Foreword

Until the mid-1990s behavioral health was defined within the strict dichotomy of primary care and fundamental mental health services – a dichotomy that failed to mirror the range and complexity of human experience and clinical needs. Today's integrated behavioral health system renders this dichotomy obsolete.

Integrated health, service delivery integration offers an organized system of care rooted in a common vision and defined by processes intended to promote continuity and quality of care, coordination of efforts, efficiencies of operation, and seamless patient movement through an otherwise bewildering array of health care services.

In the text The Integrated Behavioral Health Continuum: Theory and Practice, the authors provide the rationale for the development of a continuum of quality care for the new millennium.[1] The theme of the book is that overcoming fragmented, uncoordinated, and episodic treatment is a high priority for everyone involved. Concerned parties are the patients, family members, clinicians, and practitioners who are concerned about the distribution of scarce resources.

The authors of *Behavioral Health Continuum* advocate that we need to do a better job in caring for individual patients and families in the complex medical marketplace. Alcona Health Centers and Thunder Bay Community Health Services, both of northeast Michigan, agreed with the premise of the text and hence adopted the Strosahl Model to address their patient's primary health care and wellness needs.

The major paradigm shift that occurred in primary care in the mid 1990s has greatly expanded the role of the behavioral health therapist and psychologist. And nowhere is this paradigm shift more dramatic than at Kaiser Permanente of Northern California. Kaiser has adopted a strategy for offering traditional primary care services blended with behavioral health. Essential to the strategy is the MSW and psychologist functioning as Behavioral Medicine Specialist (BMS). The integration of the behavioral health professional in the primary care environment is commonly now referred to as the Strosahl Model. A BMS functions as an integral part of a multidisciplinary, primary care team.

Two psychologists, Kirk Strosahl PhD and Steven Tulkin PhD, have played dominant roles in the redesign effort within Kaiser. Both were presenters in a recent American Psychology Association symposium. Drawing upon his experience at the Group Health Cooperative of Puget Sound, Dr. Strosahl served as a consultant in Kaiser's efforts to implement the integrated care model.

Dr. Strosahl noted that research suggests that a staggering 70% of all primary care visits are driven by psychological factors. Dr. Tulkin, the principal Kaiser psychologist on the redesign committee, reported that of the medical visits driven by psychological factors,

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[1] Laurel J. Kiser, Ph.D., M.B.A., Paul M. Lefkovitz, Ph.D., and Lawrence L. Kennedy, M.D. The Integrated Behavioral Health Continuum: Theory and Practice, American Psychiatric Publishing, Inc., 2001, New York, NY.

the following concerns were common: depression, anxiety, somatization, chronic pain, job/family problems, and miscellaneous concerns (borderline personalities and substance abuse were mentioned).

According to Corine Giantonio PhD (Kaiser's first BMS in Northern California) research has shown that much of the treatment for depression and other behavioral health difficulties already occurs in primary care. Among the reasons for this is that many patients are reluctant to accept a referral for psychiatric services, and so their medical doctors attempt to manage them as best they can. When Kaiser included BMSs in primary care, common psychological disorders have been identified and treated earlier thus saving significant cost and providing services in a manner much preferred by many patients.

Not surprising, this paradigm shift was not driven by psychologists seeking to gain inclusion in primary care nor primary care practitioners realizing a need to integrate behavioral health professionals, but rather by business considerations. Kaiser believes it can offer superior, yet less expensive, primary care by inclusion of BMSs. Being an HMO, Kaiser is better positioned to do this than are traditional fee-for-service systems. In Sacramento, California where Kaiser also offers behavioral medicine classes and groups in addition to the presence of BMSs, 30%-40% reductions in medical visits are common.

