow the registration process and could cause confusion among staff and patients. While seemingly essential documents to the primary care behavioral health program, the forms represent another difference in the two treatment cultures. It is hoped that in the future, when there is a better understanding of the capabilities of the new electronic system, that these forms may be merged into the system, preloaded in the electronic medical record system, and available to patients upon registration in a more expeditious fashion.

It is also important to note that the approval process for the forms was not without controversy. The concept of charging a patient for a missed visit, late cancellation, and for a no show, is not consistent with the university system. This practice, although common in behavioral health practice, is not usual and customary in primary care. This is a clear demonstration of differences in treatment philosophies that exist between behavioral health and primary care (Gunn & Blount, 2009). While a missed visit can be a treatment issue in behavioral health, there is not the same significance in a primary care visit. The additional dilemma of not charging a patient for missed services, then adds a financial burden for the behavioral health provider who is expected to be clinically and financially productive. This is an example of the financial disincentives that face integrated programs (Cummings, O'Donohue, & Cummings, 2009; Robinson & Strosahl, 2009).

The second objective of the project identified hiring the clinical staff member whose services would act as the intervention for the expansion process. Reimbursement for the clinician was to be structured on a fee for service basis. This approach to reimbursement would minimize any financial risk for the clinic. This model presupposes that a certified mental health clinician would be reimbursed based on a behavioral health fee schedule. The prerequisite paneling and credentialing required by the organization would facilitate the process of billing and reimbursement. A major obstacle, which prevented this from happening, was the fact that no nonphysician clinician had ever been hired in this manner. Although the capstone project was approved by the administrators at the clinic, the fact that the university corporate affiliate would only hire physicians on a contractual basis emerged at the point of project implementation. This fact was identified

after approval of the capstone proposal, and was unknown to the Eastern Division administration. This change affected every facet of the program especially the financial aspects. The proposed budget and financial projections were essentially useless because the foundation for the proposal was based on the contractual payment agreement between the corporation, clinic and the clinician. That is, the sustainability of the position would be based on revenues generated and productivity standards that would be set. The clinician would earn a salary based on fees collected from patient visits. However, the clinician was hired as a provider who worked on a temporary, part time basis without billing for the provision of services. Paneling and credentialing by insurance companies was not necessary. There were also no productivity standards set. A masters' prepared social worker who was preparing for advanced licensure expressed interest in the position even though it was temporary (Appendix Q). This occurred because the clinician wished to experience working in an integrated system. The fact that such a qualified clinician was interested in a short term, timed limited position was very fortuitous. The administrator was able to designate monies from the budget to fund the position on a temporary basis in spite of the current hiring freeze. The clinic hiring freeze was imposed after the proposal was accepted as a pilot program.

A positive outcome from this change was that the clinician was not bound by the fiscal rules of behavioral health care. That is, there were no limitations on visits and no precertification necessary for visits necessary. Patients who had no behavioral health insurance benefits could be seen without regard to insurance issues. This allowed patients to be seen emergently and in a less traditional format. For instance, in the current primary care behavioral health structure, patient cannot be seen on the same day by both the

primary care provider and the behavioral health clinician. Rules such as this, mandated by payors, hamper the provision of care. The change in the pilot project permitted the clinician to function in the role of behavioral health consultant as described by Robinson & Reiter, (2007; Pomerantz, Coson, & Detzer, 2009; Robinson & Strosahl, 2009). While this behavioral health consultant role is discussed in the literature and promoted, it is often not possible because of financial disincentives. Ideally, the behavioral health consultant in this role employs brief solution focused counseling in a one to four visits to facilitate health rather than psychotherapy to ameliorate symptoms (Robinson & Reiter, 2007; Walker & Collins, 2009). Byran, Morrow, and Appolino (2009) believe that brief psychological interventions can be the most effective intervention in an integrated setting (Appendix R).

Another pitfall was the lack of space at the main primary care site. This organizational barrier is a very practical one and understandable. The inability to make room for behavioral health services highlights the culture differences since primary care services do seem to be more highly valued than the process oriented behavioral health interventions (Gunn & Blount, 2009). One might speculate that this is the diminishing of behavioral health services and a continuation of the dichotomous practice patterns representing a mind body split (Lipsitt, 1997). An example of the cultural differences between primary care and behavioral health is office arrangement. The office setting for the primary care provider is an exam room while the usual office setting for the behavioral health provider can look like a living room (Maine Health, 2009).

At Harpers Ferry Family Medicine, expansion of the residency program and the addition of several new faculty providers left little room for another behavioral health

provider to see patients. Therefore, the clinician was assigned to a satellite clinic within the system. This reassignment was another factor that greatly impacted the outcome of the pilot project and project evaluation. As a result, with the clinician not being in plain view, staff and faculty had to be reminded of her availability. This factor did hamper the referral process. However, faculty providers who regularly worked at the satellite clinic used the service and were pleased with the clinician's availability. Patients who completed the satisfaction questionnaire expressed satisfaction with the service, but also often expressed disappointment because the clinician would be available for such a brief period.

Colocation and dropout are important topics discussed in the literature (Blount, 2003; Robinson & Reiter, 2007). Colocation is common vernacular in integrated settings and implies that both behavioral health and medical providers are located in the same offices and share resources (Blount, 2003). This was demonstrated in the pilot project when patients who were referred from the main clinic to the satellite office did not follow through for appointments (Appendix S). Not all the patients who were referred for services were seen. Blount (2003) reports that colocation is an important factor in the success of integration. Craven & Bland (2006) identify that collaborative practice is most effective when there is colocation. Gunn & Blount (2009) remind readers that colocation is desired but not the norm.

While dropout may be attributed to lack of colocation, patient barriers should not be overlooked. During the primary care visit, patients will often agree to see the behavioral health provider for several reasons (Lacy, Paul, Reuter, & Lovejoy, 2004). One reason is because patients are truly in psychological distress. Another reason may be

that patients want to please their doctor. Time and distance between appointments, a patient's own denial of the behavioral health problem, and stigma that accompanies mental illness are variables that put the patient at risk for dropout (Goldman, Brody, & Wise, 1998; Mitchell & Selmes, 2007).

