Integrating Behavioral Health with Primary Care in Free Clinics

Amy Forsyth-Stephens, MSW
Free Clinic Solutions

Behavioral Health Services in a Free Clinic Setting: Tremendous Need and Opportunity

Free clinics today face tremendous challenges, including recession-based resource reductions and demand increases, system changes spurred by health care reform, and an increasingly complex patient profile characterized by persons with multiple chronic health conditions. This Guide focuses on those serving patients who walk through the doors of free clinics with both physical and behavioral health needs, including mental health and/or substance abuse conditions. Models of service integration are available that accommodate free clinics of diverse size, culture, structure, operation, and composition of staff. Free clinics must begin to transition along a continuum of evidence-based models for care coordination in a manner that best meets the needs of their patient population, stakeholders, and community (1).

For the purposes of this Guide, the term "free clinic" is a nonprofit, community-based or faith-based organization; provides health care services at little or no charge; serves predominantly low-income, uninsured and/or underserved populations; and, utilizes volunteer health professionals and partnerships with other health organizations. Some of the information in this Guide may also pertain to organizations that prefer to describe themselves as "charitable" or "charity" clinics, which are entities that have all or most of the characteristics of free clinics except that they require or strongly encourage the patient's payment of fees, which may be assessed either on a flat or sliding-fee scale; and may also serve and submit claims for Medicaid patients.

Comorbidity (i.e., co-occurrence in the same person) of behavioral and medical conditions is recognized to be the rule rather than the exception (2). The data are irrefutable: More than 68 percent of adults with a mental disorder have medical conditions, and 29 percent of adults with medical conditions have mental disorders (3). Sadly, persons with comorbid mental and medical conditions are at high risk for receiving poor quality of care (2). Add to this equation low socioeconomic status and no health insurance, and you have a perfect storm for crisis-driven and disjointed treatment, poor health outcomes, and shattered lives.

Predictably, persons caught in this squall are increasingly turning to our nation's free clinics as their health conditions worsen. Yet, these clinics were often founded by volunteers as grassroots operations with the mission of treating physical illness, injury, and acute conditions (4). A majority of free clinics continue to lack the manpower, facilities, and infrastructure to satisfactorily manage chronic disease among their patients, much less comorbid mental and medical conditions (5)(6). When presented with a patient that has a mental health or substance abuse condition overlaying their physical illness, many free clinic clinicians throw up their hands in frustration and make a referral to the local pubic mental health agency. The likelihood of the patient making and keeping an appointment, being offered appropriate and timely services, being able to pay for the services, and affording any prescribed medication is often very low.

This dire situation is paradoxical, in that a long-standing tenet of primary health care is to treat the mind and the body together (7). Most commonly, however, body is treated by one set of practitioners, and mind by another. Separate and distinct medical records, treatment plans, medication regimens, and service locations add to the divide.

The typical free clinic is especially ill-equipped to bridge this divide. With limited hours and all or a majority of medical care being donated by volunteers, free clinics tend to aim their

limited resources at treating their patients' primary presenting health problems (5). The rotation of clinicians at the clinic and erratic follow-up by the patient complicate the creation of a head-to-toe treatment plan. Mental health and/or substance abuse issues may be left undisclosed and untreated months into treatment.

Yet, research indicates that there are benefits to proactively treating behavioral health problems within the context of primary care. Although the outcome research has been almost exclusively conducted in the private sector, the benefits for both the patient and the organization should hold true in the free clinic sector as well. Patient-level benefits may include greater patient involvement in their health care, improved health outcomes, improved ease of health care consumption, and symptom reduction (8). Organizational benefits include the provision of higher-quality care, expanded community support, broader professional engagement, and diversification of revenues via access to new funding streams (9)(10).

Delivering Behavioral Health Services in a Free Clinic

Although the benefits are obvious, the process of integrating behavioral health care into the primary care services provided by a free clinic can be daunting. Issues of space, staffing, treatment planning, medical records, and outcome tracking must all be addressed. Not to be overlooked, a clinic must secure the resources necessary to accomplish this leap across the divide.

