Behavioral Health Counseling in Health Care Integration Practices and Health Care Systems

An American Mental Health Counselors Association White Paper

By H. Gray Otis and Joel E. Miller

AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

The only organization working exclusively for the mental health counseling profession

675 North Washington Street, Suite 470 Alexandria, VA 23214
info@amhca.org | *www.amhca.org* | 800-326-2642

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Introduction

Health care reform through new delivery and financing models is creating better patient outcomes. Although the Affordable Care Act (ACA) provides impetus to these initiatives, healthcare reform is not simply about what is codified in the ACA.

There are market forces – as well as other state and federal initiatives – that predate the ACA, and will greatly enhance the delivery of both medical and behavioral health care services in the future. The integration of mental health and primary care medical services with an emphasis on prevention is part of those marketplace and regulatory imperatives.

Integrated systems of care are going to be comprehensive, coordinated, multi-disciplinary, co-located, and interconnected through the latest technologies. Furthermore, as we move in this direction, clinical mental health counselors (CMHCs) will need to increase their knowledge and skills to participate in the emerging practices and systems which will employ evidence-based treatment approaches. (*See Section V of the Standards for the Practice of Clinical Mental Health Counseling for detailed information on the specific knowledge and skills that CMHCs should acquire and practice.*)

Many CMHCs already possess the training and experience in the promotion of wellness, a key component in successful integrated systems. The assessment and treatment of psychiatric disorders are understood from a mental health perspective. CMHCs are trained to assist clients towards achieving optimal human functioning and away from emotional and mental distress.

Many CMHCs already possess the training and experience in the promotion of wellness

Moreover, CMHCs frequently work as members of multi-disciplinary treatment teams. They are able to provide more comprehensive interventions and treatment services. Treatment teams benefit from this unique perspective of prevention, wellness, and personal growth.

Integrated care models hold promise in addressing many of the challenges facing our health care system. CMHCs possess clinical and policy expertise as primary mental health care providers. Due to their training and expertise, they will be invaluable to primary care physicians in developing innovations to improve the nation's health. This includes the goal of dramatically reducing the unacceptable high morbidity and mortality rates experienced by Americans with mental illness.

What Do We Mean by Integration?

Integrated health care is the systematic coordination of behavioral health care with primary medical care. Evidence demonstrates that physical and behavioral health problems often occur at the same time and are interrelated. By contrast, unintegrated episodic and point-of-service treatment has been demonstrated to be ineffective as well as inefficient for chronic mental, behavioral, and medical illnesses.

There is a robust body of research evidence supporting the effectiveness of integrating mental health into primary care settings, especially for adults with depression and anxiety disorders. Integrating services yield improvement in clinical outcomes and the best possible quality of life results. More than 70 randomized trials have been conducted on the collaborative care model over the past 15 years. Characteristics of this model include: a primary care provider, care management staff and a mental health provider consultant,

with close tracking of the patient's progress (analogous to the monitoring of diabetes patients) with step-ups in treatment level done in a systematic fashion if improvements are not shown. If a patient requests, or crises arise, a referral out to a specialty care provider is made. The evidence shows that such a systematic approach can overcome the clinical inertia that is often responsible for ineffective treatment of common mental disorders in primary care.[1] Trials of the collaborative care approach across diverse settings (private and public, network and staff models, different financing models, ethnic populations, insured and uninsured, and different mental conditions) have consistently demonstrated higher effectiveness than usual care.[2]

The evidence shows that such a systematic approach can overcome the clinical inertia that is often responsible for ineffective treatment of common mental disorders in primary care.[1]

An example of the effectiveness associated with collaborative care models is the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) study. The IMPACT study was the largest trial of collaborative care to date and was conducted through a program of the University of Washington, Department of Psychiatry & Behavioral Sciences. A team of researchers followed 1800 older adults with depression from 18 diverse primary care clinics in different states and different settings across the United States for two years.[3] These older persons in the study averaged 3.5 chronic medical disorders. The primary care practice team was expanded to include a depression care manager and a consulting mental health care provider. Two main clinical processes were used, systematic tracking of clinical outcomes and stepped care (the systematic adjustment of care to mental health consultations if patient improvement was not as expected).