The final phase of the project, which proposed certification for the clinicians and program, was indefinitely postponed because of finances. The cost / benefit ratio to complete these certifications was not seen as feasible. Any clinician who wishes to do this certification may incur the cost independently without reimbursement from the clinic. While this financial barrier is understandable in the wake of the economic environment, the process of primary care behavioral health integration can move forward only with trained clinicians who understand the operation of a model which is different from pure behavioral health (Robinson & Reiter, 2007; Zoberi, Niemiec, & Margolis, 2008). Gunn & Blount (2009) strongly support the need to increase the knowledge base and skills for those working in the specialized field of primary care mental health because this field is so distinct from specialty care. In a recent report by Robinson and Strosahl (2009) training of both primary care providers as well as behavioral health consultants is deemed necessary in order to truly grasp and implement integration. Blount & Miller (2009) caution that without properly trained behavioral health clinicians integrated programs could fail. Certification of the primary care behavioral health program, similar to Joint Commission Accreditation, and of the clinician by a certification program would bring a great deal of credibility to the clinic. Certification often is equated with expert knowledge by both consumer and health care provider.

Study Limitations

There were several limitations to the study. A major limitation was the lack of survey participants to study the true impact of the pilot project. That is, the number was small which often leads to nonstatistically interpretable results. Polit and Sherman (1990), however, report that nonstatistical findings are a common occurrence in both published and unpublished nursing research. Lack of statistical power can lead to mistakes and inconsistent results reflecting Type II errors (Pilot & Beck, 2008, p. 602). Power refers to the probability that a test will be statistically significant when such a difference actually exists, rejecting the null hypothesis (Zint & Montgomery, 2008). When the sample size increases, so does the statistical power of the test`. However, when a difference between groups is found, but does not actually exist, errors do occur (Zint & Montgomery, 2008).

Another significant limitation of the study was the flawed design, in that study participants were not matched at pre and post test on the surveys. Therefore, paired *t* tests were not completed. One reason for unmatched groups was the fact that clinic staff who instructed patients on how to do the survey, changed during the pre and post survey. That is, patients did not always receive a survey either prior to or after implementation of the pilot project in spite of an educational session and reminders to staff. The fact that staff at two different sites were dealing with a new behavioral health clinician at a different location may be a reason for the negative results in the post test analysis of staff, as the process became cumbersome. Clearly, communication about the clinician's availability and how to make a referral became challenging.

A short time line added to the limitations and the pilot project may have been more successful given a longer period for implementation. The confusion about the availability of the clinician at another site may have been eased over time. Patient referrals may also have increased as staff and providers became more familiar with the new process. In part, the short time line was due to budgetary constraints. There was a small time period when the clinician could be hired and paid a salary. The clinic administrator was able to dedicate funds from an unfilled staff position in order to fund the clinician's part time position. This position would end in the new fiscal year. Acting as a "champion" as identified by Walker & Collins (2009), the clinic administrator understood the value of the pilot project, sought to decrease the barriers encountered, and was cognizant of the benefit that integration brings to the patients in the clinic.

Another limitation which hampered the study was confusion about the survey questions, which lacked clarity, validity and reliability. Some of the questions were vague and did not specifically address accessibility and communication. One example is that one provider on a post implementation survey gave a low score to the communication question but noted that the clinic mental health clinician was the exception. It was noted that there was good communication between the provider and the behavioral health clinician in the clinic but that communication with community behavioral health providers was lacking.

Application of Theoretical Framework

The proposed practice change demonstrated by the pilot program was guided by Lewin's Three Step Change Theory. In this theory, Lewin, believed an issue is held in

balance by the interaction of two opposing sets of forces (Lewin, 1951). Forces seeking to change the system were labeled as driving forces, and those against the change, restraining forces (McEwen & Willis, 2007). Lewin believed that organizations are systems in which the present situation is not a static pattern but a dynamic balance of forces working in opposition (Lewin, 1951). In order for change to occur, the driving force must exceed the restraining force. This component of Lewin's theory is called force field analysis (Hershey, Blanchard, & Johnson, 1996).

Three key concepts have been identified in Lewin's theories that make planned change occur: unfreezing the status quo, moving to a new state, and refreezing the change to make it permanent (Hershey, Blanchard, & Johnson). In the unfreezing stage of this project, the problem identified was the lack of sufficient behavioral health services to meet the needs of the clinic population. The need for change was communicated to clinic management, staff and providers. A proposal was submitted that defined the proposed change. Discomfort arose from the unknown, among the administrators of the clinic and Eastern Division of West Virginia University particularly regarding the revenue generating potential of a newly hired clinician. A major obstacle occurred when it was discovered that, due to fiscal constraints in the clinic, the clinician would have to be employed rather than have contractual status.

For planned change to successfully occur, it is important to unlock the status quo (Kassean & Jagoo, 2005). The unfreezing phase which was planned in the initial project proposal was not followed because of the change in the hiring status of the clinician.

The moving or change phase occurred when the clinician was hired and began providing services. Referrals were appropriately directed to the clinician. An evaluation

of the services occurred at twelve weeks after the inception of the expansion. Surveys were given to patients regarding the availability of services and their satisfaction with the services (Appendix H). Line and support staffs were encouraged to give feedback regarding the different aspects of the program.

Hypothetically, in the refreezing phase of the capstone project, final change will be recognized. Unfortunately, because the clinician position was a temporary, part time position, services were provided for only twelve weeks and the expansion was not sustainable. Change in any system is challenging. The integration of behavioral health into primary care, which is a major change in the way that health care is delivered, is a challenging task. One might imagine the metaphor in this change process as primary care as the restraining force and behavioral health as the driving force, with the end result being an expanded integrated program.

Recommendations

This pilot study, which aimed to expand already existing behavioral health services in a primary care clinic, supports the literature on this topic and holds promise for future expansion of services. Mistakes were made and lessons were learned. The problems that arose will assist in the design of a more efficient and profitable expansion of behavioral health services in the future with a particular focus on financial issues. An opportunity to experience expanded behavioral health consultation services was presented, and permitted a comparison of current practice to an expanded model.

The comparison of the current practice and the updated model reminded the author that an integrated primary care behavioral health service has existed at Harpers

Ferry Family Medicine for ten years. Although lacking high levels of integration, there was great vision, intent, commitment and determination by providers and administration to make the program successful(Doherty, McDaniel, & Baird, 1996). A major strength has been high levels of collaboration built on existing trusting relationships (Craven & Bland, 2006). In 1999, the concept of integration was cutting edge in West Virginia. The program has served many patients and was structured on a traditional behavioral health model because that is all that was known at the time. It was designed without toolkits, manuals, textbooks and evidence based practice guidelines. However, through knowledge and experience gained in the past ten years there have been continued efforts to refine the way interventions are conducted with patients. Additionally, there continues to be a concerted effort in refining the collaborative process through frequent provider to provider conversation. Colocation is an accepted component in this integrated program as plans for a new satellite clinic include an office for a behavioral health counselor. New health and behavior billing codes hold promise for a brighter financial future (Kessler, 2006).

