CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF THE CONTROLLER

Ben Rosenfield
Controller

Monique Zmuda
Deputy Controller

January 13, 2011

The Honorable Edwin Lee
Mayor, City and County of San Francisco
Room 200, City Hall

The Honorable Members, Board of Supervisors
Room 244, City Hall

The Honorable Members, San Francisco Health Commission
101 Grove Street, Room 311

Dear Mayor Lee, Ladies and Gentlemen:

The Controller's Office is working with the Department of Public Health (DPH) on a project to integrate mental health care and substance abuse treatment with primary health care services for clients of San Francisco's public health system. I am providing with this letter a summary of the activities, findings, and recommendations to date from this effort.

DPH has a long history of providing mental health and substance abuse (also called behavioral health) services to primary care patients. Longstanding practice has been to provide these services through separate systems. However, research and experience shows that patients' needs overlap – that physical and psychological health should be addressed in an integrated fashion. Done well, integrated services can result in significantly better patient outcomes and in more efficient resource usage throughout the Public Health system.

Currently, a patient with mental health needs seeking care at a DPH primary care clinic might have to return or go to a different location, increasing the likelihood of no-shows and of patients not getting treated. Second, although a patient's behavioral health and primary care treatment plans may be closely related – e.g., chronic pain and medication management associated with a herniated disk, or depression associated with high blood pressure – it is likely that these plans would not be integrated nor would providers have the opportunity to collaborate to improve the patient's outcomes. Individuals who might benefit from behavioral health support might not seek treatment because of the social stigma associated with seeing a mental health provider. Often, primary care providers are challenged to address behavioral health needs without adequate time, training, or support.

In 2009 the Controller's Office contracted with Public Consulting Group to provide DPH with expert analysis and technical assistance to implement integrated care in DPH's primary care clinics. Goals are to increase patient access to behavioral health services, improve coordination between behavioral health and primary care providers, and improve patients' health and experience.

With successful implementation of integration, each DPH community clinic will be staffed with behavioral health professionals that can provide same-day, on demand consultation to both patients and primary care providers. Patients will have almost immediate access to behavioral health services and referral to more specialized services. In special interventions aimed at high impact groups such as diabetes management, smoking cessation, and chronic pain, behavioral health professionals and other clinic staff will offer group classes, group medical appointments, and other services. Behavioral health professionals will have the cultural and language skills to best meet patient needs.

In the report, Public Consulting Group summarizes findings from 11 DPH community clinic assessments. Findings include that there are significant wait times for appointments and a high volume of no-shows for behavioral health appointments. Significantly, there is support among clinic staff for moving to delivery of integrated care. Public Consulting Group recommends the following:

- Staff primary care clinics with behavioral health staff that meet the needs of patient populations served;
- Develop special interventions for patients in high-impact groups such as chronic pain and depression;
- Implement a performance measurement system to measure outcomes, access, and satisfaction for patients/ providers; and
- Provide training for behavioral health, primary care, and other clinic staff.

DPH is well underway with implementing these recommendations, and project activities are expected to extend through 2012.

Should you have any questions regarding the report, please contact Michelle Schurig (554-7577) or Catherine Spaulding (554-4022).

Sincerely,

Ben Rosenfield
Controller

cc:
Mayor
Board of Supervisors
Health Commission
Civil Grand Jury
Budget Analyst
Public Library

Department of Public Health
Primary Care Behavioral Health Integration Project

Phase One – Summary Report

January 13, 2011

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Background

Primary Care Behavioral Health Integration Project. In 2009, the Office of the Controller and the Department of Public Health (DPH) of the City and County of San Francisco contracted with Public Consulting Group (PCG) to conduct the DPH Primary Care Behavioral Health Integration Project. This project builds upon current integration efforts and provides expert analysis and technical assistance to implement the Primary Care Behavioral Health Integration Model (see below). Primary care clinics included in the project are those within DPH's Community Oriented Primary Care (COPC) system, San Francisco General Hospital, and the San Francisco Community Consortium Clinics (SFCCCs).

What is primary care behavioral health integration? Historically, primary care and behavioral health services have been provided through two separate systems. This separation exists despite the clear connections between a person's physical, psychological, and social situations. Many individuals who might benefit from behavioral health support do not access such services because of the social stigma associated with seeing a mental health provider. The primary goal of integrating behavioral health into DPH's primary care system is to increase patient access to behavioral health services, improve coordination of care between behavioral health and primary care providers, and improve the health outcomes of primary care patients.