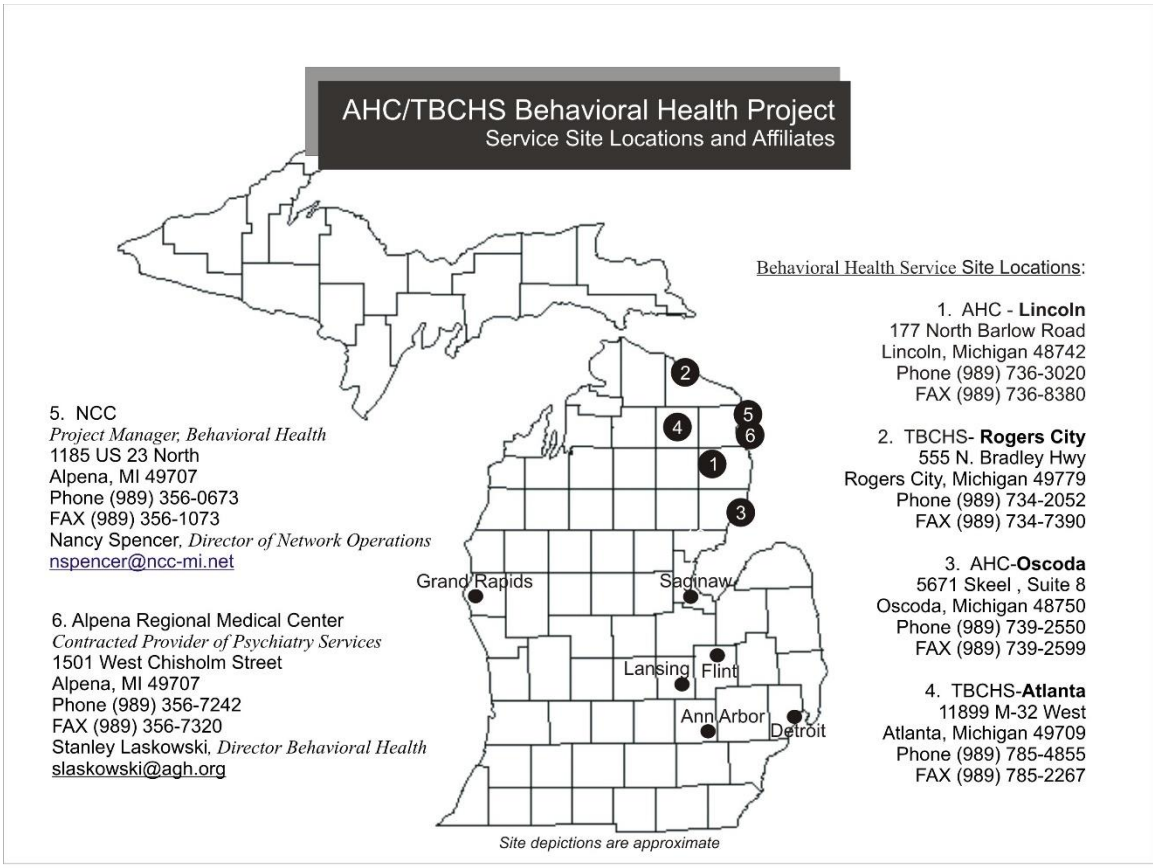
Integrated primary care is a revolutionary practice model. It has a strong basis in research, and could fundamentally alter the future course of the traditional model of providing primary care. When a paradigm shift occurs, some solutions are offered, while many new questions are generated. That will almost certainly be the case here.

Integrated Behavioral Health Project of NE Michigan – Project Introduction

In September 2004 a grant application was submitted to the U.S. Department of Health and Human Services, Health Resource and Services Administration, Office on Rural Health Policy. The Federal grant program was the *Rural Health Care Services Outreach Grant Program*. The grant Applicant was Alcona Health Centers of 177 N. Barlow Rd, Lincoln, Michigan 48742. Christine M. Baumgardner, M.A. was the Executive Director of the agency at the time of the application and remains so today.

The application proposed to launch behavioral health services at four Federally Qualified Health Center (FQHC) primary care clinic sites. Two of the clinic sites are owned and managed by Alcona Health Centers (Applicant) and two belong to another FQHC, Thunder Bay Community Health Services. The application was awarded in May 2005 and the integrated health service project was in fact initiated in the fall of that year.

The project is titled "Integrated Behavioral Health Care of Northeast Michigan" (IBHNEM) and is an expansion and enhancement project. The project uses a combination of limited licensed counselors, MSWs, clinical psychologists and psychiatrists to cover the four (4) pilot integrated behavioral health clinic sites (see map below).



As a result of being awarded the grant, Alcona Health Centers and Thunder Bay Community Health Services have implemented a Strosahl-type integrated behavioral health model at a total of four (4) clinics in the following northeast, lower peninsula Michigan counties: Alcona (Village of Lincoln), Iosco (Oscoda Township), Montmorency (Village of Atlanta), and Presque Isle (City of Rogers City).