Implementing change is a laborious process as demonstrated in this pilot project. In his conceptual model of integration, C.J. Peek posits that in order for an integrated system to be successful there must be an alignment of the clinical, organizational, and financial systems (Peek & Heinrich, 1995). All of these components must be considered when attempting integration. It was clear that an attempt to align those systems in the pilot project occurred but barriers that have been explicated in this paper were experienced and impeded the process. Serious consideration must be given to barriers that prevent true integration from occurring, such as appointment schedules, patient flow,

treatment settings, financial disincentives and philosophical differences (Gunn and Blount, 2008; Maine Health, 2009). Walker and Collins (2009) report that true integration is quite challenging and that totally integrated programs are rare. In a recent publication by the AHRQ (2008) reviewing RCT and high quality quasi –experimental design studies for integrated care components, the outcomes were positive but lacked consistency in models, approaches, and levels of integration. AHRQ recommendations included removing obstacles and barriers, creating incentives, and mandating integration (2008, p.vi).

Conclusion

It is clear that primary care behavioral health integration is effective but meets significant challenges at this time. The literature is robust in support of such practices. This pilot study guided by Kurt Lewin's Three Step Change Theory, proposed an expansion of behavioral health services in a primary care clinic. The proposal outlined three objectives upon which the pilot would be completed: (1) program design and structure; (2) clinician hire; and (3) certification. A literature review revealed supporting evidence of integrative and collaborative care. However, reports have emerged stating there is a lack of consistency in models, approaches and levels of integration (AHRQ, 2008). The proposal was based on a descriptive, longitudinal design evaluating the expansion of the behavioral health services and satisfaction of the stakeholders. Surveys were used to gather data. Although the data did not show significance, positive changes were noted.

Unexpected advantages of the pilot project provided a glimpse into more diversified services with an added staff member and the associated benefits that were afforded to patients. The project presented a traditionally trained behavioral health clinician the opportunity to experience a new approach to behavioral health consultation and permitted the author the opportunity to observe the practice change. It is the intent of this author to continue the movement towards expanding the service as more patients adopt the clinic as their medical home with increased demand for integrated services. Integrated behavioral health is no longer just an idea or a model; it is a movement whose time has come.

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Appendix A: Certificate Program in Primary Care Behavioral Health

Rationale for the Program:

If the integration of behavioral health clinicians into primary care continues to grow and spread as fast as it has in the last three years, the US will shortly face a staffing crisis. The number of training programs turning out new behavioral health professionals who have the skills to work in primary care is woefully inadequate. And training is necessary. Programs that have transferred mental health professionals straight from specialty mental health centers into primary care have often failed in the past. A transitional experience is needed to give trained mental health professionals the substantive orientation they need to become behavioral health professionals in primary care.

The Department of Family Medicine and Community Health has been training mental health professionals to provide services in primary medical care settings for over fifteen years. In January of 2007, the Department launched a program designed to train mental health professionals to function successfully as behavioral health clinicians in primary care. The program consists of 36 hours of didactic and interactive training. The program is delivered in 6 full-day workshops, one Friday per month for six months. If a participant must miss a scheduled workshop, the material and the credit can be made up by listening to a recording of the session. Participants who complete the whole program receive a Certificate of Completion. Teaching is done by members of the Department of Family Medicine and Community Health of the University of Massachusetts Medical School (see page 2 for a complete listing).

Cost:

The tuition for the program is $1600 per person (*fee subject to change without notice)*, and is due prior to the first workshop in the series. Interested professionals should contact Melissa McLaughlin at McLauM01@ummhc.org

Appendix B

Behavioral Health customer service unit

Behavioral Health programs include services to persons or families with needs related to mental illness, alcohol or other drug usage, and other addictions, such as gambling. The services may address relationship or adjustment concerns, domestic violence, and other family issues. The services may be designed to prevent potential problems and treat existing ones. Behavioral health programs are provided in a variety of settings ranging from clinics and inpatient locations to the home, school, community, or criminal justice settings.

Behavioral Health program descriptions (PDF)

Business and Services Management Network program descriptions (PDF)

Frequently asked questions

Opioid Treatment Program

Accreditation and standards

Discounted insurance premiums for qualified providers

Register for Behavioral Health seminars online

Order the Behavioral Health standards manual and other publications online

Learn more about the Value of CARF Accreditation (PDF)

Go to Promising Practices newsletter (Behavioral Health)

Accredited providers may download a CARF, CARF Canada, or CARF-CCAC logo to display on their website and printed materials.

Visit CARF Canada

Additional resources:

The HIPAA Security Rule: CMS' enforcement activities acquire teeth by Robin A. Johnson. The Security Rule requires covered entities to protect the confidentiality, integrity, and availability of its "electronic protected health information."

