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HRSA Behavioral Health Integration Grantee Training Webinar

Thursday, September 11, 2014

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Laura Galbreath, MPP
(webinar moderator)

Director, SAMHSA-HRSA Center for Integrated Health Solutions
National Council for Behavioral Health

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About the CIHS

Goal:

To promote the planning, and development and of integration of primary and behavioral health care for those with serious mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety-net provider settings across the country.

Purpose:

- To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development
- To provide technical assistance to SAMHSA PBHCI grantees and safety-net providers funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders

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Before We Begin

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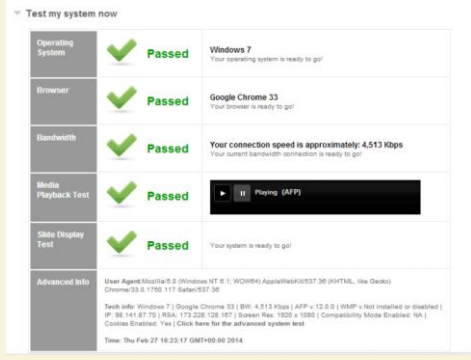

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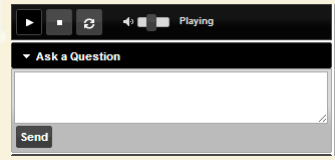

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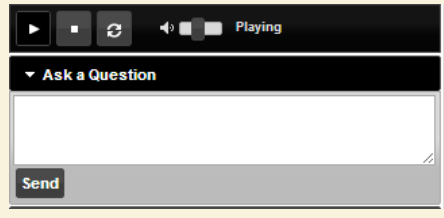

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Agenda for Today's Briefing

- ✓ Welcome from HRSA
- ✓ Setting the Stage/Guiding Assumptions
- ✓ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- ✓ Behavioral Health Consultation
  A Primary Care Level of Service Delivery
- ✓ Integration and Your Clinic Operations
- ✓ Workforce
- ✓ Making the Business Case and Financing
- ✓ Care Coordination Strategies

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Today's Speakers

- **Seiji Hayashi, MD, MPH (HRSA Opening Remarks)**
  Bureau of Primary Health Care, HRSA
- **Laura Galbreath, MPP (Webinar Moderator)**
  SAMHSA-HRSA Center for Integrated Health Solutions
- **Mia Croyle, MA (SBIRT)**
  Wisconsin Primary Health Care Association
- **Suzanne Daub, LCSW (Clinical Strategies)**
  University of Pittsburgh Medical Center, Community Care Behavioral Health
- **Gina Lasky, PhD (Workforce)**
  Health Management Associates Community Strategies
- **Roger Chaufournier (Business Case)**
  CSI Solutions
- **Jeff Capobianco, PhD, LLP (Care Coordination)**
  CIHS Senior Consultant, National Council for Behavioral Health

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Seiji Hayashi, MD, MPH
Chief Medical Officer

Bureau of Primary Health Care
Health Resources and Services Administration

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Setting the Stage/ Some Guiding Assumptions

In order to succeed, your desire for success should be greater than your fear of failure. — *Bill Cosby*

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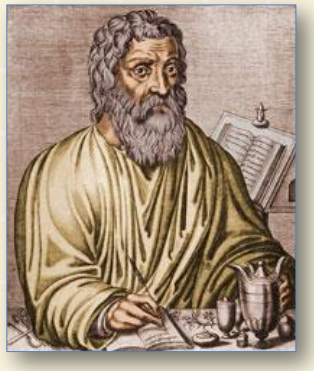

"The Body must be treated as a whole and not just a series of parts."

Hippocrates 430 BC

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Tipping Point

Behavioral health is essential to health

Prevention/early intervention is possible

Treatment is Effective and People Recover

Primary Care Level of Behavioral Health

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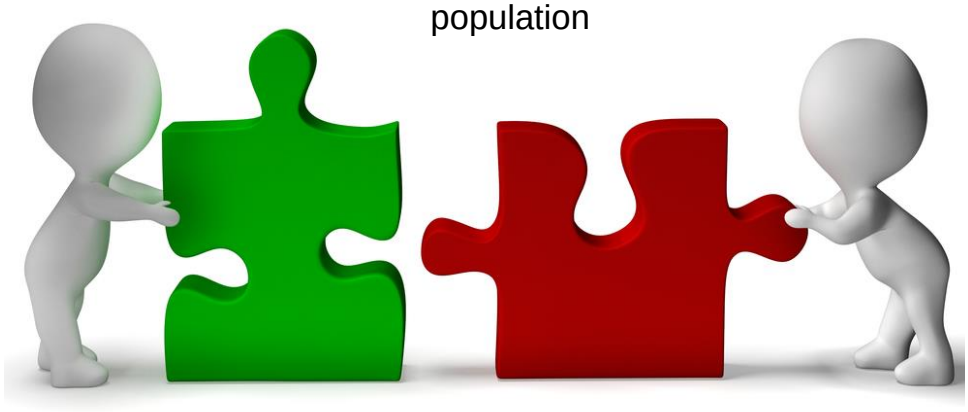
The care a patient experiences as a result of a team of PC & BH clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population



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LEVELS OF COMPLEXITY OF PATIENT'S MENTAL HEALTH NEEDS:

PREVENTIVE SERVICES & SCREENING: Applicable to all patients being seen in a primary care practice, to prevent and detect mental health problems.

EARLY INTERVENTION & ROUTINE CARE PROVISION: Applicable for patients and families with identified but relatively uncomplicated, high prevalence behavioral health clinical problems. Assessment and management is typically performed by the PCP team including a behavioral health clinical with support available from a consulting psychiatrist.

SPECIALTY CONSULTATION, TREATMENT & COORDINATION: Applicable for patients with defined behavioral health disorder/problem at intermediate level of risk, complexity or severity, requiring enhanced specialist consultation or intervention. Involves a negotiated management role between PCPs and mental health and addiction providers.

INTENSIVE MENTAL HEALTH SERVICES FOR COMPLEX CLINICAL PROBLEMS: Applicable for patients with a defined behavioral health disorder/problem at high level of risk, complexity or severity, requiring specialist consultation or intervention that may include multisystem service teams.