The target population for this project is an estimated 12,000-plus rural residents of a four county area in northeast Michigan who are in need of standard psychiatric, counseling, and referral services. This estimate of need was based on research and a resulting report published by the National Institute of Mental Health (NIMH).

According to the report by the NIMH entitled "*The Numbers Count: Mental Disorders in America*," an estimated 22.1 percent of Americans ages 18 and older suffer from a diagnosable mental disorder in a given year. It is estimated that one in seven children and adolescents (<18 yrs old) suffer from a diagnosable mental disorder in a given year. The NIMH statistics would indicate that the population of **adults** needing behavioral health services in the IBHNEM four-county area needing mental health services numbers 10,848. Additionally 1,322 **children** require services for a diagnosable mental disorder.

The original grant proposal raised a reasonable question: who is treating these over 12,000 people in need of behavioral health services in the four-county, intended service area? The answer to this question is that the vast majority needing therapy or treatment in the subject four counties are not being treated – or receiving any services at all – because of the following service-delivery crisis in the State of Michigan.

A Crisis in Michigan

For the previous nearly 25 years, the State of Michigan has moved patients needing mental health services out of the State system, and into a community care setting. Although in principle community-based care is a preferred option to institutionalizing, local communities were not prepared for the transition from the State to communities throughout Michigan, nor were they monitored adequately in the transition or adequately funded. In 2007 Michigan's local mental health services – which represents the State of Michigan's system of mental health care on the county-level – is wholly overwhelmed and struggling to serve only the persistently, severely mentally ill.

Two State-funded, community mental health agencies operate in the counties where the IBHNEM's target population resides. Au Sable Valley Community Mental Health Services operates in Iosco County (as well as three other counties), and Northeast Michigan Community Mental Health Services serves Alcona, Montmorency and Presque Isle Counties. But the two State-funded agencies are not meeting the need for mental health services[2] in the subject counties of Alcona, Iosco, Montmorency and Presque Isle. The table below illustrates the unmet need in the IBHNEM project's target population.

[2] According to Michigan's Mission-based Performance Indicator System for Persons with Mental Illness, Community Mental Health Performance Report dated March 2003, Northeast Michigan Community Mental Health was the lowest ranking CMH in Michigan for accessing a behavioral health professional

Table of Unmet Need for Integrated Behavioral Health Care of Northeast Michigan Project (IBHNEM) – 2004	*Service Population Base*	*Current Number Adults Served*	*Current Number Children Served*	*Est. Unmet Need - Adults*	*Est. Unmet Need - Children*
Northeast Michigan Community Mental Health Alcona, Montmorency, Presque Isle Counties	36445	737	268	5695	781
Au Sable Valley Community Mental Health Iosco County	27339	542	240	5153	541
TOTALS	**63784**	**1279**	**508**	**10848**	**1322**

The severely, persistently mentally ill generally require continual care and treatment, in many cases over a lifetime. But many categories of mental and emotional illness can be treated and recovery can be realized. And the 12,000 persons in our target population largely fit this description. They may suffer from the following:

- Depressive Disorders (per National Institute of Mental Health [NIMH], 9.5 percent of adult population)
- Mild schizophrenia and other mild psychotic disorders (per NIMH, 1.1 percent of adult population)
- Anxiety and panic disorders (per NIMH, 13.3 percent of adult population)
- Eating, sleep, substance, and impulse control disorders (per NIMH, 5.6 percent of adult population)
- ADD and ADHD disorders (per NIMH, 4.1 percent of youth population; 2.1percent of adult population)
- Alzheimer's Disease (per NIMH, 1.4 percent of adult population)
- Problems related to abuse and neglect

The over 12,000 persons in need of therapy and treatment in the four county, target population could reasonably be classified in categories *other than* severely and persistently mentally ill, but are most certainly suffering from a diagnosable mental disorder within the categories cited above in bullet form.

Integrated Behavioral Health Proposed Services. In Year One the Applicant and its' partners proposed to provide new psychiatric services at four FQHC clinics (Alcona Health Centers Oscoda & Lincoln sites; and TBCHS Atlanta & Rogers City sites), add two new behavioral health consultants to the at-that-time staffing at two, and new neuro-psychologist services to address the needs of our substantial elderly population. The

following a request for service; Au Sable Valley Community Mental Health was not far behind. Both CMHs failed to meet standards for providing service for follow up purposes according to that same report. The report also indicates especially older residents in the region do not feel comfortable using NEMCMH services in contrast to other CMH's in Michigan.