Primary Care Behavioral Health Integration Model. The Primary Care Behavioral Health Integration Model (PCBH Integration Model*)* provides a platform for implementation of evidence-based behavioral health interventions. It involves delivery of brief interventions by a primary care behaviorist (PCB), either a psychologist or a licensed social worker, who functions as a member of the primary care team. PCBs have an open schedule and are available to see patients during their medical appointments upon referral from the PCP (primary care provider). PCBs are physically located in the clinic and work in the primary care exam rooms. This seamless approach to same-day service significantly improves delivery of behavioral health services to primary care patients. The approach also shifts the burden of providing behavioral health services from PCPs to PCBs, thus, allowing the PCPs to meet patients' medical needs in a timely manner.

Primary care behaviorist services. PCBs provide brief intervention services (30 minute visits) for patients and consultation services to PCPs. Services include providing information, assisting with problem-solving, and developing self-management and other skills with patients to improve their quality of life. Typically, patients see PCBs one to four times for individual consultation visits. PCBs are available for drop-in follow-up visits as well. PCBs and PCPs provide "pathway" programs to high impact patient groups such as depression, diabetes management and chronic pain. PCB pathway services may include assessment, individual interventions, group classes, group medical visits, and coaching. PCBs also assist PCPs in linking patients with serious mental disorders to specialty clinic services and re-integrating them with the PCP/PCB once they are stabilized.

Activities to Date

Since December 2009, PCG has worked closely with DPH and the Controller's Office to:

- Conduct 17 Readiness Reviews (see next section) at primary care clinics within DPH's COPC system, San Francisco General Hospital, and select SFCCCs.
- Tailor the PCBH Integration Model to patients served in DPH clinics.
- Conduct a series of workshops to expose behavioral health providers to the PCBH Integration Model and PCB clinical skills.
- Conduct training sessions at six DPH COPC clinics to introduce staff to the PCBH Integration Model and prepare them for implementation of the PCBH Integration Model. Training at the remaining five COPC clinics will occur in January 2010.
- Identify and discuss coordination issues with existing behavioral health programs and providers.
- Define performance measures and set up a system for evaluating the effectiveness of integration.
- Prepare an in-depth PCBH Integration Model program manual, including information on clinic roles and responsibilities, training requirements, clinical activities, policies and procedures, outcome measurements, and quality assurance.
- Plan the development of a mobile information technology application to be used by the PCBs in clinics for screening, assessment, and collecting patient data.

Readiness Reviews. To prepare clinics for implementation of the PCBH Integration Model, PCG spent up to three days onsite at each participating clinic conducting Readiness Reviews. The objectives of the Readiness Reviews were to:

- Familiarize staff with the PCBH Integration Model.
- Obtain a snapshot of clinic operations and provide a description of the current interface of primary care and behavioral health services.
- Assess facilitating factors related to implementation of the PCBH Integration Model as well as identify challenges. For example, the current location of behavioral health providers in the primary care exam room area facilitates implementation, while PCPs being unable to access behavioral health providers for same day visits presents a challenge to implementation. Other factors include the availability and role of any behavioral health staff already on site at the clinic, behavioral health primary care policies and procedures and productivity standards, and assessment and referral practices.
- Create a qualitative and quantitative baseline of integration relative to the PCBH Integration Model by surveying PCPs, nursing staff, psychosocial staff, and clerical/administrative staff; shadowing staff as they perform their jobs; and interviewing individual staff members including leadership team members, PCPs, nursing staff, psychosocial staff, and clerical/administrative staff.
- Develop relationships with clinic staff. At each clinic, PCG met with the full clinic staff, the clinic leadership team, and the clinic staff by discipline, including the PCPs as well as nursing, psychosocial, and clerical/administrative staff.