The study found that the IMPACT trial group was more than twice as likely as those in the control group to have a substantial improvement in their depression over a year, have less physical pain, better social and physical functioning and overall quality of life. The approach has also shown positive results in depressed adolescents, cancer patients, and diabetics, including low income Spanish speaking patients.[4] These positive results for patients and providers from the collaborative care approach have also generated positive cost reductions across all categories of care, pharmacy, inpatient, outpatient medical, and mental health specialty care.[5]

1. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, By Jürgen Unützer, MD, MPH, University of Washington; Henry Harbin, MD, Health Care Consultant and former CEO of Magellan Health Services; Michael Schoenbaum, PhD, National Institute of Mental Health; and Benjamin Druss, MD, MPH, Emory University, HEALTH HOME Information Resource Center Brief, May 2014, developed for the Centers for Medicare & Medicaid Services by the Center for Health Care Strategies and Mathematica Policy Research; citing Melek S. "Bending the Medicaid Healthcare Cost Curve through Financially Sustainable Medical-Behavioral Integration" Milliman; Druss BG, Zhao L, Cummings JR, Shim RS, Rust GS, Marcus SC. "Mental Comorbidity and Quality of Diabetes Care under Medicaid: A 50-state analysis." *Medical Care*. May 2012; 50(5):428-433; Daumit GL, Anthony CB, Ford DE, et al. "Pattern of Mortality in a Sample of Maryland Residents with Severe Mental Illness." *Psychiatry Research*. April 30 2010;176(2-3):242-245.

2. Luff M. (2014) Integrating Mental Health, Primary Care is Focus of IHI Webcast, Collaborative Care Benefits Patients. *http://www.aafp.org/news/practice-professional-issues/20141210mentalprimary.html.*

3. Citing Henke RM, Zaslavsky AM, McGuire TG, Ayanian JZ, Rubenstein LB. (2009). "Clinical Inertia in Depression Treatment", *Medical Care*, 47(9): 959-967.

4. The participating clinics were associated with eight health care organizations in Washington, California, Texas, Indiana and North Carolina; including HMOs, traditional fee-for-service clinics, an Independent Provider Association (IPA), an inner-city public health clinic and two Veteran's Administration clinics. An implementation guide and team-building tools can be found at *http://impact-uw.org/files/IMPACT_Team_Building_Worksheet.pdf* and *https://aims.uw.edu/collaborative-care/implementation-guide*, on the AIMS website *aims.uw.edu*. Since the implementation of this approach in the State of Washington Mental Health Integration Program ("MHIP"), sponsored by the Community Health Plan of Washington and Seattle King County Public Health, with a pay-for-performance component, in 2008 the median time-to-improvement in depression has been cut more than in half.

5. Unützer J, Katon WJ, Fan MY, et al. (2008). "Long-term Cost Effects of Collaborative Care for Late- life Depression", *The American Journal of Managed Care*, 14(2): 95-100.

The collaborative care approach spills over into positive economic results as well, in days missed in employment, better productivity, better longevity of employment, personal income, etc. Particularly encouraging is the likelihood of Medicaid beneficiaries moving off the Medicaid rolls. With the increasing number of states who have sought and received State Plan Amendments since the passage of the ACA, there is optimism that additional significant results will be seen.[6]

The quality improvement movement in health care, including the goal that consumers should always receive the right care, at the right time, by the right caregivers, supports the idea of integrative, comprehensive health care services for people with a mental illness. Additionally, CMHCs should participate in state and local, public and private sector programs that accelerate the crucial integration between physical health care and behavioral health services to promote recovery for individuals with mental illnesses and addictions.