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Successful integration involves more than increasing access to behavioral health services; the system of care delivery is transformed.

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Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013 www.integration.SAMHSA.gov

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Behavioral Health Integration aligns with NCQA PCMH Recognition

PCMH 1: Enhance Access and Continuity

- Comprehensive assessment includes depression screening, behaviors affecting health and patient and family mental health and substance abuse

PCMH 3: Plan and Manage Care

- One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g. obesity) or a mental health or substance abuse condition
- Practice must plan and manage care for the selected condition

PCMH 4: Provide Self-Care and Community Resources

- Self-care support includes educational and community resources and adopting healthy behaviors

PCMH 5: Track and Coordinate Care

- Tracks referrals and coordinates care with mental health and substance abuse services

PCMH 6: Measure and Improve Performance

- Preventive measures include depression screening

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Behavioral Health Integration is Consistent with Principles of Recovery

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

Health : Overcoming or managing one's disease(s) or symptoms, making informed healthily choices that support physical and emotional wellbeing.

Home: a stable and safe place to live

Purpose: meaningful daily activities, such as a job, school, volunteerism, and the independence, income and resources to participate in society

Community: relationships and social networks that provide support, friendship, love and hope

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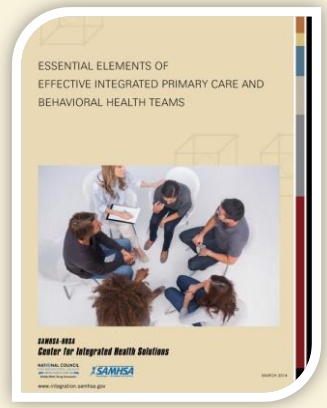
Behavioral Health Integration Requires Team-Based Care

Based on interviews with integrated teams within primary care settings, this resource explores four essential elements for effective integrated behavioral health and primary care teams and provides a roadmap for organizations designing their own teams, using examples from these best practices.

- ✓ Leadership & Organizational Commitment
- ✓ Team Development
- ✓ Team Process

Team Outcome



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Key Ingredients of the Collaborative Care Model

- ➢ Care management – Patient education & empowerment, ongoing monitoring, care/provider coordination
- ➢ Evidence-based treatments – Effective medication management, psychotherapy
- ➢ Expert consultation for patients who are not improving
- ➢ Systematic diagnosis and outcome tracking
- ➢ Stepped Care
- ➢ Technology support – Registries

Energy and persistence conquer all things

Benjamin Franklin

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SBIRT Implementation

A Framework for Integration & an Evidence-Based Practice

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Presented By:

Mia Croyle, MA
Behavioral Health Program Manager,
Wisconsin Primary Health Care Association

- Masters in Clinical Mental Health Counseling
- Experience in Community Mental Health, Inpatient Behavioral Health, various models of integrated care
- Involved in SBIRT projects since 2007
- $12.5 million grant from SAMHSA with implementation in over 30 sites representing different health systems
- Also involved in project to integrate SBIRT framework with collaborative care for depression
- Wisconsin's PCA – Behavioral Health Program Manager

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Objectives

After this session you will be better able to:

- Identify key components of SBIRT model
- Describe clinical best practices and operational examples of SBIRT
- List possible next steps for your organization
- Address issues of instruments, workforce, comorbidities, billing, documentation (EHR)

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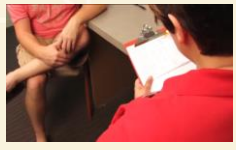
SBIRT: A framework

Screening

Brief Intervention



Referral to Treatment

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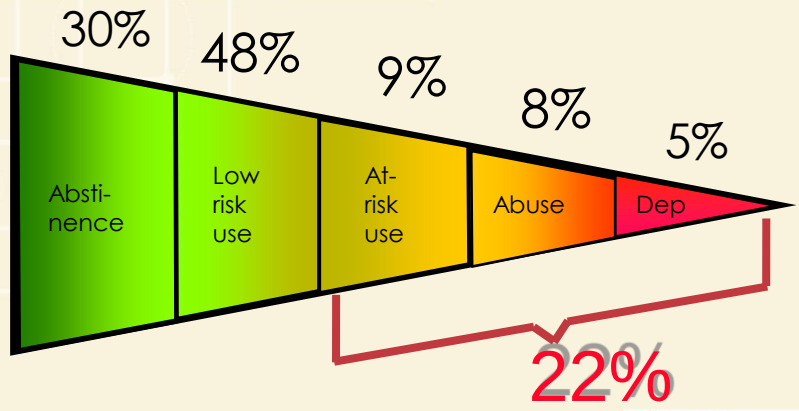
Alcohol Use in Primary Care:



Manwell, *Journal of Addictive Disease*, 1998

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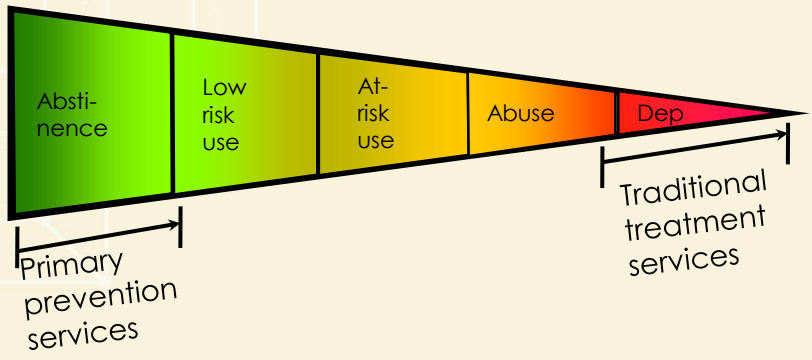
Without SBIRT