As of November 30, 2010, Readiness Reviews were conducted at all 11 DPH COPC clinics, two San Francisco General Hospital clinics, and four SFCCC clinics:

DPH COPC:

- Castro-Mission Health Center
- Chinatown Public Health Center
- Curry Senior Center
- Housing and Urban Health
- Larkin Street Clinic/ Community Health Programs for Youth
- Maxine Hall Health Center
- Ocean Park Health Center
- Potrero Hill Health Center
- Silver Avenue Family Health Center
- Southeast Health Center
- Tom Waddell Health Center

San Francisco General Hospital:

- San Francisco General Adult Medical Center
- San Francisco General Children's Health Center

SFCCC:

- Glide Health Services
- Lyon-Martin Health Center
- Mission Neighborhood Health Center
- South of Market Health Center

PCBH Integration Model Checklist. Readiness Reviews included completion of the PCBH Integration Model Checklist (see Appendix A) based on observation and questions asked of each clinic's medical director. The checklist will continue to be used to evaluate the extent to which integration-related policies, procedures, and activities currently in place are consistent with the PCBH Integration Model. The checklist includes seven domains:

1. Training
2. Competency skills
3. System and facility
4. Management
5. Program evaluation
6. Communication
7. Population impact

Findings at DPH COPC Primary Care Clinics

PCG identified the following system-wide findings as a result of conducting Readiness Reviews at 11 DPH COPC clinics:

- ***Clinic variability***. There is significant variability among the DPH COPC clinics in the scope of services, the profile of patients served, and the availability of resources, including behavioral health resources. For example, some clinics have specialized programs for specific patient types such as women or children, while others tend to serve specific populations such as the homeless. In addition, the roles of existing PCBH staff (i.e., onsite medical social workers and, in some instances, co-located psychiatric social workers) vary significantly among clinics.

- ***Broad, clinic-based support of PCBH implementation.*** There is broad support for implementation of the PCBH Integration Model among PCPs, nursing staff, operations staff, and behavioral health staff. The staff tend to believe that greater integration of primary care and behavioral health services will benefit patient care.

- ***Strong primary care staff support***. PCPs and nursing staff believe that implementation of the PCBH Integration Model will improve patient access to behavioral health services. PCPs believe that implementation will improve patient flow and increase their ability to meet productivity standards. In addition, they believe that implementation of the PCBH Integration Model will improve patient outcomes, particularly for patients with chronic diseases and/or behavioral health problems. PCPs and registered nurses (RNs) also feel that job satisfaction is likely to improve.

- ***Moderate behavioral health staff support.*** There was less support of the PCBH Integration Model among behavioral health staff currently based in primary care clinics. However, their interest appeared to improve when they were provided with more information about the PCBH Integration Model and were assured that they would be provided with training to prepare staff for new roles.

- ***PCBH productivity data lacking***. Productivity data concerning existing primary care-based behavioral health staff is unavailable or limited. Lack of information is related to: 1) separation of the behavioral health staff from the primary care teams; 2) separate appointment scheduling systems with many behavioral health staff keeping their own paper schedules; and (3) lack of consistent billing procedures for behavioral health services. Moreover, there is no system in place to regularly monitor behavioral health staff productivity or outcomes.

- ***Significant appointment wait-times***. Patients often have significant waiting periods for appointments with PCPs and current primary care-based behavioral health providers (ranging from one day to four months). This is especially true for new patients.

- ***High volume of "no show" appointments.*** The current service delivery system for primary care-based behavioral health services is associated with a high volume of "no show" appointments (ranging from 20% to 50%), as most appointments are scheduled and same-day visits are reserved only for the most urgent patients. The net result is a low rate of penetration of behavioral health services into the clinics' population and a concentration of behavioral health services on a small segment of primary care patients.

- ***Physical space limitations***. Most DPH COPC clinics have limited physical space available to perform routine functions. Often, the results are behavioral health providers being located at a distance from primary care exam rooms. The physical separation of behavioral health and primary care staff and the separate appointment scheduling systems make coordination and integration of their efforts challenging.

- ***Silo delivery systems***. Relationships between primary care clinics and the DPH Community Behavioral Health Services (CBHS) centers are variable and, for the most part, limited. Physical separation, lack of real-time communication procedures, and lack of a common record system result in strained relationships and problems with continuity of care for patients.

- ***Clinic security***. Some clinic staff expressed concern about patients demonstrating disruptive behaviors in waiting and exam rooms. Clinic security staff does provide useful services to address these issues when they arise. However, PCPs would like for these patients to have more access to behavioral health services so that they can learn skills for successful and safe use of primary care services.