A notable segment of free clinics have been bold and creative in their efforts to incorporate behavioral health care into their service menus. In fact, 30 percent of America's free clinics report offering on-site mental health care, and 8.5 percent report offering on-site substance abuse care (5). While being able to claim behavioral health care among their service

offerings, it is likely that many of these clinics have not yet achieved true integration of behavioral health care with primary care. In order to reliably achieve positive outcomes, service integration must become an organizational priority -- that is, be carefully designed, skillfully implemented, and funded adequately.

Twenty years of data has provided an ideal evidence-based approach for addressing comorbidity in free clinic patients -- the Collaborative Care Approach (11) (12) (13). This approach screens and tracks behavioral health conditions in medical settings using a multidisciplinary team. It can be adapted to free clinics of diverse organizational structures, operations, and staff compositions.

The Collaborative Care Approach requires that the model of service delivery be built around two basic elements: 1) the use of a Care Manager to coordinate treatment, manage the behavioral health/primary care interface, provide patient education, and maximize the participation of the patient, and 2) a common medical record, including an integrated treatment plan used by all practitioners who are treating the patient. For clinics serving disadvantaged populations, additional desirable elements include access to often expensive psychotropic medications and same time/same place appointments with physical health and behavioral health providers in order to minimize no-shows, reduce the travel burden of patients, and minimize barriers related to child care and time away from work.

Chart 1 presents the three broad models of the Collaborative Care Approach that have been implemented successfully by free clinics to achieve varying levels of integration of behavioral health and primary care. The chart presents an overview of each model by human and material resource needs (e.g., staff, space) and other important considerations. The selection of a model by a clinic's leadership is necessarily driven by consideration of caseload

characteristics, infrastructure readiness, and current and/or potential resources. Because every free clinic is unique in terms of structure, operation, and resources, a clinic may determine that a hybrid version -- a combination of elements from each model -- presents the best choice for them.

Model determination would include decisions on what treatment services and specialties are to be provided on-site by staff and/or volunteer clinicians, what services and specialties will be coordinated by the clinic but delivered in off-site venues by volunteers or staff of other agencies, and what services will be delegated completely to other providers.

In determining the scope of behavioral health services that a clinic will provide, planners should anticipate that patients will present with a broad range of behavioral health conditions, complicated by their co-occurring physical health issues, personal and family stressors, low income, and low health literacy. Clinics should anticipate serving patients with the most common forms of mental illness, i.e., clinical depression, generalized anxiety disorder, and bi-polar disorder. Clinics will also serve patients who are diagnosed with various types of substance dependence disorders, alcohol and nicotine dependence being the most common. Also, clinics will see patients dually-diagnosed with both mental health and substance dependence disorders. These dually-diagnosed patients may be best treated via referral to local programs that are designed to address the mental health and substance dependence diagnoses together, using evidence-based interventions specific to this group.

Other patients who may be best treated in specialized programs operated by other organizations include those patients whose behavioral health conditions are complicated by domestic violence, those who are court-ordered to mental health or substance use treatment (due to possible low motivation and/or involvement on the part of the patients), families and youth

that could benefit from in-home interventions, homeless individuals, and those persons whose behavioral health disorders are severe and persistent, necessitating long-term, intensive intervention and specialized service modalities. Because the spectrum of need will be vast, free clinics must necessarily work to bring together a network of resources, both internal and external, to achieve the best possible outcomes for their patients.

Chart 1 - Three Models for Free Clinic Integration of Primary Care and Behavioral Health Services