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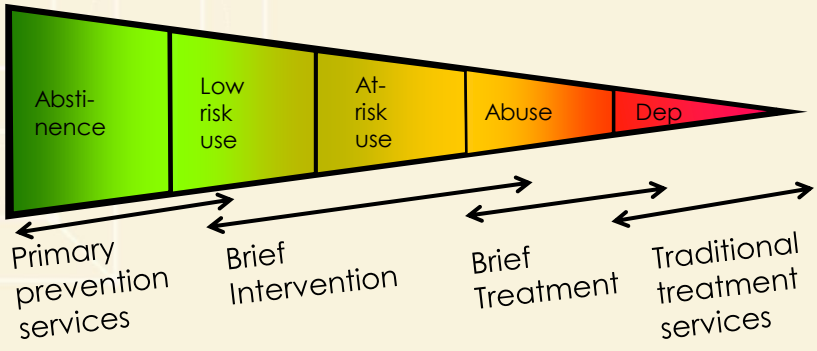
With SBIRT



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Universal Screening

Ideal: All patients should receive an annual screen

- Rapid & proactive
- Identify those with potential concern BEFORE obvious manifestations occur

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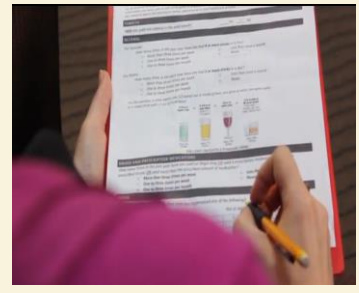
Universal Screening

- NIAAA Single Item Screen (NIAAA-1)
- NIDA Single Item Screen (NIDA-1)
- Two-Item Conjoint Screen (TICS)
- Best practice: embed in "healthy lifestyle" questionnaire with questions about mood (PHQ-2), smoking, diet, exercise, etc.)



http://www.integration.samhsa.gov/clinical-practice/sbirt/screening-page

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Universal Screening

Can be administered:

- Upon check-in
- Upon rooming
- In advance of visit
- Via technology

Considerations:

- Tracking when patients are due
- Tracking results
- Who scores and connects to next step?

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Brief Risk Assessment/ Full Screen

For patients who:

- Have a positive brief screen
- Otherwise raise clinical concern
- Categorizes patients' risk/severity level
- Allows for feedback to patient
- Allows for recommending appropriate clinical pathway

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Brief Risk Assessment/ Full Screen

- AUDIT
- CAGE
- ASSIST
- DAST
- CRAFFT (youth)
- Alcohol.screening.org
- T-ACE/TWEAK (pregnant women)

http://www.integration.samhsa.gov/clinical-practice/sbirt/screening-page#longer%20screens

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Brief Risk Assessment/ Full Screen

Can be administered:

- Upon rooming
- By person delivering brief intervention
- Paper & pencil
- Face to face
- Electronically

Considerations:

- Tracking results
- Who scores and connects to next step?

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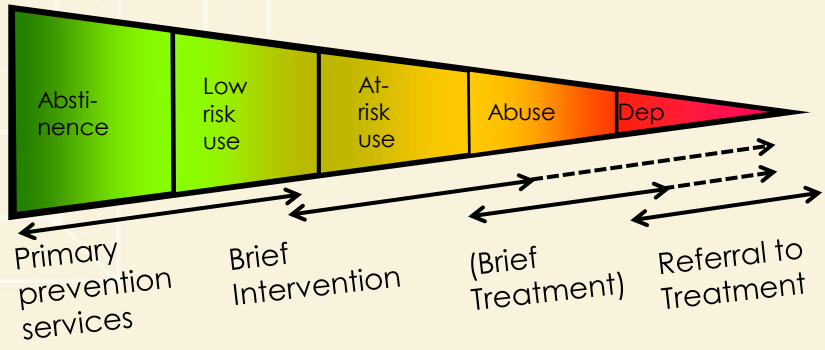
Care Pathways



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Low Risk: Education/Feedback

- Feedback on results
- Affirmation for healthy behaviors
- Primary prevention messaging
- Can be delivered by any member of care team or via other methods (visit summary, electronic messages, etc.)

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At Risk/ Harmful: Brief Intervention

Using Motivational Interviewing approach, offer:

- Personalized feedback, information about potential problems, comparative feedback, low-risk guidelines and recommendations
- Opportunity for patient to consider making changes
- Support patient in developing action plan to promote success with changes
- 15-20 minutes; 1-4 visits

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Likely Dependent: Referral to Treatment

Using Motivational Interviewing approach:

- Provide feedback and
- recommendations
- Offer opportunity to explore motivation
- for engaging in recommended
- specialty care
- Support patient in identifying
- appropriate referral resources
- Problem-solve with patient around
- potential barriers

http://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

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At Risk/ Harmful: Brief Intervention

Dedicated member of care team

- Behavioral Health Specialist
- Care Coordinator/Care Manager
- Medical Assistant
- Health Educator

Characteristics:

- Empathetic
- Organized, proactive
- Flexible, efficient

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Likely Dependent: Referral to Treatment

Opportunities:

- Warm-handoff to co-located or embedded behavioral health
- Maintain engagement with those who do not enter treatment immediately
- Medication-assisted treatments in primary care
- Improve coordination and continuity of care

http://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment

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Getting Started

- Convene Implementation Team:
  - Physician/Provider
  - Quality Improvement
  - Practice Management
  - Billing
  - Front Desk
  - MA/Nursing
  - Behavioral Health
- Prepare to hire/appoint dedicated staff to deliver brief interventions and referrals
- Spread education/awareness organization-wide

http://www.integration.samhsa.gov/clinical-practice/sbirt/workflow

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Getting Started

- Choose screening tool(s)
- Create protocol for EHR documentation
  - Forms
  - Smart sets
  - Billing
- Compile current list of referrals resources
- Prepare scripting for every transition point
- Training and practice to deliver brief intervention

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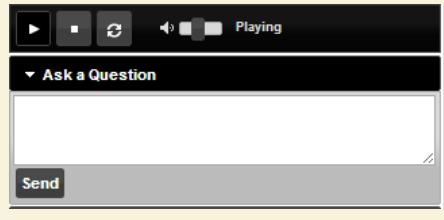

Primary & Behavioral Health Integration: The New Standard of Care

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Behavioral Health Consultation
A Primary Care Level of Service Delivery

"Voices from the Field: Patients just want to be heard; a little can go a long way."