- ***Cultural and linguistic competency.*** Cultural and language issues are important to address in moving forward with implementation of the PCBH Integration Model. For example, it is important for staff to understand how different cultures and populations perceive physical and mental health care and how those perceptions will affect their willingness to seek treatment.

Primary Care System-wide Recommendations

PCG recommends the following to assure successful implementation of the PCBH Integration Model in the DPH COPC clinics:

- ***Staff each of the DPH COPC clinics with PCBs and behaviorist assistants.*** The number of PCBs and behaviorist assistants (BAs) at each clinic should be based on the needs of the patient population served at that clinic. Appendix B shows the recommended staffing levels and special qualifications at each DPH COPC clinic.

- ***Develop pathway programs involving PCBs and BAs.*** Pathway programs should target chronic pain, depression, anxiety and worry, disease management, and other conditions identified as priorities in clinic-specific Readiness Review results. A pathway program is a set of assessment and intervention activities designed to improve outcomes for patients in a high impact group. It includes specific services provided by PCBs, BAs, and other primary care team members such as PCPs, RNs, and medical evaluation assistants (MEAs). See Appendix C for the high priority populations suggested by survey respondents as a result of the DPH COPC Readiness Reviews.

- ***Implement the performance measurement system.*** This system is defined in the PCBH program manual and includes measures on patient outcomes, access, patient/provider experience and satisfaction, and fidelity to the PCBH Integration Model. See Appendix D for an overview of the goals and objectives of the performance review plan for monitoring and evaluating the PCBH program over time.

- ***Implement training***. Since the PCBH Integration Model is a significant change in the service delivery system at primary care clinics, DPH should conduct core competency-based training for PCBs and BAs and targeted training with PCPs, RNs, and MEAs prior to and during onsite training for PCBs and BAs.

Future Planned Activities

Implementation of the PCBH Integration Model at DPH COPC clinics will begin in January 2011. PCG will provide intensive, onsite training to the new PCBs that will focus on the development of core competencies. PCG will also train the clinics' PCPs and nursing staff. These trainings will include information on how to practice support tools that help PCPs and nursing staff engage the PCBs and further develop their skills for delivery of evidence-based behavior change interventions. DPH COPC patients will begin experiencing the benefit of this additional medical resource by the end of January 2011. Training and support of the PCBs will continue into 2012.

About the Consultants

PCG has been supporting health and human services agencies across the United States for the last 25 years. With over 800 consultants across 27 offices, PCG helps improve the efficiency and effectiveness of organizations that serve the public. For this project, PCG teamed with Dr. Patricia Robinson and Dr. Kirk Strosahl of Mountainview Consulting Group of Yakama, Washington. Drs. Robinson and Strosahl have worked with hundreds of primary care clinics around the world and have conducted major PCBH initiatives with community clinics, Kaiser Permanente, and the United States Air Force.

Appendix A
Primary Care Behavioral Health Program – Integration Checklist

_____ Health Center (Dates: _____)

BASELINE

1. Didactic Training and Background Experience

Parameter	Question	Yes	No
1. BHP Workshop	Has the Behavioral Health Provider (BHP) been to a workshop on primary care behavioral health services?		
2. BHP Training	Has the BHP received didactic training on BHP practice competencies?		
3. RN Training	Has one or more RNs received didactic training on BHP practice competencies?		
4. BHP Reading	Has the BHP read one or more books on integration of behavioral health services into primary care?		
5. BHP PCBH Residency	Has the BHP worked previously in internship, residency, post-doc or other work settings where s/he received training in delivery of BH services in PC?		
6. PCP Workshop	Have 50% of the PCPs been to a brief workshop on primary care behavioral health services?		
7. PCP Training	Have one or more of the PCPs received didactic training on PCBH practice competencies?		
8. PCP Reading	Have one or more of the PCPs read one or more books on integration of behavioral health services into primary care?		
9. PCP PCBH Residency	Have one or more of the PCPs worked previously in residency or in other clinics where BHP services were available?		
10. PCP Referral Scripts	Have PCPs received scripts to reduce stigma when referring a patient to a BHP?		
11. PCP BHP Role Scripts	Have PCPs received scripts to help them accurately describe the BHP role to patients they refer?		