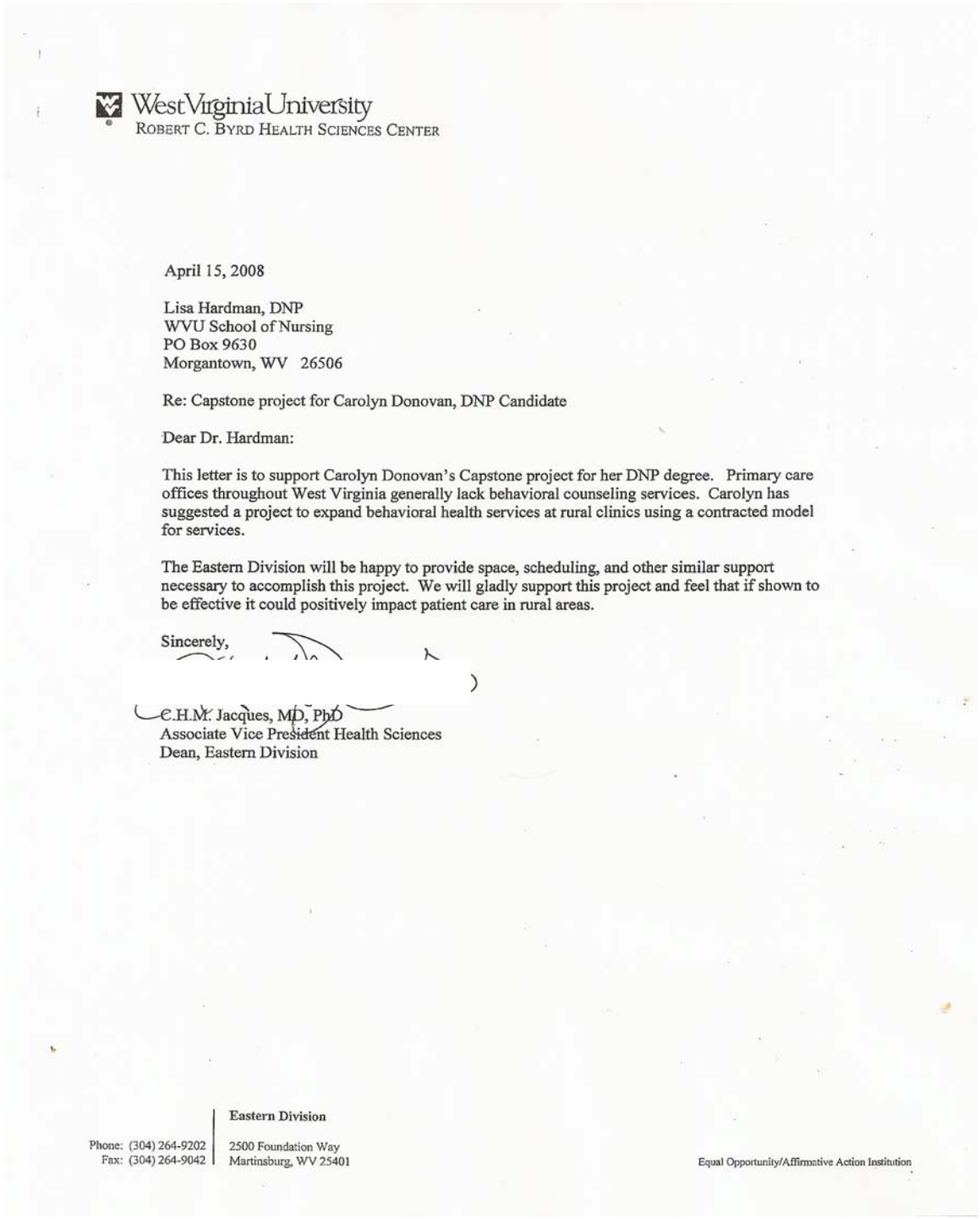
Appendix C: Force Field Analysis

Driving Forces	Restraining Forces
Increased demand for services @ HFFM Lack of time with current provide Increased demand for services @ Other offices –medical/surgical, Maternity center APRN will lead change project Dean's support Eight years of success with current program Program Director's commitment to PC/BH integration .	Continued primary care mindset by Administration Lack of space at facilities Lack of BH management expertise Low reimbursement rates for BH services vs. PC services Management concerns regarding hiring more BH FTEs

Appendix D: Proforma Budget for Behavioral Health Clinicians

Revenue		
Gross Patient Revenue	$163,200.00	2 staff X 20 sessions each X 48 weeks X $100 less an estimated 15% no show rate
Deductions	$ 57,120.00	Deduction to approximate average insurance payment of $65
Net Patient Revenue	$106,080.00	
Total Operating Revenue	$106,080.00	
Operating Expenses		
Contract Services	$ 63,648.00	60% of patient revenue paid to clinicians
UHA Operations Support (10%)	$ 10,608.00	
Deans Support (10%)	$ 10,608.00	
Non-Capital Furniture/Equipment	$ 2,000.00	Desk/chair/computer
Recruitment/Advertising	$ 500.00	
Miscellaneous Expense	$ 500.00	
Provider Tax	$ 604.66	.6% of patient revenue
Bad Debt Expense	$ 5,304.00	Assumes 5% of net patient revenue is not collected
Total Operating Expenses	$ 93,772.66	
Total Gain / (Loss)	$ 12,307.34	

Appendix E



West Virginia University
ROBERT C. BYRD HEALTH SCIENCES CENTER

April 15, 2008

Lisa Hardman, DNP
WVU School of Nursing
PO Box 9630
Morgantown, WV 26506

Re: Capstone project for Carolyn Donovan, DNP Candidate

Dear Dr. Hardman:

This letter is to support Carolyn Donovan's Capstone project for her DNP degree. Primary care offices throughout West Virginia generally lack behavioral counseling services. Carolyn has suggested a project to expand behavioral health services at rural clinics using a contracted model for services.

The Eastern Division will be happy to provide space, scheduling, and other similar support necessary to accomplish this project. We will gladly support this project and feel that if shown to be effective it could positively impact patient care in rural areas.

Sincerely,

C.H.M. Jacques, MD, PhD
Associate Vice President Health Sciences
Dean, Eastern Division

Eastern Division
Phone: (304) 264-9202
Fax: (304) 264-9042
2500 Foundation Way
Martinsburg, WV 25401

Equal Opportunity/Affirmative Action Institution

Appendix F

West Virginia University

Harpers Ferry Family Medicine

Provider Survey

Can you rate the extent to which the following present problems to you when handling individuals with mental health problems in your practice? (1 = no problem, 7 = severe problem)

1.) Access to (or waiting time for) treatment for individuals needing psychotherapy	1 2 3 4 5 6 7
2.) Access to emergency mental health assessments for adults	1 2 3 4 5 6 7
3.) Timely communication with mental health providers	1 2 3 4 5 6 7
4.) Access to information concerning the status of patients referred for mental health care	1 2 3 4 5 6 7
5). Opportunities to discuss cases with a mental health professional (counselor, social; worker, nurse, psychologist)	1 2 3 4 5 6 7

Adapted from Collaboration between mental health primary care services: a planning and implementation toolkits for health care providers and planners. February 2006.

Appendix G

West Virginia University

Harpers Ferry Family Medicine

Consumer Satisfaction Survey

Here are some questions about **the visit you just made**. In terms of your satisfaction, how would you rate each of the following?

	Excellent	Very	Good	Fair	Poor
How long you waited to get this appointment?	1	2	3	4	5
How much has the person you see for mental health care helped you with your problems?	1	2	3	4	5
The technical skills (knowledge, thoroughness, competence) of the person you saw?	1	2	3	4	5
The personal manner (courtesy, respect, sensitivity, friendliness) of the person you saw?	1	2	3	4	5
This visit overall?	1	2	3	4	5

Here are some questions about **your mental health care in general.** In terms of your satisfaction, how would you rate each of the following?

	Excellent	Very	Good	Fair	Poor
The amount of time you had to wait for your **first** appointment with a therapist/counselor?	1	2	3	4	5
Being seen for mental health care in your family physician's office?	1	2	3	4	5
Your mental health treatment overall?	1	2	3	4	5

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Adapted from Collaboration between metal health primary care services: a planning and implementation toolkit for health care providers and planners, 2006.