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Presented By:

Suzanne Daub, LCSW
Senior Director of Integration Initiatives
University of Pittsburgh Medical Center
Community Care Behavioral Health
daubs@upmc.edu

Suzanne is an integrated health consultant and a licensed clinical social worker who has provided individual, marital and family therapy for over twenty years. As the Director of Behavioral Health in Primary Care at Delaware Valley Community Health she guided the transformation from referral-based system, to co-located service delivery, and finally to a fully integrated primary care behavioral health program.

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Behavioral Health Consultation

- **Behavioral Health Consultants (BHCs) work alongside primary care providers (PCP) and make recommendations to the PCP.**
- **Immediately accessible for both curbside and in-exam room consults, same-day visits (15 – 30 minute consultation), prevention education/anticipatory guidance.**
- **Shared records: Chart in the medical record using a SOAP note format.**
- **No office, No Caseload, No "no shows"**

Robinson, P.J. and Reiter, J.T. (2007). Behavioral Consultation and Primary Care (pp 1-16). N.Y.: Springer Science + Business Media.

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Behavioral Health Consultation

- **The BHC is meeting the person in the moment to catalyze the change process in the context of the person's relationship to their physical health.**
- **BHCs do not work only with "simple cases" referring out "difficult cases". Referral is based on accessibility, patient motivation and does not involve termination of work.**
- **BHC is the equivalent of the family practice doctor who will maintain life-long relationships with patients**

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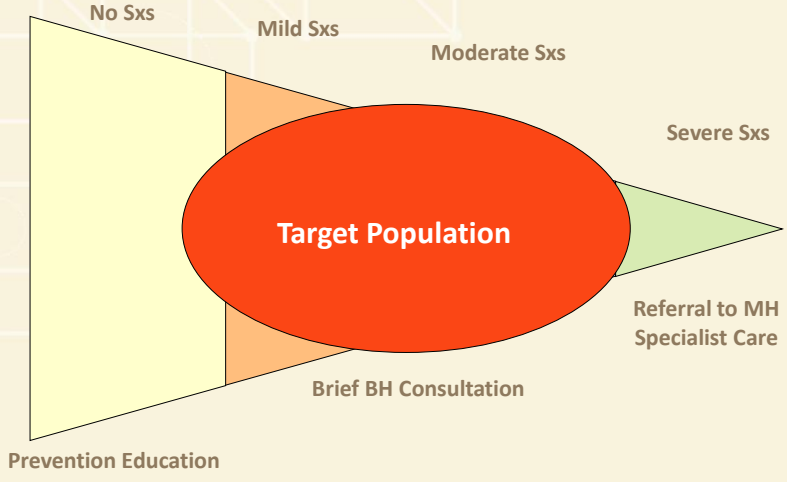
Clinical Targets

BHCs address a variety of issues common to primary care

- Affective concerns: depression; anxiety
- Response to physical illness; pain; substance use and abuse
- Health behavior change: obesity, smoking, sleep, medication adherence, self management of chronic conditions
- Prevention activities, anticipatory guidance

Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer A.C., (2009), Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention. Washington, DC: American Psychological Association



Treat to Target

- Problem-focused/functional approach to assessment and treatment of behavioral health disorders.
- Use evidenced based screening instruments and treatment interventions to develop treatment plans, monitor progress, and flexibly provide care to meet changing needs.
- Clinical Approaches:
  - Motivational Interviewing
  - Cognitive Behavioral Strategies
  - Behavioral Activation
  - SBIRT

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Collaborative Approach

- **PCPs systematically screen and do "warm hand-offs" according to patient needs.**
- **PCPs and BHCs regularly review each other's notes in the EMR.**
- **Regularly consult about care and change or adjust treatments if treatment targets are not met.**
- **PCP and BHC use** valid outcome measures to **co-monitor treatment response at each appointment.**
- **Individuals who are not improving are identified and targeted for move to a higher level of care.**

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Population-Based Care

- **Standardization of care across the population – algorithms, protocols, evidenced based assessment tools**
- **Continuous improvement systems – PDSA cycles**
- **Implement disease registries**
- **BHCs proactively reach out to patients who do not follow-up (or designate someone to reach out).**
- **Referrals to specialty care, social services, and community-based resources are seamlessly facilitated and tracked.**

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Psychiatric Consultation

- Psychiatric consultation is available for challenging patients in-person or via telemedicine.
- PCPs prescribe and manage psychotropic medications as clinically indicated.
- PCPs and BHCs collaborate to monitor treatment side effects and complications.

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Get to Know Each Other's Skills

Integrated care teams need to understand each other's skill sets and train each other on vital elements of care

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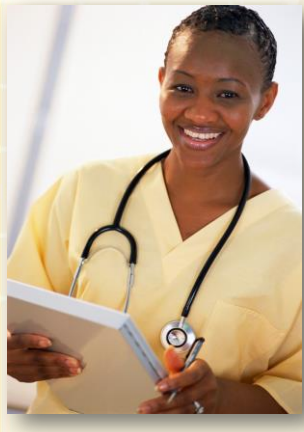
Role of PCP



- Serves as team leader
- Screens for depression, anxiety and trauma
- Refers a broad range of patients to BHC
- Uses BHC consistently at certain types of visits (chronic pain, initial dx of diabetes, well child visits…)
- Supports BHC visits
- Makes intermittent referrals to BHC over the life span of the patient
- Conducts medication evaluation, prescribing and monitoring

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Role of the BHC

- Sees patients for 15–30 min. consults in the exam room
- Conducts a functional assessment
- Teaches evidence-based skills
- Emphasizes home-based self mgmt.
- Provides prevention education on a broad range of behavioral health and health behavior topics (depression screening, sleep hygiene, smoking cessation, pain management, substance use, stress reduction)
- Makes recommendations to PCP
- Provides medication education and supports adherence

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Integrated Care Workflow
Usual Care vs. Integrated care

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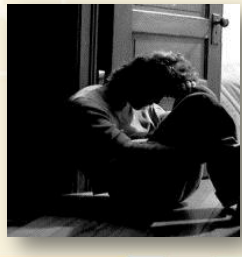
Usual Care
January 3

- Individual presents complaining of symptoms of depression
- Prescribed antidepressant and told to return in a month



Integrated Care Clinic
January 3

- Individual presents complaining of symptoms of depression
- PHQ-9 is used to determine the severity of the depression and algorithms to apply.
- BHC consultation requested by PCP: Medication??
- MI used to discuss medication and lifestyle issues (sleep, exercise, diet, substance use, social contact…).
- Develop a self management plan.
- Antidepressant prescribed by PCP.
- Given an appt. to be seen in 2 weeks.

