**DRAFT**

**Title: Improving Access to Evidence-Based Integrated Mental Health and Substance Use Disorder Services in Primary Care Act**

1. Whereas, one in five Americans experienced mental illness in the past year.[[1]](#footnote-1)
2. Whereas, mental health and substance use disorders (MH/SUD) are often chronic conditions that people experience with other health conditions, such as heart disease and diabetes.
3. Whereas, only 25 percent of patients receive effective care, including in primary care settings, where most patients with mental health and substance use disorders receive their usual care.[[2]](#footnote-2)
4. Whereas, half the patients receiving a referral for mental health services never follow through.[[3]](#footnote-3)
5. Whereas, effective integration of behavioral health and general medicine has proven to improve patient satisfaction and health outcomes, while reducing healthcare costs and the stigma associated with mental illness.
6. Whereas, studies estimate that $26 - $48 billion could be saved annually through effective integration of mental health and other medical care.[[4]](#footnote-4)
7. Whereas, the Collaborative Care model has over 80 randomized control studies demonstrating its effectiveness in a variety of primary care settings, including in rural and urban areas.[[5]](#footnote-5)
8. Whereas, the Center for Medicare and Medicaid Services has acknowledged the quality of delivering care through the Collaborative Care Model by adopting Current Procedural Terminology (CPT) codes specifically for this model.
9. Whereas, training and technical assistance in the Collaborative Care model is available for practices interested in implementing the model.
10. Include State stats

SEC. XXXX. **INcentive GRANTS**

1. DEFINITIONS
2. Collaborative Care is the model originally developed by Katon and colleagues at the University of Washington, demonstrated to be clinically effective in randomized control trials (W. Katon et al. 1995; W. Katon et al. 1996). Collaborative Care is a specific type of integrated care that operationalizes the principles of the Chronic Care Model (E. Wagner 2001) to improve access to evidence based mental health treatments for primary care patients.[[6]](#footnote-6)
3. Behavioral Health refers to the array of professional services delivered to populations suffering with mental illnesses, substance use disorders and maladaptive health behaviors, such as lack of exercise, poor dietary habits and lackluster engagement in care.
4. Primary Care Provider is a primary care physician, physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS).
5. Care Manager is a social worker or psychologist who works with a Primary Care Provider, and, is trained to deliver evidence-based care coordination and brief behavioral interventions.
6. Psychiatric Consultant is a Psychiatrist, Nurse Practitioner, or Clinical Nurse Specialist or Physician Assistant with psychiatric training.
7. Population-Based Care: A care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.
8. Measurement-Based Treatment to Target: Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools like the PHQ-9 depression scale. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved. Sometimes called Stepped Care.
9. Evidence-Based Care: Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. These include a variety of evidence-based psychotherapies proven to work in primary care.
10. IN GENERAL. —The Department of Health Services shall award incentive grants to primary care practices to enable them to implement the Collaborative Care Model to ensure that –
    1. Individuals with mental health and substance use disorders have timely access to mental health services,

* 1. The physical and mental health needs of individuals are met to improve patient outcomes, and
  2. Decrease the use of higher intensity services, such as hospitalizations, residential treatment, and emergency room visits.

(c) DURATION. —A grant under this section shall be for a period of not more than 2 years.

(d) ELIGIBILITY. — The term “eligible entity” means a primary care practice that can demonstrate that –

1. It has incorporated the following principles into treatment:
   1. Patient-centered team care
   2. Population-based care
   3. Measurement-based treatment to target
   4. Evidence-based care
2. Collaborative care will be:
3. Active, using established protocols for an identified patient population;
4. Coordinated using a patient tracking tool to promote regular, proactive outcome monitoring and treatment-to-target using validated and quantifiable clinical rating scales; and
5. Regular (typically weekly) with systematic psychiatric caseload reviews and consultation by a psychiatric consultant, working in collaboration with the behavioral health care manager and primary care team

(e) USE OF FUNDS. — An eligible entity shall use amounts awarded under subsection (B)(1) to deliver high-quality, integrated care for people with behavioral health problems using a care team, led by a primary care provider and must include a full-time or shared care manager and a psychiatric consultant. Funds may be used to –

1. Support the start-up costs of implementing evidence-based integrated care, including hiring a care manager, patient tracking and administrative costs;

(f) REPORTING REQUIREMENTS – XXXX

(g)Authorization Of Appropriations or incentive funds.— XXXXXXX

1. Department of Health and Human Services. “Mental Health Myths and Facts.” http://www.mentalhealth.gov/basics/myths-facts/ [↑](#footnote-ref-1)
2. Unützer J et al. “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.” Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013 [↑](#footnote-ref-2)
3. Grembowski DE, Martin D, Patrick DL, et al. (2002) Managed care, access to mental health specialists, and outcomes among primary care patients with depressive symptoms. Journal of General Internal Medicine, 17(4), 258-269. [↑](#footnote-ref-3)
4. Milliman, Inc. “Economic Impact of Integrated Medical-Behavioral Healthcare. Implications for Psychiatry.” April 2014. [↑](#footnote-ref-4)
5. Advancing Integrated Mental Health Solutions (AIMS) Center. “Evidence Base.” https://aims.uw.edu/collaborative-care/evidence-base [↑](#footnote-ref-5)
6. Taken from APA report, *Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model* [↑](#footnote-ref-6)