Appendix H

West Virginia University

Harpers Ferry Family Medicine

Staff Survey

Can you rate the extent to which the following present problems to you when handling individuals with mental health problems in the practice? (1 = no problem, 7 = severe problem)

1.) Access to appointments for adults needing counseling within the practice 1 2 3 4 5 6 7

2.) Access to emergency mental health assessments for adults in the practice 1 2 3 4 5 6 7

3.) Access to appointments for adults within the community referred for mental health care 1 2 3 4 5 6 7

4.) Positive patient reports that counseling services are offered in this clinic 1 2 3 4 5 6 7

5.) Difficulty dealing with patients who are identified as having a mental health problem 1 2 3 4 5 6 7

Adapted from Collaboration between metal health primary care services: a planning and implementation toolkit for health care providers and planners, 2006.

Appendix I

UHA - Harpers Ferry Family Medicine
Integrated Behavioral Health Services
Counseling Policies

Harpers Ferry Family Medicine Integrated Behavioral Health Services (IBHS) offers brief, solution-focused counseling services. A referral from your provider will alert our front desk staff to provide you with the opportunity to make an appointment with the mental health provider after signing this document. At the initial assessment session, the mental health provider will assist you in defining your concerns and establishing a treatment plan. If at any point it is established that another service outside the clinic may be more suitable, you will be assisted in identifying more appropriate resources.

Please arrive promptly for your appointments. A late arrival of 15 minutes or more, without notification and approval, will be considered a ***late cancellation and will result in a fee of $35.*** Missed appointments reduce our ability to provide services to other patients. ***If you are unable to keep your appointment, you must cancel at least 24 business hours in advance. A fee of $35 will be charged for no-shows.*** To cancel your appointment, you must speak to a scheduler during work hours. Cancellations left on voicemail overnight or on weekends will result in a ***fee of $35.*** Failure to pay the fee may prevent you from receiving further behavioral health services until the fee is paid. Repetitive no-shows or late cancellations may lead to dismissal from behavioral health services.

Psychiatric medications may be prescribed by nurse practitioners who specialize in behavioral health. Risks and benefits of the medications will be discussed with you as well as side effects. It is the responsibility of the patient to request medication refills in a timely manner. Please contact your pharmacy, which will in turn call the clinic with the request. A 72 hour time period is required. Neither the clinic nor the provider is responsible for monitoring refills. Routine medication refills are authorized only during regular clinic hours. Do not contact the doctor on call for medication refills.

Patients who are on maintenance medications are required to be seen at the minimum of twice yearly. Some patients whose medications require lab tests may be seen more frequently. Patients who neglect to keep the required follow up appointments will not receive refills.

Every effort is made to verify insurance coverage. Some insurance companies do not cover mental health benefits. Ultimately, it is the patient's responsibility to contact their insurance company to verify coverage. Patients will be required to sign a ***payment waiver***. The mental health billing specialist is available to assist you with any questions you may have about this policy.

Harpers Ferry Family Medicine is a training site. Medical students, family medicine residents and nurse practitioner students may sometimes participate in patients' counseling sessions as part of their learning experience. Their observation is important to their education. However, if you are uncomfortable with this, please feel free to discuss with the provider.

In keeping with ethical standards and federal law, all information is kept confidential except as outlined in the NOTICE OF PRIVACY PRACTICES that you are requested to endorse. The professional staff has the legal responsibility to disclose patient information without consent when a patient is likely to harm him/herself or others unless protective measures are taken, when there are reasonable suspicions of abuse or neglect of children, dependent adults or the elderly, when the patient lacks the capacity to care for him/herself and when there is a valid court order for the disclosure of patient files. However, these are rare situations. By signing a consent form, the patient gives us permission to communicate with the emergency contact designated if the staff believes you are at risk. Any questions about this may be addressed with the behavioral health provider.

Counseling and therapy can have both risks and benefits. The counseling process may include discussion of personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, anger and frustration. On the other hand, counseling has been shown to have many positive benefits. It can often lead to improved social relationships, better work performance, solutions to specific problems and reductions in feelings of distress. However, there is no assurance of these benefits.

I agree and understand the above policies related to my participation in behavioral health services.

_____
Patient Name (print)

_____
Patient Signature

_____
Guardian if patient under 18 years of age

_____
Date

C:\Documents and Settings\donovanc\Local Settings\Temporary Internet Files\OLK7A\BMED_Counseling_Policies.doc

171 Taylor Street (Bolivar)
Harpers Ferry, WV 25425
(304) 535-6343 ph (304) 535-6618 fax

Appendix J

UHA - Harpers Ferry Family Medicine
Integrated Behavioral Health Services
Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our Duty to Safeguard
Your Protected Health Information

Information about your past, present, or future health or condition, the provision of healthcare to you, or payment for the healthcare is considered "Protected Health Information" ("PHI"). We are required to protect your PHI and to give you this Notice about our privacy practices that explains how, when, and why we may use or disclose your PHI. Except in very specific situations, we will only release the minimum necessary information to carry out the request.

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new notice from your therapist or office staff.

How We May Use and Release
your Protected Health Information

We use and release information about you for many reasons. We have a limited right to use and/or release information about your for purposes of treatment, payment, or healthcare operations. For uses beyond that, we must have your written permission unless the law permits or requires us to make the use or disclosure without your permission. If we have to give out information to another person or business to perform a function on our behalf, then we have to make sure that they will protect your information the same way we are required to protect your information. For instance, if you have Medicaid, we are required to send information about you to the West Virginia Bureau of Behavioral Health and Health Facilities and American Psych Systems so that Medicaid will pay for your services. We have to have a written agreement with them to insure us that they are going to protect the information we send them.

Uses and Releases Relating to Treatment, Payment, or Health Care Operations

Here are some examples of how information about you is shared or released:

For Treatment: We will share information with doctors, nurses, and other healthcare personnel in our facilities that are involved in providing your healthcare. For example, information about you will be shared among members of your treatment team at this agency or for consultation purposes.

To Obtain Payment: We may use/disclose information about you in order to bill and collect payment for your healthcare services. For example, we may release information about you to Medicaid, Medicare, or a private insurer so we can be paid for services delivered to you.

For Healthcare Operations: We may use/release information about you in the course of operating our agency. For example, we may use information about you to evaluate the quality of our services or when we are audited.

Appointment Reminders: Unless you provide us with different instructions, we may send letters or call your home about canceled or rescheduled appointments.

Uses and Releases of Information About You from Medical Health Records Not Requiring Consent or Authorization

There are times when the laws allows us to release information about you without your consent in the following ways:

When Required by Law: The law requires we report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity. IF we receive a signed court order by a judge, we must release the information requested in the order. Sometimes we have to release information to the Medical Examiner (Coroner) if there's an investigation of a death. We must also release information to authorities that monitor us in carrying out these privacy requirements.