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Usual Care
January 17

- Individual misses appt.
- No system exists to follow up, so rely on individual's initiative to reschedule
- News flash: Individual stopped meds after 1 week due to side effects.

Integrated Care
January 17

- Individual misses appt.
- Tracking database alerted BHC to missed appt. and individual is called and rescheduled.
- During phone conversation, BHC learns that individual stopped his antidepressant after 1 week due to side effects.
- PCP will make some plans at a follow up visit to adjust meds.

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Usual Care

Integrated Care
January 24

- Individual comes in for a PCP visit and is restarted on a different antidepressant.
- BHC recommendations are reviewed and reinforced.

Integrated Care
February 19

- Returns to see BHC. Discuss self management.
- PHQ-9 re-administered – 50% reduction in symptom severity.
- This gives the BHC/PCP a good sense of his progress.

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Usual Care
March 28

- **Individual returns to clinic.**
- **He's still depressed and is not taking any meds.**

Integrated Care
April 3

- **BHC Re-assesses with PHQ-9. He still has some remaining symptoms.**
- **Discuss self management strategies and option of therapy.**
- **Following evidence based algorithms PCP increases the dosage of antidepressant to see if they can make further progress.**

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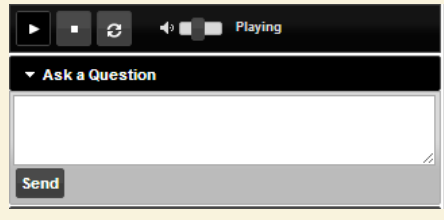

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Operations

Voices From the Field: *"Buy-in has to be obtained from primary care medical staff and mental health staff. Intense collaboration requires rethinking of everything – EMR, warm handoffs, billing, screening tools, staff training, staffing, accreditation, PCMH, adapting services to make a good fit for both agencies."*

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Laura Galbreath, MPP
Director, SAMHSA-HRSA Center for Integrated Health Solutions
National Council for Behavioral Health

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CQI/Quality Management Work Plans

Given that all chronic medical conditions have a behavioral health component (behaviors and conditions) it is important to ensure that ALL QI projects are inclusive of behavioral health, across QI projects and professional disciplines

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Behavioral Health and Measurement: A Quality Imperative

- Why Measurement?
  - Improve individual outcomes by assisting in treatment planning
  - Group level outcomes can serve as benchmarks and goals that can be used as critical information to confirm or address effectiveness of service model changes
  - Creates a common language across disciplines and providers to promote *effective* collaboration

CIHS Presentation by Henry Chung, M.D.

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Translating PHQ-9 Depression Scores into Initial Planning

Score	Description	Actions
1-4	Community Norms	No further action
5-9	Mild Symptoms	Watchful waiting, periodic re-screening, education, patient activation and evaluation
10 – 14	Moderate Symptoms	Develop treatment plan, consider counseling, education, assertive follow-up and evaluation, pharmacotherapy
15 – 19	Moderate -Severe	Immediate institution of treatment including medication and/or counseling
≥ 20	Severe	Pharmacotherapy, counseling & referral to mental health specialist

CIHS Presentation by Henry Chung, M.D.

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Using the PHQ-9 to Monitor & Adjust Treatment at 4-6 Weeks

PHQ-9	Treatment Response	Treatment Plan
Drop of 5 points from baseline	Adequate	No treatment change needed Follow-up in four weeks
Drop of 2-4 points from baseline	Possibly Inadequate	May warrant an increase in antidepressant dose
Drop of 1 point, no change or increase	Inadequate	Increase dose; Augmentation; Informal or formal psychiatric consultation; Add psychotherapy

CIHS Presentation by Henry Chung, M.D.

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Clinical Measures

UDS - Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized Examples of depression screening tools include but are not limited to: • Adolescent Screening Tools (12-17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2 • Adult Screening Tools (18 years and older) Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (SDS), Cornell Scale Screening and PRIME MD-PHQ2

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Atlas of Integrated Behavioral Health Care Quality Measures

- Care Team Expertise
- Clinical Workflow
- Patient Identification
- Patient and Family Engagement
- Treatment Monitoring
- Leadership Alignment
- Operational Reliability
- Business Model Sustainability
- Data Collection and Use
- Patient Experience

Source: Atlas of Integrated Behavioral Health Care Quality Measures

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Measure Examples

Patient/Client Satisfaction Surveys

PHQ9 scores (baseline, diagnostic, measure improvement)

# of warm hand offs

BHC Monitor patients referred for longer term care

- Make smooth transition
- Don't fall through the cracks
- Staying in service

- Follow up reports to Primary Care Provider from BHC
- BHC encounters for sustainability for 100 hours a month
- Patient outcomes

- Patients with a repeat PHQ-9 score of less than five within 1 year of the elevated PHQ-9.
- Patients with a positive alcohol and/or substance abuse screening who were referred for treatment.
- Patients with at least 2 follow up visits per year after initiation of medication.
- # of visits per month per behavioral health provider
- # of patients per month seen by behavioral health
- Minutes Provider delay for BH concerns

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Performance Measurement Goal for SBIRT

Complete SBIRT Checklist

	Correct	Incorrect	Absent
Screening			
Asks the InSight three question screen	☐	☐	☐
Negative Screen			
Provides supportive statement	☐	☐	☐
Positive Screen			
Uses AUDIT, DAST, CRAFFT correctly	☐	☐	☐
Provides results and feedback on score	☐	☐	☐
Brief Intervention			
Asks permission to explore substance use further	☐	☐	☐
Uses readiness ruler to assess readiness to change	☐	☐	☐
Provides appropriate BI based on readiness level	☐	☐	☐
Uses open-ended questions	☐	☐	☐
Demonstrates listening through reflections	☐	☐	☐
For Abuse/Dependence ***Referral to Treatment***			
Uses readiness ruler to assess readiness for referral	☐	☐	☐
Makes appropriate plan/referral with patient based on readiness	☐	☐	☐