The Issue of Unrecognized and Untreated Mental Illness

Mental health conditions are under-recognized and undertreated. Over 25 percent of primary care patients have depression or anxiety disorders.[7] Unfortunately, primary care practices do not address a large percentage of mental health conditions. Patients with a mental illness frequently present to primary care with physical health symptoms (e.g., fatigue, insomnia, heart palpitations, gastro-intestinal symptoms, etc.). Primary care doctors, focusing on physical ailments, frequently overlook underlying psychological causes.[8]

At the same time, nearly 65 percent of primary care providers report that they are unable to connect patients with outpatient mental health providers due to a perceived shortage of mental health providers and health insurance barriers.[9] Concurrently, over 67 percent of adults with a mental health disorder do not get mental health treatment.[10] Only 13 percent of people diagnosed with a mental health condition receive minimally adequate treatment in a general medical setting; for substance use disorders that number drops to a dismal five percent.[11]

Primary care has become the de facto location for these patients to receive treatment. Unfortunately, the majority of their care is suboptimal due to time constraints and the lack of access to mental health specialists such as CMHCs, that could enhance their access to effective, comprehensive treatment services.[12, 13]

Numerous studies show that primary care providers often do not have the time or resources to provide effective treatment for many behavioral health conditions, including depression, anxiety disorders, post-

6. 27 States have received approval by CMS to date, see *http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html*
7. Vermani, M., Marcus, M., & Katzman, M. A. (2011). Rates of Detection of Mood and Anxiety Disorders in Primary Care: A Descriptive, Cross-Sectional Study. The Primary Care Companion to CNS Disorders, 13(2), PCC.10m01013. *http://doi.org/10.4088/PCC.10m01013populat*
8. Ibid.
9. Cunningham, PJ. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs* (Project Hope), 28(3), w490-501.
10. Kessler, R., McGonagle, K., Zhao, S., Nelson, C., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51(1), 8-19.
11. Wang, PS, Lane, M., Olfson, M., Pincus, HA., Wells, KB, & Kessler, RC. (2005). Twelve-month use of mental health services in the United States: Results from the national comorbidity survey replication. *Archives of General Psychiatry*, 62(6), 629-640.
12. Regier, DA, Narrow, WE, Rae, DS, Manderscheid, RW, Locke, BZ, & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system. epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(2), 85-94.
13. Wang, PS, Demler, O., Olfson, M., Pincus, HA, Wells, KB, & Kessler, RC. (2006). Changing profiles of service sectors used for mental health care in the United States. *The American Journal of Psychiatry*, 163(7), 1187-1198.

traumatic stress disorder, substance use disorders, bipolar disorder, personality disorders, and other psychiatric conditions.[14] Patients may receive medications but they rarely receive any mental health counseling interventions. Research has repeatedly demonstrated that medical treatment combined with psychotherapy yields significantly improved patient outcomes as well reduced overall treatment costs.[15] In addition, less than 20 percent of primary care providers feel "prepared" to identify substance use disorders. Most patients with a substance use disorder say their primary care provider did nothing to address their disorder.[16] CMHCs are trained to treat substance use disorders, the co-morbid mental health issues, and also the underlying causes of these health concerns. Typically, primary care physicians do not possess the training, experience, or the time necessary to achieve successful outcomes for complex substance use disorders.

Integrating mental health into primary or physical health care settings is critical to addressing the overall clinical needs of people with behavioral health conditions. More than a quarter (29 percent) of adults with physical health problems, also suffer from a mental illness. For example, depression is 2 to 3 times more common following a heart attack or stroke and leads to worse outcomes.[17] In another example, head and neck patients with mild or moderate traumatic brain injuries, including concussions, often develop depression due to facial disfigurement after surgery.[18] Furthermore, gastro-intestinal disorders most commonly have co-occurring mental distress or post-traumatic stress which is often a major contributing factor to the origin of the physiological health issue.[19]

The mental health challenges of acute or complex specialty care are often related to the medical condition being treated. Often overlooked, is the accompanying mental distress of family members. Rarely are simplistic, single minded solutions the best solution to multidimensional health concerns. On the other hand, CMHCs have proven to be effective in assessing total behavioral health and providing comprehensive behavioral health counseling, psychoeducation, family therapy, and other innovative approaches so that individuals and families can achieve optimal health outcomes as well as future mental health resilience.