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2. Practice Competencies

Parameter	Question	Yes	No
12. BHP Competency	Has the BHP been evaluated using the BHP Core Competency Tool (by direct observation or video tapes)?		
13. BHP Competency	Has the BHP achieved Basic Competency ratings or a minimum of 3 in all areas?		
14. BHP Mentor Service	Does the BHP have access to a mentor (BHP with long-term experience and training) concerning development of skills in weak areas?		
15. RN Competency	Have one or more of the RNs been evaluated using the RN Core Competency Tool (by direct observation or video tapes)?		
16. PCP Competency	Have one or more of the PCPs been evaluated using the PCP Core Competency Tool (by direct observation or video tapes)?		
17. PCP Competency	Have one or more of the PCPs achieved Basic Competency ratings or a minimum of 3 in all areas?		
18. PCP Support	Do the PCPs have access to a PCP with experience and interest in working with a BHP?		

3. Clinic System and Facility Factors

Parameter	Question	Yes	No
19. Minimum Staffing Standard	Does your clinic have Behavioral Health Provider (BHP) services 20+ hours / week?		
20. Optimal Staffing Standard	Does your clinic have full-time BHP services?		
21. Co-Location of Service	Is the practice location for the BHP located in the exam room area of the clinic?		
22. Shared Appt Systems	Is there one system for making both primary care and behavioral health appointments?		
23. Schedule Template	Is there a specific person responsible for making the BHP schedule template?		
24. Immediate Access	Does the BHP template include a minimum of 40% same-day visits?		
25. Same-Day Appointments	Does the clinic have a system for scheduling BHP same-day visits?		
26. Same-Day Follow-Ups	Does the clinic have a system for scheduling same-day follow-up appointments with the BHP?		
27. Chart Note Integration	Are BHP chart notes placed in the same location as PCP chart notes?		
28. BHP Chart Note Access	Are BHP chart notes available in the medical record within 24 hours of BHP-patient contact?		

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Primary Care Behavioral Health Program – Integration Checklist

29. Schedule Accessibility	Can PCPs (directly or through assistance from aid or technician) quickly & easily access BHP schedule information?		
30. Open Scheduling	Do PCPs (directly or through assistance from aid or technician) routinely schedule appointments directly into the BHP schedule?		
31. Program Staffing	Do PCPs believe that the BHP staffing is adequate?		
32. Scheduling Support	Does the BHP have scheduling and reception support on par with PCPs in the clinic?		
33. Triage Support	Does the BHP have medical assistant or technician support in keeping with that available to PCPs in the clinic?		
34. Facilities Design	Does the BHP have access to the space needed to conduct on site psycho-educational classes & group medical appointments?		
35. Access to Group Space	Does the BHP have access to the space needed to conduct on site group appointments at the time preferred for patients served in groups?		
36. Equipment	Does the BHP have access to equipment available to PCPs in the clinic (computer, printer)?		
37. Equipment	Does the BHP have a pager or cell phone so that s/he can be reached immediately by PCPs?		
38. Equipment	Does the BHP have bulletin board space available for posting BH information for PCPs, nursing and assistant staff?		
39. Equipment	Does the BHP have wall-hanger space for displaying outcome instruments and patient education materials?		

Appendix A
Primary Care Behavioral Health Program – Integration Checklist

4. Management Practices

Parameter	Question	Yes	No
40. Policy Manual	Does the clinic have a policy manual concerning BHP services?		
41. Billing / Coding	Does the policy manual specify billing and coding strategies for BHP services?		
42. Quality Assurance	Does the policy manual specify a quality assurance process for BHPs?		
43. Staffing Standard	Does the policy manual specify a staffing standard for determining BHP staffing (e.g., 6 hours / week / 1000 unduplicated clinic users)?		
44. Access to Manual	Do all providers in the clinic have access to the PCBH policy manual?		
45. Manual Revisions	Is there an inclusive plan for routinely updating the policy manual?		
46. Access to Administrator	Does the BHP have regular meetings with clinic management to discuss issues related to system operations and other issues?		
47. Administrator Feedback.	Does the clinic administrator provide the BHP with productivity data on a monthly basis?		
48. Timely Evaluations	Are performance evaluations for the BHP provided in a timely manner on an annual basis?		
49. Barriers to Integration	Does the clinic administrator address identified integration barriers effectively?		
50. Training Support RNs	Does the clinic administrator support necessary training related to integration for nurses and technicians?		
51. Training Support PCPs	Does the clinic administrator support necessary training related to integration for PCPs?		
52. PCP Feedback	Do PCPs routinely receive feedback on number of referrals to BHP per month?		
53. Productivity Standards	Does the clinic have established productivity standards for the BHP?		