For Public Health Activities: We may release information when we are required to collect information about disease or injury to the public health authority.

For Health Oversight Activities: We may release information to state or federal agencies that come in periodically to check the way we provide our services and keep our records.

To Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, we may release information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For Specific Government Functions: We may release information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Uses and Disclosures of PHI from Alcohol and Other Drug Records Not Requiring Consent or Authorization: The law provides we may use/release information from alcohol and other drug records without consent or authorization in the following circumstances:

When Required by Law: The law requires we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity. If we

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receive a signed court order by a judge, we must release the information requested in the order. Sometimes we have to release information to the Medical Examiner (Coroner) if there's an investigation of a death. We must also release information to authorities that monitor us in carrying out these privacy requirements.

To Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, we may release information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Uses and Releases Requiring You to Make an Opportunity to Object: In the following situations we may disclose a limited amount of information if we inform you about the disclosure in advance and you do not object, as long as the disclosure is not otherwise prohibited by law.

To Families, Friends, or Others Involved in Your Care: We may share with these people information directly related to their involvement in your care, or payment for your care. WE may also share information with these people to notify them about your location, general condition, or death.

Your Rights Regarding Your Protected Health Information: You have the following rights related to the protection of your health information:

To Request Restrictions on Uses/Releases: You have the right to ask that we limit how we use or release information about you. We will consider your request, but are not legally bound to agree to the restriction. To the extent we do agree to any restrictions on our use/release of your information, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/releases required by law.

To Choose How We Contact You: You have the right to ask we send you information at an alternative address or by alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

To Inspect and Request a Copy of Your Protected Health Information: You have the right to see your protected health information unless your treatment team feels it is not in your best interest to see it. We will respond to your written request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your information, you will be charged a copying fee as allowed by state law. You have the right to choose what portions of your information you want copied and to be informed of the cost of copying.

To Request Amendment of Your PHI: If you believe that there is a mistake or missing information in our record of your information, you may request, in writing, we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the information is (1) correct and complete (2) not created by us and/or not part of our records, or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, added to your record. If we approve the request for amendment, we will change the information and inform you, and tell others that need to now about the change in your information.

To Find Out What Disclosures Have Been Made: You have a right to get a list of when, to whom, or for what purpose, and what content of your record has been released other than instances of disclosure for treatment, payment, and operations, to you, your family, or any release made with your authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

To Receive This Notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

How to Complain About Our Privacy Practices: If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your record, you may file a complaint with the Secretary of the US Department of Health and Human Services at 200 Independence Avenue, SWW, Washington, DC 20201 or call 1-877-696-6775. We will take no retaliatory action against you if you make such complaints.

I understand these rights as I have read them and/or they have been explained to me. I understand I will be given a written copy of the Notice of Privacy Practices at my request.

_____
Consumer/Guardian Signature

_____
Print Name

_____
Date

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Appendix K

UHA - Harpers Ferry Family Medicine
Integrated Behavioral Health Services
INFORMED CONSENT TO TREATMENT WITH MEDICATION

I, _____ a patient of _____, have received the complete explanation of my medication(s).

Description of Medications: (check appropriate category)

_____Antipsychotic*	_____Mood Stabilizer	_____Antidepressant
_____Anti parkinsonian agent	_____Psychostimulant	
_____Anxilytic agent	_____Cognition Enhancer	
_____Hypnotic / Sedative	_____Other: _____	

My provider has discussed with me the nature of my psychiatric / behavioral problems for which medication has been prescribed. My provider has discussed with me the reasons why medication may be helpful, including the likelihood of my psychiatric / behavioral problems improving or not improving with medication, and I have been informed of the consequences of my refusing medication. If effective treatment alternatives are available, my provider has discussed them with me. I have been informed of the potential side effects and risks reasonable to be expected from this medication. I have decided to accept medication as prescribed for the treatment of my psychiatric / behavioral problems at this time. I understand that I may change my decision to accept medication and that if I change my decision I will contact my provider. It is important to report to my provider the emergence of any side effects.

**The symptoms and risks of Tardive Dyskinesia and NEuroleptic Malignant Syndrome have been explained to me.*

_____ _____
Patient Date

_____ _____
Representative Date

_____
Relationship to Patient

_____ _____
Person Giving Explanation Position

_____ _____
Provider Date

If this consent is for treatment of a minor or for a patient that is unable to give consent, the following information must be provided:

a) Name of one or both parents, if known: _____

b) Name of managing conservator or guardian or person, if appointed: _____

_____

c) Date on which treatment is to begin: _____

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Appendix L

UHA - Harpers Ferry Family Medicine
Integrated Behavioral Health Services
INFORMED CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____ _____, date of birth _____. ___ authorize UHA - Integrated Behavioral Health Services, to exchange information related to my treatment with _____. _____

_____ _____ _____

_____ _____ _____ _____ _____ _____

The purpose of this release is _____ _____ _____ _____

_____ _____ _____ _____

I understand that this authorization may be revoked and updated by me at any time except for information that has already been released under this or previous authorizations. I hereby release UHA – Integrated Behavioral Health Services from all liability that may arise from the release of the information requested. I understand that my records are protected under the federal regulations governing. Confidentiality of Alcohol and Drug Abuse, Patient Records, 42 CFT Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance on it.

_____ _____
Date Patient Signature

_____ _____ _____
Signature of Parent, Guardian of Authorized Representative

_____ _____ _____
Witness

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Appendix M

UHA - Harpers Ferry Family Medicine
Integrated Behavioral Health Services
PATIENT INTAKE FORM ***Self Information Sheet***

PATIENT NAME: _____ AGE: ___ SEX: M F DATE: _____

Person completing this form: _____Patient _Guardian Other _____

Depression _____
Does not feel joy _____
Hopelessness _____
Worthlessness _____
Energy level _____
Concentration _____
Sleep _____
Weight _____
Memory problems _____
Appetite _____
Irritability _____
Sexual issues _____
Suicidal thoughts _____
Thoughts of harming others _____

Provider Notes: _____

_____

_____

Do you have any problems with alcohol or other drugs? Yes No

If yes:

Do you need to cut down on alcohol/drug use? Yes No
Do you feel angry when someone talks about your alcohol/drug use? Yes No
Do you feel guilty about your alcohol/drug use? Yes No
Do you need alcohol/drugs to get you going in the morning? Yes No

Does stopping alcohol/drug cause:

Palpitations, flushed skin, sweating Yes No
Increased hand tremors Yes No
Insomnia Yes No
Nausea/vomiting Yes No
Hallucinations Yes No
Agitation Yes No
Anxiety Yes No
Seizures Yes No
Social impairment Yes No

Money spent on alcohol/drug per day ____
Legal problems due to alcohol/drug _____

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Financial problems due to alcohol/drug _____

Provider Notes: _____

Have you ever had any of these symptoms over a period of time?