Applicant also proposed to provide telepsychiatry in Years Two and Three of the grant. Finally, the Applicant proposed to provide behavioral health services to 5,019 adult and children during the three-year grant period.[3]

The Integrated Behavioral Health Project of Northeast Michigan met the HRSA Rural Health Outreach grant program stated goals on several levels. The Project as proposed focuses on primary care, serves as a wellness and prevention strategy, involves Federally Qualified Health Centers, is located in HPSA areas, uses telehealth to improve access to care, and significantly addresses mental health service needs.

The proposed expansion is possible due to the established, formal and functional partnership between AHC, TBCHS, Northern Collaborative Care and Alpena General Hospital. In our integrated behavioral health care model (Strosahl), psychiatrists, psychologists and behavioral health consultants are to be integral members of the primary care system at Alcona Health Centers and Thunder Bay Community Health Services. State of Michigan health departments and the regional community mental health department will serve as referral agents for the project. A formal evaluation process is proposed using FERA of Ann Arbor, Michigan as the independent evaluator firm. This expansion of service is holistic, cost efficient and very much needed.

Needs/Barriers to be Addressed. It is estimated there are over 12,000 persons in the area served by our consortium who are in need of mental health services. The two, state-funded community mental health service agencies operating in the same areas as the subject clinics cannot provide services to anyone unless they are <u>severely and persistently</u> mentally ill. The 12,000 adults and children in need are faced with multiple obstacles to service, including HPSA, MUA status; low income, education, and cultural barriers; isolation and rurality; stigmas; no facilities or resources; funding disparities; and age discrimination. Due to current clinic staffing levels, in FY2003, our clinic behavioral health staff had just 1,561 encounters with patients. With this grant, our goal is to provide an additional 5,019 new encounters during this three-year project.

Consortium Members. The primary consortium members are: Alcona Health Centers, a five site FQHC rural health clinic & this grant and project manager/fiduciary; Thunder Bay Community Health Services, a three site FQHC rural health clinic provider; Alpena Regional Medical Center, a 146-bed rural hospital with a full service behavioral health department; and Northern Collaborative Care, a model network provider and the administrative services umbrella to the two FQHC partners. Consortium members have a 20-year relationship of partnering on projects and jointly solving regional health care issues. Secondary partners in our consortium are State of Michigan District Health Departments #2 & #4 and the Northeast Michigan Community Mental Health Department serving as key referral sites.

[3] This goal was later amended to 5,019 total encounters versus persons.

Project Program Goals

Program Goal	***Anticipated Outcomes***	***Deliverable(s)***	***Funds Used/Time***
A. Enhance and strengthen the organizational structure, operations, and outreach of the consortium	Creates a stronger, better organized and managed program, to the benefit of patient-users, project consortium members.	All consortium members have worked to develop a formal structure, including a signed Memorandum of Agreement among members; developing protocols for patient care and processing, scheduling, communications between consortium members and practitioners, and administrative processes. **Goal accomplished.**	Travel to OHRP Conference, $1,593. Time used per Conference schedule and travel time, opportunity costs. Attorney costs for MOA drafting, execution, $2,831. Contracted expense. Travel expense, Mileage for meetings, $97.24 All expenses listed Federal.
B. Complete scheduling policy and protocols for psychiatrists within first 90 days of program funding	Ensures that resources are used effectively, to the benefit of both patient users and clinics; assists providers and patients; provides for sustainability of project.	Scheduling process and treatment protocols are agreed upon. **Goal accomplished.**	N/A
C. Recruit and hire one (1) psychiatrist, bringing AGH complement to four (4) psychiatrists within first 90 days of program funding	Fulfills AGH behavioral health strategic plan recommendation; reduces workload on current, three psychiatrists on staff at AGH. Allows for better program service.	Psychiatrist hired. Full complement of four psychiatrists in place (Arora, Barba, Gallardo, Rajasekhar). Credentialing process being completed. **Goal accomplished**. Services begin January 3, 2006.	N/A
D. Recruit and hire one (1) neuro psychologist within first 90 days of program funding	Fulfills AGH behavioral health strategic plan recommendation; reduces workload on AHC Project Director, and existing and proposed new therapists. Allows for better program service.	Neuro psychologist identified and negotiations being completed. To begin service on January 3, 2006.	N/A
E. Recruit and hire two (2) behavioral health therapists, one each for AHC and TBCHS within first	Fulfills AHC, TBCHS, NCC behavioral health plan recommendation; reduces workload on current, two therapists.	Both behavioral health consultants have been hired (Hubbard, Donajkowski). **Goal accomplished**.	N/A