5. Program Evaluation

Parameter	Question	Yes	No
54. Plan	Does the clinic have a written program evaluation plan?		
55. Evaluation	Is the program evaluated yearly?		
56. Distribution	Do all stakeholders receive yearly program evaluation results?		
57. Fidelity	Does the program evaluation include measures of program model fidelity?		
58. Link to Practice Management	Does the program evaluation plan include distribution of practice management information to BHPs (including productivity and model fidelity) on a monthly or quarterly basis?		
59. Link to Clinical Practice	Are BHPs able to access information about specific patient populations targeted for development of new services that include BHP services (e.g., chronic pain patients, diabetics)?		

Appendix A
Primary Care Behavioral Health Program – Integration Checklist

6. Communication Practices

Parameter	Question	Yes	No
60. PCP same-day referral	Do PCPs routinely refer patients for same-day visits with the BHP?		
61. PCP use of BHP for urgent consults	Do PCPs use established protocols for contacting the BHP for urgent consults (even when the BHP is not in the clinic)?		
62. Curbside Consultation	Do PCPs routinely discuss patient care issues with the BHP prior to and after same-day referrals or prior to scheduled initial visits?		
63. Same-day Feedback	Do BHPs routinely provide same-day feedback on scheduled patients?		
64. Same-day Feedback	Do BHPs routinely provide same-day feedback on same-day patients?		
65. BHP Expertise	Do PCPs routinely request advice from the BHP concerning care they deliver to patients with behavior change issues (even if they are not referring the patient for a BH consult)?		
66. BHP Expertise	Do PCPs routinely request that the BHP assist with researching a question related to treatment?		
67. BHP Expertise	Do PCPs ask the BHP to develop patient education materials?		
68. BHP Expertise	Do PCPs ask the BHP to provide brief continuing education presentations on topics of interest?		
69. BHP Meetings	Does the BHP attend all PCP meetings?		
70. BHP Actions	Does the BHP routinely speak, even briefly, at PCP meetings?		
71. BHP Education	Does the BHP routinely provide brief written statements about the evidence for treating BH related problems (half-page handouts, bulletin board items, e-mails)?		
72. BHP Champion	Does the BHP routinely consult with a PCP that is a champion for BHP services?		
73. PCBH Steering Committee	Does the clinic have a PCBH steering committee that meets at least quarterly for a half hour to discuss directions for the program?		

7. Population Impact

Parameter	Question	Yes	No
74. Screening	Have the PCPs been surveyed by the BHP in the past 2 years concerning patient populations they would like to better identify and serve?		
75. Screening	Does the BHP use standard screeners for common adult conditions (e.g., the PHQ-9 and GAD-7)?		
76. Screening	Does the BHP make standard screeners available to PCPs and nursing staff?		
77. Screening	Do PCPs use the same screeners for common adult conditions as the BHP (e.g., the PHQ-9 and GAD 7)?		