Model #1: The Staff-Based Model (full integration). **Staff of the free clinic provide integrated primary and behavioral health care services via a multidisciplinary treatment team.**	
Staffing Requirements	• Care Manager (full-time, paid staff position) • One or more paid behavioral health staff (e.g., counselor, clinical social worker, psychologist) • Consulting Psychiatrist or Psychiatric Nurse Practitioner
Space Requirements	Treatment occurs on site at the free clinic, often in exam rooms that have been outfitted with comfortable seating for patient and practitioner.
Other Considerations	Best For: Larger free clinics with paid clinical staff members, appointment-based patient scheduling, physical facilities that allow for co-location of services, and electronic medical records. Benefits: Offers the highest degree of control, greatest accessibility for the patient, and the highest likelihood of true treatment integration. Patients can receive care at one familiar and accessible site. Challenges: The most resource-intensive of all models, and therefore the most challenging to sustain.
Model #2: The Volunteer-Based Model (partial integration). **Behavioral health providers who volunteer for the free clinic deliver needed behavioral health services according to an integrated treatment plan.**	
Staffing Requirements	• Care Manager (part-time, paid staff position) • Volunteer Coordinator
Space Requirements	Treatment usually occurs off-site at the offices of volunteering mental health professionals. Commonly referred to as a "Clinic without Walls."
Other Considerations	Best For: Midsized free clinics that have few paid clinical staff members, limited hours, and insufficient resources to develop fully integrated practices. Benefits: Mental health professionals are eager, low-cost volunteers. A group of part-time volunteers can provide greater breadth of expertise than a single employee. The work of many volunteers can be coordinated by a single Care Manager. Challenges: Off-site services may be difficult to coordinate and track. Face-to-face team meetings are a challenge to arrange. Volunteers may be hesitant to use one integrated medical record. Patients must travel to different sites to receive care.
Model #3: The Partner-Based Model (facilitated referrals). **The free clinic conducts screenings and coordinates referrals to behavioral health providers.**	
Staffing Requirements	• Care Manager (volunteer dedicated to this role)
Space Requirements	Treatment may occur wherever community partners conduct their work (e.g., schools, student-run clinics, public agencies, social service organizations).
Considerations	Best For: Start-up free clinics with no paid clinicians, small administrative staffs, and part-time walk-in operations. Benefits: Community collaboration usually represents a highly efficient use of resources. Challenges: No integrated medical record, as each organization has unique paperwork requirements. Often, patients must go through multiple intakes. Transfer of health information between organizations can be irregular, slow, or even prohibited due to confidentiality protocols. Patients must travel to different sites to receive care.

Building a Fully Integrated Treatment Team

As depicted in Chart 1, the Collaborative Care Approach and the multidisciplinary treatment team are central components of Model 1 (full integration) and Model 2 (partial integration). A multidisciplinary treatment team is just that—a *team* of providers that plans, delivers, monitors, and adjusts the treatment for ongoing patients of the free clinic who have complex or chronic health conditions. To achieve integrated behavioral health care, the team must include those with behavioral health expertise. How the team operates (the frequency and modality of their group work) depends on the availability of various team members. In the free clinic sector, a clinician's availability is often correlated with the amount of their paycheck. Thus, volunteer clinicians are less available for team work, part-time staff clinicians are more available, and full-time staff clinicians are most available. If the team consists entirely of on-site paid clinical staff, the location and modality of team meetings is straightforward. A regular schedule, tight organization, and productive outcomes result in satisfied and reliable team members.

If volunteers make up a majority of the team, face-to-face team meetings may be difficult to arrange. In this situation, the Care Manager organizes regularly-scheduled team meetings, which would include all primary and assisting clinicians treating a specific patient or group of patients. Depending on caseload size and characteristics, these team staffings could occur weekly or bi-weekly. They often work best if scheduled to occur on a regular day and time. Virtual meetings (e.g., video conferencing) work well with volunteer clinicians if all parties have access to the required equipment and computer applications.

The team must be tasked with creating, monitoring, and adjusting a fully integrated treatment plan for each patient identified through screening as having a behavioral health

condition. Ideally, the Care Manager ensures that the patient is involved in the development of this plan. This single treatment plan includes all recommended treatments for the patient, including overlapping and interrelated medical and mental health conditions, all medications prescribed, healthy behaviors for mind and body, necessary monitoring, additional/outside resources to secure, and future actions.

A fully integrated team would ideally include the following members:

Care Manager: The heart of the team, this person coordinates the meetings of the team, provides patient education, aids patients with treatment decisions and symptom tracking, arranges for follow-up care, and communicates with the team when important information must be considered. Often, a nursing or social work professional can fill this role. A sample job description for a Care Manager is included in the Additional Resources section of this Guide.