90 days of program funding	Allows for better program service.		
F. Complete Education Plan for behavioral health project within first 90 days of program funding	Pivotal to creating public awareness and acceptance of integrated behavioral health care services; tied to increased visit Goals.	Education plan is being finalized, and will begin implementation in January, 2006.	N/A
G. Strengthen scheduling coordination function among consortium members	Scheduling efficiencies helps long-term sustainability of program, to the benefit of current and prospective users.	Ongoing.	N/A
H. Increase number of CHILDREN visits for behavioral health issues in Year One at Alcona Health Centers Oscoda and Lincoln sites by minimum 25%, target 156 encounters; Increase in Year Two by minimum 25%, target 275 encounters; Increase in Year Three by minimum 25%, target 361 encounters.	Number of children ages 17 & under presently not accessing behavioral health services in and around the counties of Alcona and Iosco reduced, and number of new encounters among this target population increased.	Two (2) new therapists are seeing patients, both children and adults. Encounters are as follows: Thunder Bay Community Health Services: 228 encounters, 8/15/05 – 11/23/05. Alcona Health Centers: 276 encounters, 6/13/05 – 11/23/05. **On Track.**	$37,261, half portion Federal, behavioral health consultant.
I. Increase number of CHILDREN visits for behavioral health issues in Year One at Thunder Bay Community Health Services Atlanta and Rogers City sites by minimum 25%, target 107 encounters; Increase in Year Two by minimum 25%, target 189 encounters; Increase in Year Three by minimum 25%, target 247 encounters.	Number of children ages 17 & under presently not accessing behavioral health services in and around the counties of Montmorency and Presque Isle reduced, and number of visits among this target population increased.	Two (2) new therapists are seeing patients, both children and adults. Encounters are as follows: Thunder Bay Community Health Services: 228 encounters, 8/15/05 – 11/23/05. Alcona Health Centers: 276 encounters, 6/13/05 – 11/23/05. **On Track.**	See above H note.
J. Increase number of ADULTS (18+) visits for behavioral health issues in Year One at Alcona Health Centers Oscoda and Lincoln sites by minimum 25%, target	Number of Adults 18+ presently not accessing behavioral health services in and around the counties of Alcona and Iosco reduced, and number of visits among	Two (2) new therapists are seeing patients, both children and adults. Encounters are as follows: Thunder Bay Community Health Services: 228 encounters, 8/15/05 – 11/23/05.	See above H note.

430 encounters; Increase in Year Two by minimum 25%, target 760 encounters; Increase in Year Three by minimum 25%, target 994 encounters.	this target population increased.	Alcona Health Centers: 276 encounters, 6/13/05 – 11/23/05. **On Track.**	
K. Increase number of ADULTS (18+) visits for behavioral health issues in Year One at Thunder Bay Community Health Services Atlanta and Rogers City sites by minimum 25%, target 295 encounters; increase in Year Two by minimum 25%, target 522 encounters; increase in Year Three by minimum 25%, target 683 encounters.	Number of Adults 18+ presently not accessing behavioral health services in and around the counties of Presque Isle and Montmorency reduced, and number of visits among this target population increased.	Two (2) new therapists are seeing patients, both children and adults. Encounters are as follows: Thunder Bay Community Health Services: 128 encounters, 8/15/05 – 11/23/05. Alcona Health Centers: 186 encounters, 6/13/05 – 11/23/05. **On Track.**	See above H note.
L. Acquire and install 4 units of Desk View for installation at clinics	Allows for consistent transmission quality and software communication; benefit to practitioners, patients.	Abandoned per correspondence from Alocna Health Center to ORHP/HRSA; revising strategy.	N/A
M. Acquire and install 6 units of bandwidth optimizer data compressors	Allows for consistent transmission quality and software communication; benefit to practitioners, patients.	Abandoned per correspondence from Alocna Health Center to ORHP/HRSA; revising strategy.	N/A
N. Ensure cooperation and coordination in information services functions	Telehealth is essential to the long term sustainability of the project. Patient-users will benefit from costs savings resulting from telehealth.	On hold pending decision on T-1 lines and need for additional IT and transmission equipment (see CARRYOVER above.	N/A