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78. Screening	Is there one or more passive screening strategies in practice in the clinic (e.g., a substance abuse poster in exam rooms)?		
79. Screening	Are BHPs involved on a same-day basis when Adult Physical, or Well-Child screening results indicate the need for assistance (e.g., risk for becoming obese, symptoms of trauma, parenting problems, etc.)?		
80. Assessment	Does the BHP use a standard assessment measure (e.g., the Duke Health Profile) at the beginning of all consults with adults?		
81. Assessment	Does the BHP use a standard assessment measure (e.g., the Pediatric Symptom Checklist) at the beginning of all consults with children and youth)?		
82. Assessment	Does the BHP use gold standard measures for common conditions (e.g., the Vanderbilt for children suspected of having ADHD)?		
83. Assessment	Does the BHP make child screeners and assessment measures available to PCPs (e.g., by placing them in wall hanging files and training PCP assistants and / or by advocating for their inclusion in EMRs)?		
84. Referral (prevention)	Are patients routinely referred to BHP for assistance with developing healthy lifestyle behaviors (e.g., creating social support, establishing exercise programs and patterns of healthy eating)?		
85. Referral (risk)	Are patients routinely referred to BHP for assistance with changing health risk behaviors (e.g., smoking, excessive drinking, unsafe sexual practices)?		
86. Referral (chronic)	Are patients routinely referred to the BHP for development of skills for self-managing chronic disease (e.g., diabetes, hypertension, chronic pain)?		
87. Referral (somatic)	Are patients routinely referred to the BHP for assistance with managing somatic complaints that have a lifestyle or stress component (e.g., headaches, IBS, insomnia)?		
88. Referral (MH)	Are patients routinely referred to BHP for assistance with common mental health problems (e.g., anxiety, depression, trauma)?		
89. Referral (SAHC)	Are patients routinely referred to BHP for assistance with substance abuse problems?		
90. Referral (Social Needs)	Are patients routinely referred to BHP for assistance with meeting social and basic needs (e.g., housing, durable medical equipment, etc.)		
91. Referral (Psych)	Are adult patients routinely screened for behavioral health problems (e.g., depression, PTSD, alcohol and drug abuse) prior to or during a medical visit?		
92. Referral (bio / protocol)	Do PCPs use biomedical markers to trigger referrals to the BHP (e.g., A1-C > 8 or BMI > 29)?		
93. Pathways (risk)	Does the clinic have one or more pathways involving use of BHP services concerning health risk behaviors (e.g., problematic use of alcohol)?		

Appendix A
Primary Care Behavioral Health Program – Integration Checklist

94. Pathways (chronic)	Does the clinic have one or more pathways involving use of BHP services concerning chronic disease (e.g., an established practice of referring all newly diagnosed diabetes for a BHP consult or a chronic pain pathway involving monthly group visits)?		
95. Pathways (somatic)	Does the clinic have one or more pathways involving use of BHP services for patients with somatic problems (e.g., an established practice of referring all patients with insomnia for a BH consult)?		
96. Pathways (Psych)	Does the clinic have one or more pathways involving use of BHP services for patients presenting with psychological symptoms (e.g., a PHA/PDHRA pathway or depression / trauma symptom pathway that calls for specific measurements and specific interventions)?		
97. Groups	Does the BHP offer at least one group service?		
98. Groups	Does the clinic offer at least one group based service involving co-delivery of services from the BHP and a PCP?		
99. Penetration Targets	Does the clinic have established penetration targets for BHP services?		
100. Penetration Feedback	Do clinic providers receive feedback about penetration targets on a regular basis?		

Notes:

Appendix B
PCBH Integration – Staffing Plan for DPH COPC Clinics

	Health Center	Implement	Target	Current 2922 Sr Med SW	Current 2932 Sr PsySWs	Current 2920 MedSWs	Current 2930 PsySWs	Vacant 2920 MedSWs	Vacant 2930 PsySWs	New 2930 PsySWs	Transfer CBHS Clinicians	Total PCBs	Not Included	BAs Health Worker II	Special Qualifications
1	Castro-Mission Health Center	Feb-11	2.0			1.00					1.0	2.0		1.0	HIV, Spanish
2	Ocean Park Health Center	Feb-11	2.0			0.90			1.0			1.9		1.0	Russian, Cantonese
3	Chinatown Public Health Center	Feb-11	2.0			1.00					1.0	2.0		1.0	Cantonese, Mandarin
4	Maxine Hall Health Center	Feb-11	3.0	0.80				1.0			1.0	2.8		2.0	Spanish, Cantonese, Homeless
5	Silver Avenue Family Health Center	Feb-11	2.0					1.0			1.0	2.0		1.0	Women/Children, Spanish, Cantonese
6	Potrero Hill Health Center	Feb-11	2.0			1.00				1.0		2.0		2.0	Adults, Spanish, Cantonese
7	Larkin Street Clinic	Feb-11	1.0								1.0	1.0		-	Youth
8	Southeast Health Center	Feb-11	3.0			1.00				2.0		3.0		2.0	Adults, African American, Southeast Asian, Spanish
9	Curry Senior Center	Feb-11	1.0							1.0		1.0		1.0	Older Adults, Southeast Asian
	TOTAL FY10-11		18.0	0.80	-	4.90	-	2.0	1.0	4.0	5.0	17.7		11.0	6 HWII positions have job reqs, others will be 9924s
10	Housing & Urban Health Clinic	FY11-12	2.0								2.0	2.0		1.0	Homeless, HIV
11	Tom Waddell Health Center	FY11-12	6.0			4.00				1.0	1.0	6.0		4.0	Homeless, HIV, Spanish, Transgender
	TOTAL FY11-12		8.0	-	-	4.00	-	-	-	1.0	3.0	8.0		5.0	
	GRAND TOTAL		26.0	0.80	-	8.90	-	2.0	1.0	5.0	8.0	25.7		16.0	

Appendix C
High Priority Populations

High Need Patient Populations	Number of Survey Respondents (DPH COPC Readiness Reviews only)
Attention Deficit Hypertension Disorder	7
Anger Problems	24
Anxiety/Worry	49
Child Behavior Problems	14
Chronic Pain	56
Depression	56
Disease Management	41
Family/Relationship Problems	20
Housing Problems	15
Hypertension	10
Overweight/Obesity	15
Parenting Stress	4
Sleep Problems	18
Substance Abuse	28
Violence/Trauma	18
Total Number of Survey Respondents	**74**

Appendix D
PCBH Integration Performance Goals and Objectives

I. Patient Outcomes	Objective
1. Patients' health related quality of life indicators improve through provision of PCBH model of care	A. Adult primary care patients who receive services from a PCB show improvement in their health-related quality of life
	B. Children/youth who receive services from a PCB show improvement in their psychosocial wellbeing
	C. Patients participating in Pathways (self care – self management) show improvement in one or more areas of health
	D. Patients who are identified as high risk/high cost who are only engaged in urgent/emergent services (e.g., HUMS patients) are connected to a PCP
II. Access	**Objective**
1. Access to PCPs improves	A. PCPs demonstrate an increase in the average number of patient encounters per clinical hour
	B. Wait times for PCP appointments decrease
	C. High users of primary care visits who participate in Pathways demonstrate a reduction in PCP visits
2. Access to behavioral health services for patients in the primary care setting improves	A. Patients who have no histories in CBHS have their behavioral health issues detected and addressed in the PCBH model of care
	B. Patients who have only urgent/emergent histories in CBHS have their behavioral health issues detected and addressed in the PCBH model of care
	C. Patients in need of specialty behavioral health services are referred and connected
III. Experience and Satisfaction	**Objective**
1. Patients experience the PCBH model of care as beneficial	A. Patients (or their parents) express overall satisfaction with services provided in the PCBH program
2. PCPs experience the PCBH model of care as beneficial	A. PCPs report reduced barriers to use of PCBH services
	B. PCPs indicate a stronger likelihood of working with the PCBH staff to develop and support a behavior change plan for their patients
	C. PCPs indicate confidence in the PCBH program as beneficial to most of their patients
	D. PCPs indicate belief that PCBH services help them provide better primary care to their patients
3. PCBH staff (PCB and BA) experience the PCBH model of care as beneficial	A. PCBH staff express satisfaction with providing PCBH services
	B. PCBH staff indicate confidence that PCBH services are beneficial to their patients
	C. PCBH staff indicate confidence that PCBH services are beneficial to PCPs
IV. Fidelity to the Model	**Objective**
1. PCPs utilize the PCBH Program	A. PCPs refer a minimum of 10% of their patients to the behaviorist
2. PCBs demonstrate fidelity to the PCBH model	A. Less than 5% of patients who see a PCB see the PCB for more than 11 individual visits / year
	B. PCBs complete eight or more face-to-face patient visits/day in year one; and ten in year two
	C. 50% of new referrals to PCBs receive a PCB visit on the same day of the medical visit (i.e., via a "warm hand-off"
	D. On average, less than 15% of patients seen by the PCB are referred to Specialty CBHS

Appendix E
Acronyms

BA – Behaviorist Assistant

BH – Behavioral Health

BHP – Behavioral Health Provider

CBHS – Community Behavioral Health Services

DPH – Department of Public Health

DPH COPC – Department of Public Health Community Oriented Primary Care

HUMS – High Utilizers of Multiple Systems

MEA – Medical Evaluation Assistant

PCB – Primary Care Behaviorist

PCBH – Primary Care Behavioral Health

PCBH Integration Model – Primary Care Behavioral Health Integration Model

PCG – Public Consulting Group

PCP – Primary Care Provider

RN – Registered Nurse

SFCCC – San Francisco Community Consortium Clinics