Primary Care Physician or Nurse Practitioner: The team must include the full participation of the practitioner who is attending to medical needs of the patient.

Counseling or Therapy Provider: The team must include the behavioral health provider who is attending to the behavioral health needs of the patient. This might be a professional counselor, clinical psychologist, clinical social worker, marriage and family therapist, and/or substance abuse treatment professional. Licensed professionals are preferable for liability reasons and provide an unquestionably high standard of care. Less costly and often more available are those pre-professionals from formal training programs or post-degree individuals working toward licensure.

Psychiatric Specialist: Since medication is a critical component of the treatment plan for many clients with behavioral health conditions, the participation of one or more clinicians who can competently prescribe psychiatric (also known as psychotropic) medications is critical. This role

could be filled by a psychiatrist, a psychiatric nurse practitioner, or a family physician with a special interest and up-to-date training in behavioral health treatments. Psychiatric coverage is typically part-time, even in a large free clinic, and thus the use of the Consulting Psychiatrist, either paid or volunteer, is often pursued.

Social Worker: A social worker may be a welcome addition to a team, to serve as the patients' "health navigator" when outside providers and resources need to be tapped, and to empower patients to address life problems that may be impacting their health status and treatment compliance.

Residents, Interns and Students: Often, those training to work in primary care or behavioral health can provide substantial clinical manpower to a free clinic and to the integrated treatment team. Look to forge relationships with medical schools and higher education departments of counseling, psychology, and social work. A range of options may be available which would benefit both the clinic and the school. These include full-time primary care residency programs, semester or year-long block internships, and summer externships. Students always need to have a supervisor who works with the student and the clinic to ensure a quality experience for each.

Screening for Behavioral Health Disorders in a Free Clinic Setting

Not every free clinic patient may need the attention of the multidisciplinary treatment team. Therefore, screening for common behavioral health disorders is of primary importance, in order to target the energies of the team and the resources of the clinic where they are most needed. Clinics which are proactively integrating behavioral health services often screen every patient for mental health and substance use disorders. The screening tool(s) become a routine part of the intake process, and are reviewed by the initial attending practitioner. Those patients

for whom follow-up is recommended are referred to the Care Manager, who arranges for a complete behavioral health intake, and possible referral to the multidisciplinary treatment team.

Four commonly used brief screening tools are described and Internet links provided in the Additional Resources section of this Guide. All are designed for easy use in primary care settings. The first two are mental health screening tools and the second two are substance abuse screening tools.

- *The MacArthur Initiative on Depression and Primary Care Patient Health Questionnaire (PHQ-9)*
- *The Modified MINI Screen (MMS)*
- *The NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST)*
- *The CAGE Adapted to Include Drugs (CAGE-AID)*

Ensuring Medication Access for your Behavioral Health Patients

A minimum of 30 percent of free clinic patients who are treated for a behavioral health condition will likely have psychotropic medications as a component of their treatment plan (9). Psychotropics can be among the most expensive of medications, necessitating a low-cost source of access.

Options for access to affordable psychotropics include all those sources available to free clinics for other medications: samples, patient assistance programs operated by pharmaceutical companies, donated medicines from a variety of sources (e.g., AmeriCares), and central-fill pharmacies. If medications are purchased for patients, there may be generic versions of products that offer cost advantages. Be aware, however, that mandating the exclusive use of generics is

not recommended in the treatment of behavioral health disorders. Side effects can be common and serious, and patients may prefer and respond best to a very specific formulation. Switching may lead to symptom escalation and more intensive treatment, which in the end is more expensive than the name-brand drug.

A useful website that specializes in providing access to low-cost psychotropic medications is included in the Additional Resources section of this Guide.

Tapping Community Partners to Increase Access to Behavioral Health Services

Under any model of integration, successfully working with local partner organizations is key to achieving access to a full continuum of services for free clinic patients. Whether a free clinic's behavioral health services are provided by staff or volunteers of the clinic or by outside agencies, no single entity can provide every type and modality of behavioral health care service that may be central to the integrated treatment plan or that may complement the plan.