Practitioner and Consultant Survey, Interviews

The value and efficacy of program evaluation can be perceived differently by affected parties. In behavioral health research conducted by the Stanford University Children's Health Council, findings indicated that psychiatrists are less cooperative and more

skeptical of program evaluation than non-physician therapists.[4] In our evaluation effort, we sought to include physicians (both DO and MD), PhD psychologists, nurse practitioners, physician's assistants, behavioral health consultants (MSW and LPC), and psychiatrists. All were involved through the completion of a written survey in 2007, and through face-to-face interviews conducted in 2006 and 2007. The survey results and findings are presented first, with a summary of interview highlights from the face-to-face meetings closing out this section of the evaluation.

A tip of the hat to the Stanford research referenced above: we found non-physician willingness to participate in the process of program evaluation to be enthusiastic and supportive; physicians were less able or willing to participate. We believe that this has more to do with the crucial role physicians play in federally qualified health center revenue generation, and the perceived and real value of physician time.

Practitioner Survey

The results of the practitioner survey are presented below with evaluator comment presented that is relevant to the evaluation process. There were 21 participants in the survey, which does not provide a statistically significant sampling to be applicable to other organizations and settings. However for the purpose of determining Alcona Health Centers and Thunder Bay Community Health Services staff and practitioner opinion, the pool is more than adequate.

Question 1. Type of primary health care provider: *(Check one)*

N=21

42.86%	*Family Practice Physician*
14.29%	*Internal Medicine Physician*
0.00%	*Pediatric Physician*
38.10%	*Physician Assistant*
4.76%	*Nurse Practitioner*
0.00%	*Psychiatrist*

Evaluator Comment: In the written survey, we experienced excellent physician participation, with over 57% of returned surveys coming from physicians.

Question 2. Generally speaking, are your patients who you referred to the Behavioral Health Program experiencing any of the following? *(Check as many as appropriate)*

N=21; however, more than one selection may be made

47.62%	*Decrease in physical symptoms*

[4] Lynne C. Huffman, Jacqueline Martin, Luba Botcheva, Sharon E. Williams, Jennifer Dyer-Friedman, Evaluation & the Health Professions, Vol. 27, No. 2, 165-188 (2004).

75.71% *Improved overall health*
23.81% *No change in health status since referral*
0.00% *Worsening health*

Evaluator Comment: Perception of respondents is that the overall health of patients improves when they are referred to behavioral health services, though less than half see this improvement in terms of physical health. It is clear that the practitioners see this improvement of health status being balanced between mental and physical health.

Question 3. How long do your patients participate in the behavioral health program on average? (Check one)

N=21

0.00% *< 1 month*
28.57% *1-3 months*
52.38% *4-6 months*
19.05% *7-12 months*
0.00% *> 12 months*

Evaluator Comment: More than eighty percent of patients referred to behavioral health services participate less than six (6) months; only one-fifth continue beyond six months.

4. The assessment by your patients regarding the quality of their behavioral health care has been: *(Check one)*

N=21

4.76% *Excellent*
42.86% *Very good*
52.38% *Good*
0.00% *Fair*
0.00% *Poor*

Evaluator Comment: The response indicates a perceived high level of satisfaction with the behavioral health care with greater than 47% of respondents indicating perceived satisfaction of very good or excellent.

5. How would you rate your <u>WORKING RELATIONSHIP</u> with the following BH practitioners?
(Check one box for your response for each class of BH practitioner)

N=21

	Behavioral Health Consultants *(MSW, etc)*	***Psychologists*** *(PhD)*	***Psychiatrists*** *(MD)*
Excellent	*28.57%*	*23.81%*	*9.52%*
Very Good	*47.62%*	*28.57%*	*28.57%*
Good	*23.81%*	*38.10%*	*28.57%*
Fair	*0.00%*	*0.00%*	*9.52%*

Poor	*0.00%*	*0.00%*	*4.76%*
Do Not Know	*0.00%*	*9.52%*	*19.05%*

Evaluator Comment: We provided opportunity for physicians, physician assistants, and nurse practitioners to rate the interaction with and clinical acumen of the behavioral health practitioners.