☐ Yes ☐ No Racing thoughts _____

☐ Yes ☐ No Excessive spending _____

☐ Yes ☐ No Self-importance _____

☐ Yes ☐ No Impulsive behaviors _____

☐ Yes ☐ No Cannot sleep _____

☐ Yes ☐ No Mood swings _____

☐ Yes ☐ No Talks too fast _____

☐ Yes ☐ No Excessive energy _____

☐ Yes ☐ No Increased sexual drive _____

☐ Yes ☐ No Dangerous behaviors _____

Provider Notes: _____

Mild elevation of mood _____

Positive thinking for few days _____

Increased energy for few days _____

Provider Notes: _____

Have you been constantly anxious/worried with these symptoms for at least 6 months?

☐ Yes ☐ No Cannot control worry _____

☐ Yes ☐ No Increased irritability _____

☐ Yes ☐ No Muscle tension _____

☐ Yes ☐ No Sleep disturbance _____

☐ Yes ☐ No Decreased concentration _____

☐ Yes ☐ No Increased fatigue _____

☐ Yes ☐ No Restlessness or feeling keyed up, on edge _____

Provider Notes: _____

Have you had any of these symptoms over a period of time?

☐ Yes ☐ No Panic attack _____

☐ Yes ☐ No Palpitations _____

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PATIENT NAME: _____ _____ AGE: ___ SEX: M F DATE: _____

☐ Yes ☐ No Sweating_____

☐ Yes ☐ No Trembling_____

☐ Yes ☐ No Shaking_____

☐ Yes ☐ No Shortness of breath_____

☐ Yes ☐ No Chest pain_____

☐ Yes ☐ No Nausea_____

☐ Yes ☐ No Fear of dying_____

☐ Yes ☐ No Fear of losing control_____

☐ Yes ☐ No Unusual sensations (e.g. tingling in arms/legs) _____

Provider Notes: _____

_____

_____

☐ Yes ☐ No Excessive fear or anxiety when among strangers

☐ Yes ☐ No Avoid people/places because of anxiety

Provider Notes: _____

_____

_____

☐ Yes ☐ No Persistent thoughts, impulses, images which are intrusive/inappropriate and cause anxiety

☐ Yes ☐ No Recognize that thoughts are product of own mind

☐ Yes ☐ No Repetitive or ritualistic behavior

Provider Notes: _____

_____

_____

Have you witnessed or undergone a life-threatening event? ☐ Yes ☐ No

If yes, please describe the event: _____

_____

_____

☐ Intense fear, helplessness, horror about the incident

☐ Reliving experience (flashbacks)

☐ Distressing recollections or dreams

☐ Avoidance of stimuli that are associated with the trauma

☐ Fear that something bad is going to happen (hyper vigilance)

Provider Notes: _____

_____

_____

☐ Memory impairment

☐ Language problem

☐ Impaired motor activities

☐ Failure to recognize objects

☐ Disturbance in executive functioning

☐ Pain causes significant distress or impairment in social, occupational, or other areas of functioning:

Provider Notes: _____

_____

_____

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Intense fear of weight gain
Refusal to maintain weight
_____Absence of menstruation
_____Distorted body image
_____Binge eating
_____Lack of control over eating
_____Eating all the time
_____Self-induced vomiting
_____Use laxatives, diuretics, enemas
Provider Notes: _____

_____Cannot go to sleep (or stay asleep) for at least 1 month
Provider Notes: _____

Failure to resist aggressive impulses that result in serious assaultive acts or destruction of property
Degree of aggression greater than any psychosocial stresses
Provider Notes: _____

_____Delusional (unusual beliefs)
_____Hallucinations (hearing voices/seeing things)
_____Speech that does not make sense
_____Catatonic behaviors (mute all the time)
_____Stays in one place all the time
_____Unable to work or perform normal social functions
Duration _____
Provider Notes: _____

Other complaints/symptoms: _____

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Appendix N

UHA - Harpers Ferry Family Medicine
Integrated Behavioral Health Services
TELEPHONE APPOINTMENT REMINDER CONSENT

I, _____ give _____
Patient Name (print) Provider Name (print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply): _____ Home _____
_____ Work _____
_____ Cell _____

Yes, this office may leave (check all that apply):

_____ Voicemail at my Home _____ Voicemail at my Work _____ Voicemail on my Cell

_____ Messages with people at my Home _____ Messages with people at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____ _____
Patient Signature Date

_____ _____ _____
Parent / Guardian Signature Parent/Guardian Name Print Date

_____ _____ _____
Witness Signature Witness Name Print Date

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Appendix O

Integrated Behavioral Health Clinician (Therapist)
Job Description

SUMMARY:
The Integrated Behavioral Health Clinician, as part of the primary care treatment team, identifies triages and manages patients with behavioral health problems within the primary care setting. In addition, the Integrated Behavioral Health Clinician will provide skill training through psycho-education and patient education strategies and will develop specific behavioral change plans for patients and behavioral health protocols for target populations.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Provide brief mental health assessment, treatment, and/or referral to specialty mental health services.
- Assess patients' needs as defined by specified physician consultation.
- Evaluates current behavioral and psychosocial symptoms and provides feedback to the PCP and team.
- Provides patient education regarding symptoms and diagnosis.
- Provides interventions that are culturally sensitive, evidence – based, simple and applies patient strengths.
- Consults with the PCP team on various behavioral health and psychosocial issues.
- Triages patients to specialty mental health as needed.
- Documents patient visit, patient care and treatment decisions in the medical record. The referring provider will have access to such medical record.

QUALIFICATIONS:

- Good working knowledge of behavioral health and evidence-based treatments for mental health conditions
- Ability to make expeditious and accurate clinical assessments of mental and behavioral conditions
- High level of comfort working with primary care providers
- Ability to work through brief patient contacts
- Ability to work effectively in a team interfacing with patients, primary care providers, mental health providers and with administrative and support staff
- Ability to provide short term solution focused interventions and psychoeducation

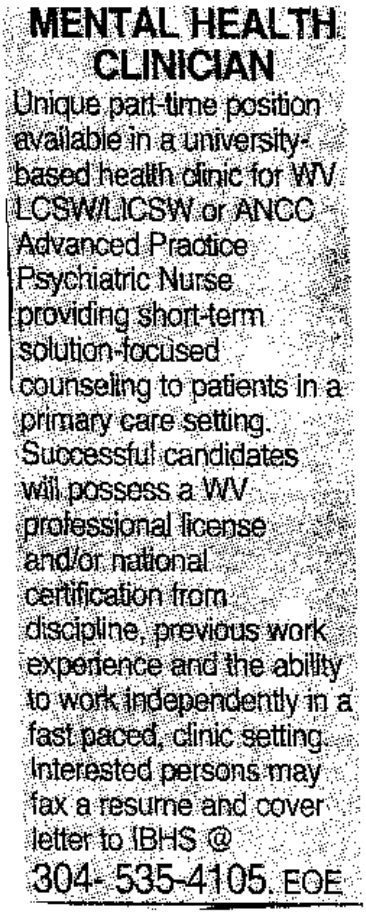
EDUCATION and/or EXPERIENCE:

- Masters in Social Work or
- PhD/ PsyD in Psychology or
- Masters prepared Advanced Practice Psychiatric Nurse

LICENSE and CERTIFICATION:

- Current WV license as an LCSW or
- Current WV license as a psychologist or
- Current WV RN licensure, MSN in nursing, and ANCC certification as an advanced practice psychiatric nurse

Appendix P



MENTAL HEALTH CLINICIAN

Unique part-time position available in a university-based health clinic for WV LCSW/LICSW or ANCC Advanced Practice Psychiatric Nurse providing short-term solution-focused counseling to patients in a primary care setting. Successful candidates will possess a WV professional license and/or national certification from discipline, previous work experience and the ability to work independently in a fast paced, clinic setting. Interested persons may fax a resume and cover letter to IBHS @ 304- 535-4105. EOE

Appendix Q

Education:

Masters in Social Work: West Virginia University, June 2003

Bachelor of Science in Psychology: Vanderbilt University, Nashville, TN, 1988.

High School: The Madeira School, Greenway, Va., 1985.

Employment History:

Shenandoah Women's Center. August 2004 – present.
Martinsburg, WV
Title: Counselor/Social Worker.

My job responsibilities include providing therapy services to referred clients. This is a part-time, fee for service position. In addition to providing therapy services, a major accomplishment in the past year has been taking on an additional responsibility for the purpose of helping the Center to keep grant funding at risk of being lost. I coordinated, expanded and revamped the sexual assault prevention program at the Center which enabled this program to meet grant goals and maintain funds. I have followed up by helping to train and acclimate the new individual who has been hired as the prevention specialist to take over this role.

Veterans Affairs Medical Center. August 2003 – June 2004
Martinsburg, WV

Title: Social Worker, Center for Addiction Treatment (CAT .) at the VAMC.

My job responsibilities included acting as primary therapist for a number of individuals in the Cornerstone Work Recovery track of the CAT 5 program. In addition to being a therapist, I was responsible for providing vocational assistance to patients in the program. I developed job contacts and regularly explored job opportunities through local companies for veterans, and assisted them with finding transportation. I developed and led a class entitled "Job Readiness from a Recovery Viewpoint." In addition, I performed psychosocial assessments on many of the newly admitted patients.

Accomplishments in Job Development: I established three community partnerships with local businesses. These businesses agreed to partner with the VA and interview referred veterans seeking employment. In addition, I developed a standardized procedure for individuals seeking employment.

VAMC, August 2002 – May, 2003
Martinsburg, WV

Title: Graduate Student Intern, Center for Addiction Treatment at the VAMC
My job responsibilities included performing psychosocial assessments on the newly admitted patients. I also led group sessions for patients in the program. I conducted educational groups on topics such as effective communication skills and problem solving abilities, and general issues related to substance abuse. I provided supportive therapy (using cognitive/behavioral techniques) and counseling for individual patients throughout my field placement. I was responsible for orienting the new patients.

East Ridge Health Systems, September 1990 – July 1994.
Water Street, Martinsburg, WV.

Title: Community Development Specialist for Substance Abuse Prevention

I acted as a community organizer for Morgan, Berkeley and Jefferson Counties. My job responsibilities included bringing national efforts in prevention to the Eastern Panhandle of West Virginia. Some of the campaigns included Red Ribbon Week in October and Alcohol Awareness Month in April. I also coordinated educational seminars and conferences. The topics included substance abuse prevention, fetal alcohol syndrome and parenting classes. I worked with many different community groups, schools and agencies to start projects and programs in the local area that community members felt were needed. A few examples include a Boys and Girls Club in Morgan County, summer camps for at-risk children at a nursing home for interaction with senior residents, and summer camps in public housing projects.

Donghia Furniture and Textiles, 1989.
Soho, New York NY.

Marketing Department of the central corporate office.

Boards and Committees I have Served on Include:

- Women's Health Advisory Group, City Hospital
- Chairperson for the Health and Human Services Task Force for FOCUS
- Health and Human Services Task Force, Community Partnership for Berkeley and Morgan Counties
- Perinatal Issues Task Force, FOCUS
- Planned Approach to Community Health Committee
- School Drop out Prevention Committee, Berkeley County Schools
- Community Against Substance Abuse, Berkeley County Schools
- Board Member, Berkeley County Coalition for the Homeless
- Board Member, Morgan County Boys and Girls Club
- Board Member and Secretary for Just Say No of Berkeley County
- Board Member, Community Partnership for Morgan and Berkeley Counties
- Core Team, Jefferson County schools
- Migrant Workers Task Force for Prevention

Awards:

- Award from my prevention colleagues throughout the state for making substance abuse prevention efforts grow in the state of West Virginia, 1994
- Community Partnership award for outstanding contributions to prevention, 1994
- Award from the FOCUS coalition on substance abuse for prevention, 1994

References available upon request

Appendix R

Social Worker Introduction

My name is [redacted] and I am a Social Worker. I am working at Harpers Ferry Family Medicine and Jefferson Maternity Center for three months as part of a project. I will be working under the supervision of your physician. The project permits me to provide counseling and education to patients who have expressed concerns about situations in their lives which need to be addressed. Your provider will refer you to see me to discuss these situations. After an interview with the nurse practitioner, I will meet with you for four to six sessions to help you learn about your illness and learn new ways of coping. I do not provide long term psychotherapy sessions. Instead, it is my job to help you and your provider better manage the stress in your life and make lifestyle changes.

Information discussed in the sessions is confidential with a few exceptions. One exception is if you reveal the intent to hurt yourself or someone else. In addition, I am obligated to report incidences of child abuse.

Please let me know if you have questions. I look forward to working with you.

Appendix S

REFERRAL FORM

Name of referral_____

Birth date_____

Reason for referral:

Psychiatric history:

Current medical problems:

Current medications:

Individual making referral_____