Free clinics are prudent to explore meaningful partnerships, and the creation of formal referral arrangements, with a variety of public, community-based, and educational institutions, and local private behavioral health practitioners with unique areas of specialization. These include:

- ***Publicly-supported Mental Health and Substance Abuse Service Agencies:*** These organizations offer a diverse array of services in the areas of mental health, developmental disability, and substance abuse/addiction. Typically, these agencies receive state funding and serve persons who are covered by Medicaid. They may charge on a sliding scale for those who are uninsured. Public agencies often target their services to the most severely ill individuals -- those whose illnesses cause disability and frequent use of inpatient-based care.

Public agencies may offer special programs for those with dual diagnoses or who have been involved in the criminal justice system.

- ***Student-Based Clinics:*** Universities that have psychology, counseling or social work graduate programs may operate student-staffed community clinics. Care is overseen by a licensed faculty member. Payment is often on a sliding scale, or services are free. Waiting lists can be long.
- ***Individual Behavioral Health Professionals:*** Licensed psychologists, counselors and psychiatrists in private practice may offer essential specialties, such as child and family-centered treatment, addiction treatment, and neuropsychological testing/treatment. Area specialists may also be the best source of treatment for patients who present with very specific behavioral health disorders, such as phobias, eating disorders, and bi-polar disorders.
- ***Federally Qualified Health Centers (FQHCs):*** If the local health care community includes a Federally Qualified Health Center (FQHC), this organization likely provides or contracts for behavioral health services. Innovative collaboration could result in shared staff, referral sources, space, and administrative costs.
- ***Addiction Self-Help Groups:*** Peer-run self-help groups may be useful supplements to treatment provided by or arranged by the free clinic. Most communities have active chapters of Alcoholics Anonymous (AA), Narcotics Anonymous NA), and Al-Anon (family support). Secure a comprehensive listing of all available support groups, and distribute this to all patients -- not only those identified as having a behavioral health need.

Fundraising for Integrated Programs

One of the advantages to free clinics of behavioral health and primary care integration is access to new and varied sources of funding for this sophisticated treatment model. Clinics can explore relationships with local, regional and national private and corporate foundations (http://foundationcenter.org/) that focus on mental health, addiction issues, or dually-diagnosed individuals. Examples include pharmaceutical company foundations, health care system or hospital foundations, and insurance company foundations. Clinics may also find that new sources of government grants are available to support treatment integration. A good place to start is the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) grant seekers' website (www.samhsa.gov/grants/). Also be sure to discuss this work with statewide free clinic associations (http://freeclinics.us/about-us/stateregional-associations) to determine if special state-specific funding initiatives exist or could be developed to support clinics in their movement toward integrated care.

Finally, as service integration will hold great appeal for groups of individual stakeholders and advocates passionate about quality behavioral health care services, clinics' contribution campaigns can be broadened to include new categories of potential supporters. People to consider engaging include local chapter members of Mental Health America (http://www.nmha.org/), the National Alliance for the Mentally Ill (http://www.nami.org/), and local behavioral health/addiction professionals. Use all forms of available media to ensure that the community is aware of integration plans and efforts, and what the clinics' specific resource needs are at launch and as you progress.

Looking Ahead

The Patient Protection and Affordable Care Act, signed into law in March 2010, creates new conditions and arrangements that will impact the priorities and approaches of free clinics across the nation. The Act's emphasis on patient-centered medical homes, team management of chronic disease, and accountable care organizations all underscore the necessity of the free clinic sector's movement toward adaptation of coordinated care models and the integration of behavioral health and primary care. Because of their relative freedom from regulatory constraint, free clinics have the opportunity now to set the standard in care coordination for the health care safety net of America. Free clinic patients deserve no less.