The term "working relationship" refers to the communication, responsiveness, professionalism, mutual support, and role fulfillment exchanged between co-laborers. With regard to working relationships, the masters-level consultants received the highest ratings (>76% Very Good or Excellent) with medical professionals. PhD psychologists were rated second (>52% Very Good or Excellent). Neither consultants nor psychologists received Fair of Poor ratings.

Psychiatrists were rated lowest, with a 38% Very Good or Excellent rating, 28% Good rating. Psychiatrists were the only behavioral health professionals with Fair or Poor ratings, combined at >14%. Psychiatrists also had a high "Do Not Know" selection at 19%, which may be attributed to the fact that the physicians do not interact with psychiatrists regularly, and that psychiatrists are only at the clinics 1-2 days per week. Finally, psychiatrists are not employees of the clinics, and therefore may be viewed as "outsiders."

6. How would you rate the quality of your <u>COMMUNICATION</u> with the following BH practitioners? *(Check one box for your response for each class of BH practitioner)*

N=21

	Behavioral Health Consultants *(MSW, etc)*	***Psychologists*** *(PhD)*	***Psychiatrists*** *(MD)*
Excellent	*33.33%*	*19.05%*	*9.52%*
Very Good	*47.62%*	*42.86%*	*38.10%*
Good	*19.05%*	*28.57%*	*19.05%*
Fair	*0.00%*	*0.00%*	*9.52%*
Poor	*0.00%*	*0.00%*	*4.76%*
Do Not Know	*0.00%*	*9.52%*	*19.05%*

Evaluator Comment:

7. How would you rate the quality of the <u>MEDICAL RECORD ENTRIES</u> of the following practitioners? *(Check one box for your response for each class of BH practitioner)*

N=21

	Behavioral Health Consultants *(MSW, etc)*	***Psychologists*** *(PhD)*	***Psychiatrists*** *(MD)*
Excellent	*14.29%*	*9.52%*	*14.29%*
Very Good	*52.38%*	*38.10%*	*42.86%*

Good	*23.81%*	*33.33%*	*19.05%*
Fair	*9.52%*	*9.52%*	*4.76%*
Poor	*0.00%*	*0.00%*	*0.00%*
Do Not Know	*0.00%*	*9.52%*	*19.05%*

Evaluator Comment:

8. Are behavioral health team members communicating patient status and progress to your satisfaction? *(Check one)*

N=21

95.24% *Yes*
4.76% *No*

Evaluator Comment:

9. How do behavioral health team members communicate patient status and progress? **(Check one)**

N=21

0.00% *Verbal only*
4.76% *Medical record only*
95.24% *Combination of verbal and medical record*
0.00% *None of the above*

Evaluator Comment:

10. Approximately what percent of your patients is SELF REFERRING OR REQUEST A REFERRAL to the behavioral health program? **(Check one)**

N=21

61.90% ***1-10 %***
23.81% ***11-20%***
4.76% ***21-30%***
4.76% ***31-40%***
4.76% ***41-50%***
0.00% ***>50%***

Evaluator Comment:

11. Approximately what percent of your patients ARE YOU REFERRING to a behavioral health team member (MSW, PhD, Psychiatrist)? **(Check one)**

N=21

19.05%	***1-10 %***
23.81%	***11-20%***
23.81%	***21-30%***
14.29%	***31-40%***
9.52%	***41-50%***
9.52%	***>50%***

Evaluator Comment:

12. Generally, how receptive are your patients to being referred to the behavioral health program?
(Check one)

N=21

14.29%	*Very receptive*
52.38%	*Receptive*
28.57%	*Somewhat receptive*
4.76%	*Somewhat resistant*
0.00%	*Resistant*
0.00%	*Very resistant*

Evaluator Comment:

13. How would you rate the program's impact on the overall health of your patient? *(Choose one)*

N=21

9.53%	*Excellent*
28.57%	*Very Good*
61.90%	*Good*
0.00%	*Fair*
0.00%	*Poor*

Evaluator Comment:

14. Please indicate if you would agree with this statement:

"The behavioral health program at the clinic(s) where I work is truly integrated into the primary care setting. I view the BH program as an integral partner in patient care at our clinic."

N=21

(Choose one)

42.86%	*Strongly Agree*
38.10%	*Agree*

14.29% *Somewhat Agree*
4.76% *Somewhat Disagree*
0.00% *Strongly Disagree*

Evaluator Comment: