DRAFT proposed language, Senate Health & Welfare – Healthcare Reform bill
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1) FQHC-Designated Agency Collaboration:

The Blueprint for Health will survey the designated agencies to identify those FQHC's already partnering with their local designated agency to ensure those with serious and persistent mental illness have access to both physical and mental health services; the survey will also collect information on evidence-based behavior change models in use at the FQHCs and the designated agencies. The survey will identify such collaboration models and enumerate their benefits and challenges. With this information, the Blueprint for Health will devise a framework for creating such collaborations; the framework will allow for adjustments to make the model most effective on the local level. The Blueprint for Health will then offer trainings in the framework for Blueprint project managers and teams. These trainings will include information on available federal matching dollars for such collaborations.

This care-collaboration would in no way limit the choice of the patient regarding where services are received.

Supporting Information:

FQHC-Designated Agency Collaboration:

The Blueprint for Health will survey the designated agencies to identify those FQHC's already partnering with their local designated agency to ensure those with serious and persistent mental illness have access to both physical and mental health services; this survey will also collect information on behavior change models in use at FQHCs and Designated agencies.

The survey will identify collaboration models and enumerate their benefits and challenges. With this information, the Blueprint for Health will devise a framework for creating effective collaborations; the framework will allow for adjustments to make the model most effective on the local level. The Blueprint

for Health will then offer trainings in the framework for Blueprint project managers and teams. These trainings will include information on available federal matching dollars for such collaborations.

This care-collaboration would in no way limit the choice of the patient regarding where services are received.

Research[1] has found that "the public health burden associated with major chronic diseases is much higher in people with severe mental illness. The majority of excess deaths in this population are due to physical illnesses, in particular cardiovascular disease, respiratory illness and cancer."

Staff at the designated agencies report that many patients with severe and persistent mental illness refuse to seek services elsewhere. For their part, primary care practice staff are rarely accustomed to working with patients whose behavior may not align with usual waiting-room practice. In addition, as researchers have found,[2] stigma remains within primary care practice. The typical 15-minute appointment allotted within primary care practice is also problematic, since psychiatric patients may require more time to accept a proposed examination or treatment. Researchers also note an issue with "the possibility of regarding physical complaints as psychosomatic symptoms."

In order to increase access and improve health outcomes for Vermonters with severe and persistent mental illness, Northwestern Counseling and Support Services, in Franklin County, has developed and implemented a partnership with the local Federally Qualified Health Care Center to provide physical health care services at NCSS for those clients who choose not to seek care at the FQHC. Northeast Kingdom Human Services has also developed a promising model that it has yet to implement.

[1] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951586/
[2] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951586/

In addition to providing choice for those served by the designated mental health agencies, such collaboration is eligible for federal matching dollars, which maximizes the ability of providers to serve all Vermonters equally. FQHC's are reimbursed at a higher rate for psychiatry and licensed mental health staff for traditional services, but are not equipped to provide the service planning, support and psychosocial rehabilitation services that are provided by designated agencies. Collaboration would allow the FQHC's to bill for licensed providers who are brought in under their umbrella, while designated agency funds would become available to provide more of the specialized/rehabilitation services. The system as a whole would be able to provide more services, yet would not increase costs to the state. In addition, this would address current competition between FQHCs and the designated agencies, which creates redundancy of some practitioners and limits services available due to funding constraints when operating separately. Neither is able to provide the full spectrum of care that they could provide through collaborations.

Use of Evidence-based behavior change models:

According to the National Institutes of Health, "Human behavior accounts for almost 40% of the risk associated with preventable premature deaths in the United States. Health-injuring behaviors such as smoking, drinking, and drug abuse, as well as inactivity and poor diet are known to contribute to many common diseases and adverse health conditions[3]." Further, according to "Putting Evidence into Practice, The OBSSR Report of the Working Group on the Integration of Effective Behavioral Treatments into Clinical Care," published by the Office of Behavioral and Social Sciences Research, of the National Institutes of Health[4]

> Behavioral treatments and interventions can reduce health care demand and thus, health care costs. Studies have shown that health care utilization is not necessarily related to

[3] http://obssr.od.nih.gov/scientific_areas/health_behaviour/behaviour_changes/#hbi
[4] http://obssr.od.nih.gov/pdf/everpt3.pdf

disease frequency or severity, but often depends on patients' individual perceptions and attitudes about their symptoms. Patient suffering, for example, has driven health care demand, which has resulted in higher costs for both patients and providers. By addressing this suffering through counseling, self-care, patient education, and prevention-oriented interventions, it is possible to reduce health care utilization, length of hospital stays, and the need for more expensive and invasive treatments. Behavioral interventions can also help to lessen the burden of chronic disease, which exacts considerable economic and human costs, by changing behaviors that contribute to the progression of chronic disease and to costly complications.