About the Author

Amy Forsyth-Stephens is one of the nation's foremost experts on integrating behavioral health with primary care in community-based settings. Amy served as Executive Director of the Free Clinic of the New River Valley and the Mental Health Association of the New River Valley (in southwestern Virginia) over a 13-year period of extraordinary growth. In 1997, Amy led the development of Virginia's first "free mental health clinic" - the Pro Bono Counseling Program. The program won national acclaim as an innovative model for extending critical mental health services to low income, uninsured persons. Under a HRSA Rural Health Outreach Grant, *ARMS Reach: Access to Rural Mental Health Services* was developed and became a groundbreaking rural mental health outreach program, tackling transportation and stigma barriers by taking mental health services to familiar locations in remote Appalachian settings.

In tribute to her pioneering work in mental health programming, Amy was selected as one of 25 health professionals across the nation to be featured in a 2004 book entitled *The Faces of Public Health*. Amy received a Master of Social Work degree with a specialization in Program Evaluation from Florida State University in 1982. She worked for the State of Florida evaluating community-based systems of mental health care in the early 1980's. She then worked in King County, Washington, developing and evaluating intensive community support projects for inner city homeless.

About Free Clinic Solutions

Established in 2006, Free Clinic Solutions is a national organization that provides strategic consulting, training, coaching, research, writing, and public speaking to free clinics and charitable clinics across the U.S., their associations, and other organizations that support and partner with them. Services are provided by a team of professionals who have extensive experience in the health care safety net and subject matter expertise in relevant disciplines. Founder and Principal Mark R. Cruise served as Executive Director of the Virginia Association of Free Clinics from 1997-2006. For more information, visit www.freeclinicsolutions.com or call (804) 306-3975.

Bibliography

1. Institute of Medicine. *Adaptation of Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions.* Washington : s.n., 2006.
2. Robert Wood Johnson Foundation. *The Synthesis Project: Mental Disorders and Medical Comorbidity.* 2011.
3. *The US National Comorbidity Survey Replication (NCS-R): Design and Field Procedures.* Kessler, R. C., Berglund, P., Chiu, W. T., Demler, O., Heeringa, S., Hiripi, E., Jin, R., Pennell, B. E., Walters, E. E., Zaslavsky, A., Zheng, H. 2, 2004, International Journal of Methods in Psychiatric Research, Vol. 13.
4. Weiss, G. L. *Grassroots Medicine: The Story of America's Free Health Clinics.* Oxford : Rowman & Littlefield Publishers, 2006.
5. *Free Clinics in the United States: A Nationwide Survey.* Darnell, J. S. 2010, Archives of Internal Medicine.
6. *A Survey of Patients and Providers at Free Clinics Across the United States.* Gertz, A. M., Scott, F., Blixen, C. E. 1, 2011, Journal of Community Health, Vol. 36, pp. 83-93.
7. *Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface.* Mauer, B. J., Druss, B. G. s.l. : Carter Center Mental Health Program, 2007. American College of Mental Health Administration Summit. p. 37.
8. Butler, M., Kane, R. L., McAlpine, D., Kathol, R. G., Fu, S. S., Hagedorn, H., Wilt, T. J. *Integration of Mental Health/Substance Abuse and Primary Care.* Agency for Healthcare Research and Quality. Rockville, MD : Minnesota Evidence-Based Practice Center, 2008.
9. Forsyth-Stephens, A. *Pro Bono Mental Health Program.* Blacksburg, VA : Mental Health Association of the New River Valley, 2000.
10. Models for Practic, Focus Area: Mental Health and Mental Disorders. [book auth.] L. D., Hutchinson, L. L., Dabney, B. J., Dorsey, A. M. Gamm. *Rural Healthy People 2010: A companion Document to Healthy People 2010.* College Station, Texas : The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003, pp. 171-173.
11. Butler, M., Kane, R., McAlpine, D., Kathol, R. G., Fu, S. S., Hagedorn, H., Wilt, T. J. *Integration of Mental Helath/Substance Abuse and Primary Care.* Minneapolis : Minneapolic Evidence-Based Practice Center, 2009.
12. *Collaborative Care for Depression: A Cumulative Meta-Analysis and Review of Longer-Term Outcomes.* Gilbody, S., Bower, P., Fletcher, J., Richards, D., Sutton, A. J. 21, 2006, Archives of Internal Medicine, Vol. 166.
13. *Integrating Mental Health and Primary Care.* Thielke, S., Vannory, S., Unutzer, J. 3, 2007, Primary Care, Vol. 34.
14. *Health Care Reform and Cost Control.* Orszag, P. R., Emanuel, E. J. 7, 2010, New England Journal of Medicine, Vol. 363.

Additional Resources

SCREENING TOOLS

The Patient Health Questionnaire (PHQ-9)
The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. Website includes the questionnaire and scoring and diagnosis guides.
http://www.depression-primarycare.org/clinicians/toolkits/

Modified MINI Screen (MMS)
22 Yes-No items that screen for anxiety and mood disorders, trauma exposure and PTSD, non-affective psychoses, and co-occurring disorders. The MMS can be administered in 5-10 minutes and scored in less than five minutes. The MMS is extensively used throughout New York State.
Tool: *http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-mms-scoringsht.pdf*
User Guide: *http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-mms-userguide.pdf*

The NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST), National Institute on Drug Abuse
This web-based interactive tool guides clinicians through a short series of screening questions and, based on the patient's responses, generates a substance involvement score that suggests the level of intervention needed. The website also includes a tool reference guide and a clinician's resource guide.
http://www.nida.nih.gov/nidamed/screening/

CAGE Adapted to Include Drugs (CAGE-AID)
A modified version of the CAGE screen for alcohol problems, the CAGE-AID is a four-item conjoint screen for alcohol and substance abuse. Very short and easy to administer and score, the screen can be administered in less than five minutes.
http://www.agencymeddirectors.wa.gov/Files/cageover.pdf

AFFORDABLE PSYCHOTROPIC MEDICATION ACCESS

Mental Health Today
This website provides a useful list of pharmacy patient assistance programs by psychotropic medication, and drug discount card programs.
http://www.mental-health-today.com/helpmeds.htm

JOB DESCRIPTION FOR CARE MANAGER

A sample Job Description for an Integrated Treatment Care Manager is provided on the following page.

INTEGRATED TREATMENT CARE MANAGER

JOB DESCRIPTION

Job Summary

The Integrated Treatment Care Manager is responsible for coordinating integrated medical and behavioral health care for patients in a free clinic setting.

The Integrated Treatment Care Manager arranges regular meetings of the multidisciplinary treatment team, enlists patients' participation on the team, coordinates the completion of an integrated treatment plan for each patient, educates patients about chronic medical and behavioral health disorders and their treatments, monitors symptoms and response to medical and behavioral health treatments using structured instruments and patient interviews, works closely with the primary care provider and a consulting psychiatrist to monitor patient outcomes and revise the treatment plan as necessary.

Duties and Responsibilities

1. Conducts assessment of patient, including completion of standardized screening instruments and behavioral health intakes.
2. Conducts initial visit including detailed patient health history and education about the nature of behavioral health disorders and the goals and expectations of treatment.
3. Consults with patient and multidisciplinary treatment team about treatment options and preferences; coordinates initiation of treatment plan.
4. Monitors patient closely (in-person and by phone) for changes in severity of symptoms and medication side effects; educates patients about medications and medication side effects, as needed; encourages treatment adherence.
5. Coordinates and participates in regular multidisciplinary team meetings with all clinicians serving the patient, focusing on new patients and patients not adequately improved within specified timeframe.
6. Coordinates and facilitates communication between patient, primary care physician, consulting psychiatrist; and other providers; provides recommendations to multidisciplinary team for change in treatment plan; supports implementation of new plan.
7. Documents all encounters according to organizational policies and procedures; monitors health outcome measurements.
8. Facilitates and monitors treatment referrals, as needed.

Requirements

Degree in nursing, social work, counseling, marriage and family therapy or psychology. Effective written and verbal communication skills. Demonstrated ability to establish rapport quickly with a wide range of people. Minimum two years clinical experience in a relevant setting. Knowledge of community resources for low income and uninsured persons and families. Desired experience with behavioral health conditions and treatment. Experience working directly with chronically ill adults.