The mental health challenges of acute or complex specialty care are often related to the medical condition being treated.

Primary care settings and new and emerging integrated care systems, should include dedicated mental health providers, specifically, clinical mental health counselors who understand the mental health needs of the patients they treat, detect developing mental health conditions, and intervene early. CMHCs will improve patient value and should occupy such roles.

Preventing the Worsening of Mental Health Conditions

The best health care systems are the ones that focus on prevention. This helps those individuals with serious

14. Cunningham, PJ. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs* (Project Hope), 28(3), w490-501.
15. Asarnow JR, Rozenman M, Wiblin J, Zeltzer L. (2015) Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis. JAMA Pediatr. 169(10):929-37. *http://www.ncbi.nlm.nih.gov/pubmed/26259143*
16. CASAColumbia. 2000. The National Center on Substance Abuse at Columbia University. Missed opportunity: national survey of primary care physicians and patients on substance abuse. National Center on Substance Abuse at Columbia University; New York.
17. Druss BG, Walker ER. (2011). Mental disorders and medical comorbidity. The Synthesis Project: Research Synthesis Report. *Robert Wood Johnson Foundation*: (21):1–26.
18.*http://www.revolvy.com/main/index.php?s=Complications%20of%20traumatic%20brain%20injury*
19.*http://www.ptsd.va.gov/professional/co-occurring/ptsd-physical-health.asp*

or chronic conditions from exacerbating their condition or increasing adverse side effects which might require prolonged or additional hospitalizations or other expensive interventions.

Avoiding repeat emergency department visits and hospitalizations for preventable problems is becoming a major area of focus for "value-based purchasing" cost control and quality improvement for employers and health plans. They are now also realizing expenditure reductions as well effective patient health outcomes by focusing on mental health conditions.For example, there are very expensive illnesses such as bipolar disorder and major depression where patient services and care are frequently uncoordinated. In many case, patient hospitalizations for exacerbated symptoms and co-morbid behaviors such as substance use or self-injury can be prolonged and costly.

Additionally, many patients with chronic illnesses become depressed or anxious because of their health problems. Their depression often aggravates their other illnesses because they fail to consistently take their medications, exercise, fail to adhere to a treatment plan, or some other health care prescription. They can become more isolated and depressed patients who overuse the health care system because it offers attentive social interactions.

Primary care settings and emerging integrated care systems should include dedicated mental health providers such as CMHCs. These behavioral health care specialists understand the mental health needs of the patients they treat, detect developing mental health conditions, and intervene early. CMHCs should occupy such roles because research shows that they significantly improve patient outcomes and patient value.

Strengthening the behavioral health care services in primary care is critically needed for four reasons:

1. The majority of individuals with behavioral health conditions get their mental health care in primary care
2. The quality of behavioral health care in primary care is often suboptimal due in part to lack of access to behavioral health care specialists such as CMHCs
3. There are now excellent evidence-based interventions that add behavioral health expertise to primary care practices that significantly improve patient outcomes
4. Effectively treating patients with behavioral health conditions within primary care offers improved patient satisfaction and greatly reduced medical costs. CMHCs are trained and prepared to assist primary care practices in delivering holistic, quality services.

What are Integration Models?

Under the Affordable Care Act, the Centers for Medicare and Medicaid Services' (CMS) Innovation Center was created, and is currently implementing "health homes" under Medicaid, and Accountable Care Organizations (ACOs) under Medicare. These health care facilities are designed to improve the quality of patient care while reducing health care costs.[20]

CMHCs have the expertise in integrated care, care coordination and service delivery. They should play an important role in the implementation of these new models of care as well as other emerging strategies, as they play out both in the public and private sectors. Health homes and Accountable Care Organizations have the potential to unleash powerful incentives to better coordinate integrated behavioral health and primary care services. Since they contain several new elements to improve care they can be labeled as taking integration to the next level.

The health home construct is a service delivery model that is being tested by several public and private sector

20. *https://www.ahcancal.org/facility_operations/Documents/Overview%20of%20CMS% 20Demonstration%20and%20Initiatives.pdf*

health insurance and provider organizations to better coordinate services and programs for people with chronic illnesses. Health homes are collaborative care models. The primary care doctor serves as the center of care and makes referrals as necessary. This offers an opportunity to improve coordination and integration of behavioral healthcare and primary care systems. Health homes are a promising strategy for revitalizing and redefining the primary care system. Highly functioning and responsive health homes can enhance quality efficiencies while increasing access to needed health care and support services, including appropriate referral to specialty services such as behavioral health care provided by CMHC's.[21]

ACOs are vertically and horizontally integrated care systems designed to manage and coordinate care, especially to Medicare fee-for-service beneficiaries.[22] There are strong parallels to public mental health system constructs for a single point of clinical and financial accountability which includes comprehensive home and community-based services. All providers participate and share in risk-payment arrangements.

Key Principles: Clinical Mental Health Counselors in the Integrated Medical Model

Principle 1: The role of clinical mental health counselors is to identify, treat, triage and manage primary care patients with medical and/or behavioral health problems.

Principle 2: CMHCs function as a core member of primary care teams, providing consultative services.

Principle 3: CMHCs seek to enhance delivery of behavioral health services at the primary care level and works to support a smooth interface between primary care and specialty services (e.g., mental health and substance use disorder co-morbid treatment).

Principle 4: The integrated behavioral health model is grounded in a population-based care philosophy.

Treatment of Mental Health Needs in the Primary Care Model

The need for mental health treatments and interventions to adhere to the primary care model, means they should be brief and solution-focused. This aspect is critically important to the success of CMHCs especially in providing mental health services to patients with less complex presentations.

Additional training and knowledge that CMHCs need in order to be successful in integrated primary care organizations, including the following:

- Strong generalist training and knowledge of development that will enable them to competently provide basic mental health services to patients of various ages.
- Ideally, training in health psychology, family therapy, brief therapy, behavioral medicine, child development, and techniques for addressing behavioral health problems in primary care.
- Other suggested training or knowledge, covering topics such as
    - common chronic illnesses in primary care (e.g., asthma, diabetes, heart disease, irritable bowel syndrome), including symptoms, mechanisms, common co-occurring mental health problems, and appropriate treatment;
    - biological components of health and disease;
    - interaction between biology and behavior;

21. *http://www.nasmhpd.org/sites/default/files/NASMHPD%20Integration%20Issue%20Paper_FINAL%20-%209-26-14.pdf*
22. *http://khn.org/news/aco-accountable-care-organization-faq/*

- other factors that may influence health, including memory, perception, cognition, emotions, and motivation; and
- child and adult psychotropic medications, and their uses and common side effects.

CMHCs should be competent in selecting and using the appropriate evidence-based therapies and intervention techniques for a patient's presenting problem, and should be able to monitor progress and coordinate care. Considering the high rate of co-occurring disorders in primary care, CMHCs need to be knowledgeable about population-based interventions, rather than just interventions that are disease-specific. (See Appendix 1)

CMHCs also should be skilled at implementing interventions that focus on improving patient function, rather than personality or symptom reduction. Many patients with mental health needs can be treated appropriately in primary care; however, patients with more complex problems may need to be referred to specialty services.

Specific Skills that Primary Care Practices Seek By Condition and Intervention

1. Emotions Related from a Primary Care Practice Perspective
   - Coping with depression and mood disorders
   - Coping with Bipolar Disorder
   - Coping with anxiety and stress related disorders
   - Coping with Obsessive Compulsive Disorder
   - Coping with chronic distress, psychological trauma, and PTSD
   - Coping with Panic Disorder
   - Coping with ADHD and other attention deficit or learning disabilities
   - Coping with Autism Spectrum Disorder
   - Self-harm and harm to others behaviors
   - Suicidality
   - Coping with other DSM-5 disorders

2. Weight Management Focus from a Primary Care Practice Perspective
   - Exercise
   - Diet
   - Nutrition, hydration, and elimination
   - Cognitive approaches to weight management
   - Body image
   - Eating disorders

3. Self-Regulation Skills to Learn to Put Control of Health under One's Own Personal Locus of Control.

Examples of Specific Assessments Needed in Primary Care Integrated Settings

1. Trauma-Informed Care
   Traumatic life experiences, especially multiple traumas, raise the risk for:
   - Alcoholism and alcohol use, substance use
   - Obesity

- Respiratory difficulties
- Heart disease
- Multiple sexual partners
- Poor relationships with others
- Smoking
- Suicide attempts
- Unintended pregnancies
- A broad spectrum of behavioral health issues and psychiatric disorders

2. Treating Diabetes and Patient Compliance
   - Tests used in diagnosing and treating Diabetes
   - The range of medical treatments used
   - What lifestyle changes are encouraged for patients to better control their diabetes
   - How to deal with non-compliant patients who resist doing what they need to do to take better control over their blood sugar issues

Outcome Goals of Mental Health Interventions in Primary Care Settings

- Prevent disease onset
- Lower blood pressure
- Lower serum cholesterol
- Reduce body fat
- Reverse or manage atherosclerosis
- Decrease or manage pain
- Reduce surgical complications
- Increase post-surgical prescriptive compliance
- Decrease complications of pregnancy
- Enhance immune response
- Increase compliance with treatment – medication plans
- Increase relaxation
- Increase functional capacity
- Improve sleep
- Improve hygiene
- Improve nutrition and hydration habits
- Improve productivity at work & school
- Improve strength, endurance, and mobility
- Improve quality of life

Integrated Health Care Practice-Level Competencies and Internal Policies

It is critically important for CMHCs to have appropriate operational and system supports for the successful implementation of integrated clinical services.

A. Integrated Health Care Practice Workflow and Operations
   - Organized and streamlined procedures should be in place so primary care physicians, CMHCs, and patients are in frequent communication to enhance whole-person, team-based, integrated care.
   - Clear workflows that support regular screening of mental health needs.
   - Workflows that allow behavioral interventions to occur in a timely fashion when a need is

identified
- Workflows that support quick consultations and warm handoffs.
- Defined processes for triaging patients and referring patients with more complex problems to specialty services.
- Shared electronic health records (EHRs) between primary care staff and behavioral health staff.
- Proactive outreach and follow-up contact with the patient as well as the systematic tracking of outcomes.
- Shared patient registries that systematically track each patient's progress and facilitates the adjustment of treatment as needed when a patient is not responding.
- Shared protocols for coding and billing services.

B. Integrated Health Care Practice Administration and Leadership
- For integrated care to work, health care practices need strong leadership that aligns clinical, operational, and financial processes, and ensures appropriate allocation of resources.
- Clear and regular communication should be established between leadership, staff, and providers about the purpose of integration and about expectations for clinic services.
- Ongoing training for staff to build relationships and teach the value of integration.

C. Integrated Health Care Practice Organizational Support
- Integrated health care practices should work to create unified payment coverage policies across payers and should regularly seek the integration of funding support.
- Since integrated care efforts are constantly evolving, practices should develop built-in processes that support continuous quality improvement efforts.
- Practices must have measureable goals and implement measurement-based care along with processes to track outcomes. This requires a structured and well-organized information tracking system such as an EHR system.
- An electronic health record system can help practices manage data related to patient screening, follow-up, scores on clinical tools such as the PHQ-9, and can support other complex information-based tasks.

D. Integrated Health Care Practice Facilities

Primary care practices may request information on CMHC office facilities so CMHCs must be ready to provide information on
- office location, phone, internet, hardware and any other tangible item or service including specific, specialized clinical services;
- general handling of non-clinical patient facing interactions such as the intake process, administrative phone calls, reception and scheduling, eligibility and verification checking, handling of patient payments, no show and cancellation policies; and
- back office functions such as medical billing including patient records management, transcription services, and handling of documents.

Primary Care Culture: Strategizing Provider Workflow

The fast-paced primary care culture requires providers to become skilled at managing their brief encounters with patients. The literature suggested that behavioral health visits in primary care should be 15-30 minutes, rather than the traditional 50-minute session.[23] CMHCs, therefore, must know how to introduce themselves quickly, describe their role in the patient's care, and obtain proper informed consent.

23. *https://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcadLitReview.pdf*

Evaluations should be brief to quickly identify and focus on the patient's primary problem. During the brief behavioral health visit, CMHCs should conduct the appropriate evidence-based intervention and arrange follow-up care for the patient.

Other competencies necessary for working within the primary care culture and effectively managing sessions include the ability to

- orient the patient to the visit;
- quickly elicit behavioral health problems and patient history;
- be flexible and comfortable with frequent interruptions;
- work and adapt quickly; and
- understand the medical culture and common medical terms. (24)

Communication Style

CMHCs should embrace the communication style of the primary care physician and be able to summarize a patient's problems succinctly in both verbal and written communications.

- It is recommended to avoid using "psycho-babble" when describing the patient and the patient's health beliefs, treatment approaches, and progress. Instead, CMHC's should use language that is easy for medical providers and patients to understand.
- Similarly, clear and efficient communication is needed between CMHCs and patients. CMHCs and staff need to have strong interpersonal skills and communicate with patients in a warm and open manner. Specific communication competencies include the ability to
  - elicit mental health concerns from patients and their families;
  - communicate information to patients and their families using terms that are easy to understand and culturally acceptable;
  - use language that is appropriate to the patient's age and education level, to facilitate understanding of the rationale for treatment techniques and plan; and
  - address the patient using culturally appropriate terms, in the patient's primary language.
- It is the provider's role to explain diagnosis, prognosis, and treatment rationale clearly to patients early in their sessions with them. This can be facilitated through patient handouts.

It is critical that providers ask patients direct questions about their level of understanding, and then alter their language as needed in order to improve patients' understanding.

24. *http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf*

Appendix 1

Knowledge of Evidence-Based Practices

1. Possess expertise on the ICD-9-CM and ICD-10-CM codes for all of the major disorders which CMHCs and other mental health providers offer in their clinical practices.
2. Possess knowledge on clinical descriptors for the following mental health disorders: 1) Autistic Spectrum Disorder; 2) Attention Deficit Hyperactivity Disorder (ADHD), 3) Bipolar Disorder; 4) Depressive Disorders; 5) Anxiety and Trauma and Stressor-Related Disorders; 6) Phobias; 7) Post Traumatic Stress Disorder (PTSD); 8) Obsessive Compulsive Disorder (OCD); 9) Anorexia; 10) Bulimia; 11) Alcohol Use Disorders; 12) Substance and Medication Use Disorders; 13) Co-Occurring Disorders.
3. Possess knowledge on common symptoms for these disorders.
4. Identify common populations treated for these disorders.
5. Common treatment settings for these disorders.
6. Possess expertise on Evidence Based Practices for treating these disorders.
7. Know common psychopharmacological treatments for these disorders.