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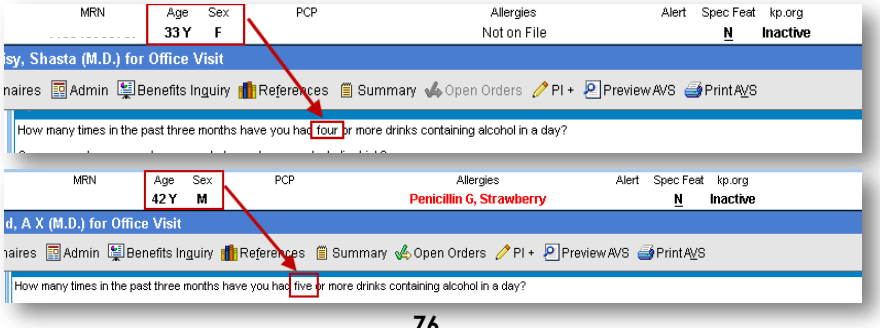
Utilizing Health Information Technology to Support Behavioral Health Integration

- Additional prompts for when to screen patients based on their level of risk
- Problem lists, flagging, and other mechanism used to support behavioral health follow-up
- Decision supports embedded into the EMR to support primary care providers and behavioral health clinicians
- Embedded referral protocols
- Intranet resources for staff
- Patient portal resources for families and patients

Alcohol Screening: prompt in EHR

Logic: Will appear once a year (or at six months if prior positive screening). The first question is gender & age specific.



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Source: *Brigid McCaw, Permanente Medical Group*

"Transition of Care" (CCR) Summary May Also Contain

- Vital signs
- Insurance information
- Health care providers
- Encounter information
- Procedures
- Necessary medical equipment
- Social history
- Family history
- Care plan

http://www.corepointhealth.com/sites/default/files/whitepapers/understanding-the-continuity-of-care-record-ccr.pdf

Patient: Jeffery Surrett
347 Grove Street
Williamsport, PA, 17701
tel: +1-(570)837-9933

MRN: 00004201

Birthdate: September 24, 1990

Sex: Male

Allergies and Adverse Reactions

Substance	Adverse Event Type	Reaction	Status	Note
AMPICILLIN TR 250 MG CAPSULE	propensity to adverse reactions		Active	Diarrhea, nausea, vomiting

Medications

Medication	Instructions	Start Date	Status
Atorvastatin (LIPITOR 10 MG TABLET)	1 tablet(s), oral, QD		Active
Potassium Chloride (KLOR-CON 10 MEQ TABLET)	1 tablet(s), oral, BID		Active
Furosemide (LASIX 20 MG TABLET)	1 tablet(s), oral, BID		Active
Glyburide (DIABETA 2.5 MG TABLET)	1 tablet(s), oral, OD, AM		Active
Buprenorphine naloxone (SUBOXONE 12 MG FILM)	1 film sublingual, OD, AM		Active

Problems

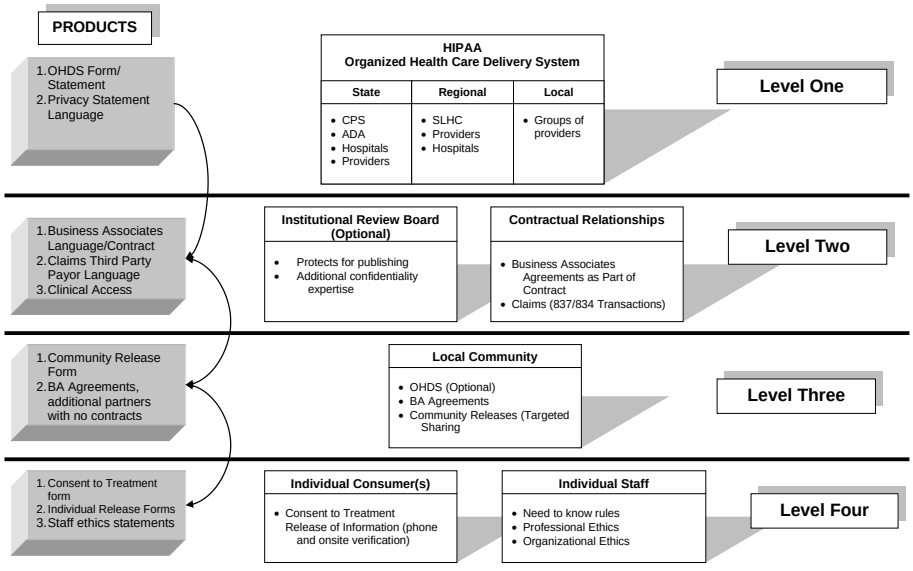
Problem Name	Type	ICD-9-CM	Status
DIABETES UNCOMP TYPE II UNCONT	Diagnosis	250.02	Active
401.9 - HYPERTENSION ESSENTIAL	Symptom	401.9	Active
272.4 - HYPERLIPIDEMIA OTH/UNSPEC	Condition	272.4	Active
304.00 - OPIOID DEPENDENCE	Diagnosis	304.00	Active

Results

Test	LOINC	
HDL Cholesterol (40 - 999mg/dl)	14646-4	43mg/dl
Total Cholesterol (0 - 200mg/dl)	14647-2	162mg/dl
Creatinine (0.5 - 1.4mg/dl)	14682-9	1.0mg/dl
Fasting Blood Glucose (70 - 100mg/dl)	14771-0	178mg/dl*
Triglycerides (0 - 150mg/dl)	14927-8	177mg/dl*
BUN (7 - 30mg/dl)	14937-7	18mg/dl
LDL cholesterol (0 - 100mg/dl)	2089-1	84mg/dl
Toxicology screen (0-2000 ng/mL)	8220-6	2500 ng/mL
Chest X-ray, PA	24648-8	No disease is seen in the lung fields or pleura

Core Concepts in Confidentiality for PC/BH Integration

- HIPAA – Organized Healthcare Delivery System
- 42CFR
- State Confidentiality Policy
- Privacy Statement
- Consent Forms
  - Community Release
  - Individual Release
  - Need to know/staff ethics
- Business Associates Language



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Other Considerations

- Human Resources
  - Job Descriptions, Performance Assessments, Credentialing
- Compliance
- Policy and Procedures
  - Protocols for patients with suicidal ideation
  - Protocols/decision trees for front desk staff/security
- Patient Satisfaction Surveys

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Presented By:

Gina Lasky, PhD

Project Manager, Health Management Associates Community Strategies

Gina Lasky is a licensed psychologist with 16 years of hands-on experience in the behavioral health public sector working on multi-disciplinary teams. In 2011, Gina served as the Director of Behavioral Health for Axis Health System, a community behavioral health agency transforming into an integrated healthcare organization in Colorado. In that position she and the Director of Psychiatry helped lead the opening and development of an integrated care clinic. Gina learned first-hand about the challenges of implementation of integrated care which furthered her interest in the unique leadership required and the importance of team development as essential elements of this innovative model. In the last year and half, Gina has been consulting with organizations nationally on behavioral health system design, integration of behavioral health and primary care, and team development. In her work at HMA Community Strategies she is expanding integrated care to include community based organizations addressing the social determinants of health. She is currently pursuing a master's in Public Leadership with a Specialization in Multi-Sector Management at George Washington University.

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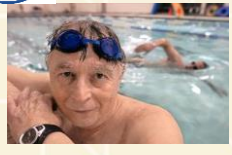
IMPACT

Collaborative Care Model

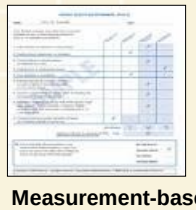


Informed, Activated Patient

Effective Collaboration

PCP supported by Behavioral Health Care Manager

Practice Support



Measurement-based Stepped Care

Caseload-focused psychiatric consultation

Training

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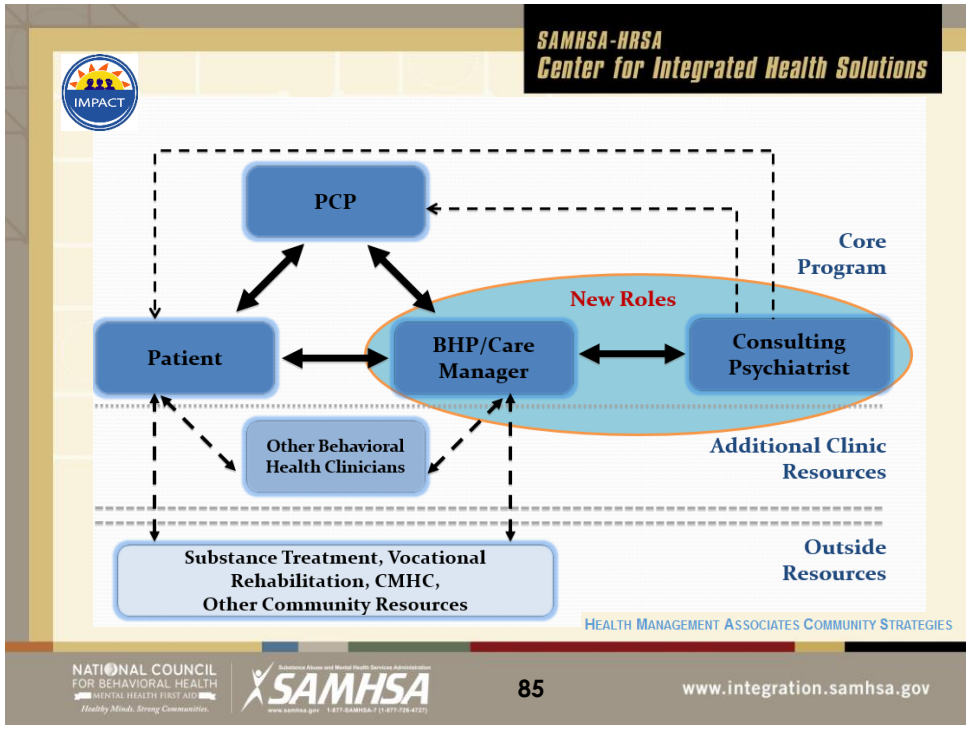
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IMPACT
PCP
Core Program
New Roles
Patient
BHP/Care Manager
Consulting Psychiatrist
Other Behavioral Health Clinicians
Additional Clinic Resources
Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources
Outside Resources
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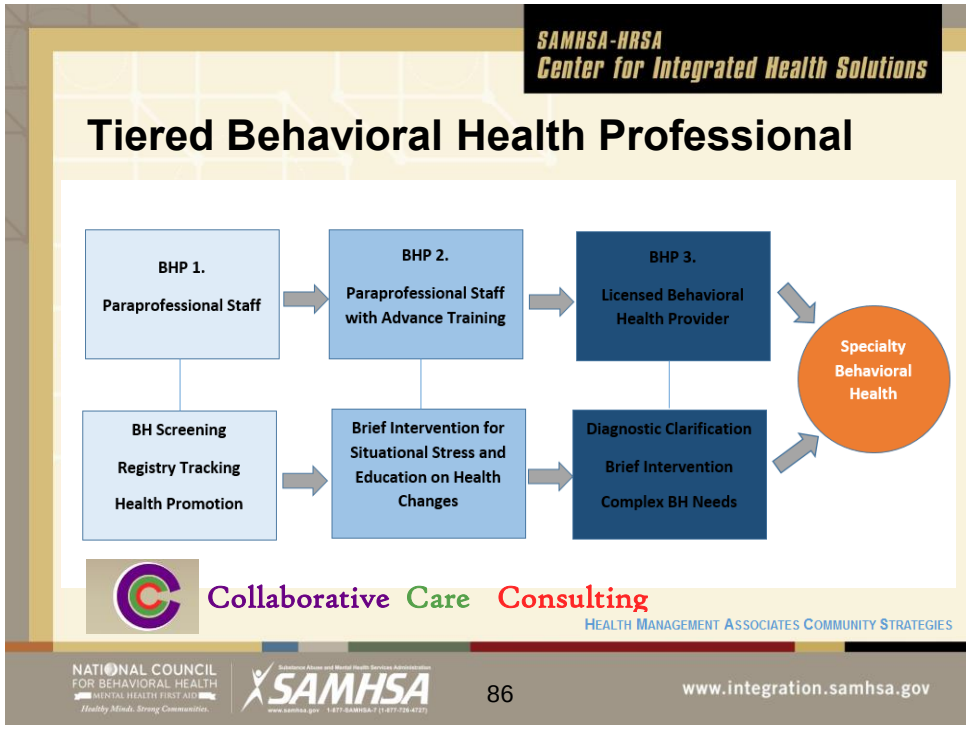
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Tiered Behavioral Health Professional
BHP 1.
Paraprofessional Staff
BHP 2.
Paraprofessional Staff with Advance Training
BHP 3.
Licensed Behavioral Health Provider
Specialty Behavioral Health
BH Screening
Registry Tracking
Health Promotion
Brief Intervention for Situational Stress and Education on Health Changes
Diagnostic Clarification
Brief Intervention
Complex BH Needs
Collaborative Care Consulting
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Integrated Care Team

"The care that results from a practice team of primary care and behavioral health clinicians, **working together with patients and families**, using a **systematic and cost-effective approach** to provide **patient-centered** care for a **defined population**."

Peek CJ and the National Integration Academy Council. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: *Agency for Healthcare Research and Quality. 2013.*

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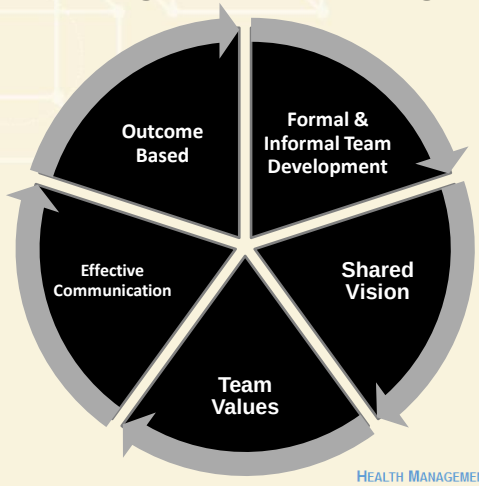
Elements of High Functioning Teams



Lardieri, Lasky, Raney, SAMHSA-HRSA CIHS 2014

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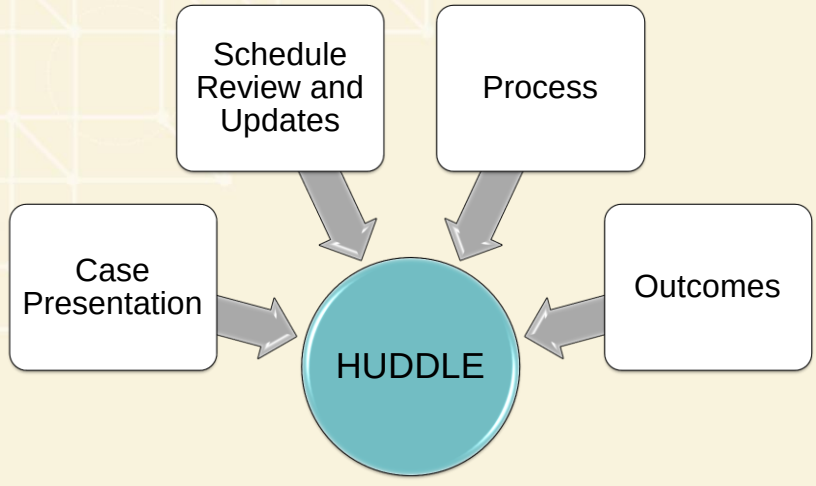

Core Competencies

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Characteristics of Integrated Team Members

- Flexible-Open to Changing Approach
- Creative
- Value Team Based Approach-Embrace Feedback
- Effective Communication
- Ego is not the focus yet Professionally Strong
- Develop Quick Rapport with Patients and Staff
- Trained in Brief Intervention

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Cross-Training is Essential

- Population Specific Diagnoses and Characteristics
- Screening Tools
- Integrated Vitals
- Specific Techniques (EBP's)
- Team Process
- Community Resources

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Recruitment and Retention

- Right People on the Bus
  -Transparent Model at Entrance
- Monetary Incentives and Rewards
  -National Health Service Corps
- Non-Monetary Incentives and Rewards
  -Development of Model
  -Job Satisfaction
- Supervision and Support

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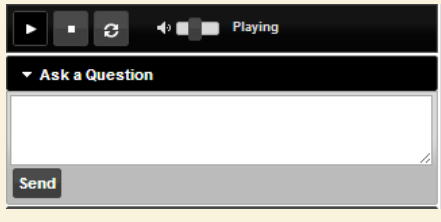

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Making the Business Case

Voices from the Field: "We have found that our medical providers lives are so much easier now. They all agree that they are NOT specialists in behavioral health and they love having providers accessible who can assist them with this."

Presented By:

Roger Chaufournier
CEO, CSI Solutions
Bethesda, Maryland

Mr. Chaufournier has been an innovator, leader and teacher in the health care industry for more than thirty years. He has held senior leadership positions in academic medical centers, managed care organizations and as CEO of a publicly traded company. Mr. Chaufournier led a process to develop a statewide plan for integration of behavioral health and primary care in the state of West Virginia and served as faculty for the NACHC-SAMHSA Behavioral Health Integration Pilot. He continues to serve on the faculty of the Institute for Healthcare Improvement and the Johns Hopkins University.

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The Business Case for Integration

We will discuss:

- Understanding the concept of a business case and a process to develop one
- Current reimbursement considerations
- Resources to assist you with building your business case

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Poll Question Case Study:

Rosie Health Center is exploring integration of behavioral health into their new primary care patient centered medical home model. Rosie has the following payer mix: Medicare 12%; Medicaid 40%, Commercial 8%; Uninsured sliding fee 40%

After review it was determined that neither the Commercial payers nor Medicaid will reimburse for Behavioral Health Services. Is there a business case for integration of behavioral health for Rosie Health Center?

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First, what is a business case?

- A business case is generally defined as a justification for initiating a project, task or service.
- It is the compelling argument for sustaining a service or program.
- For our viewers today, the business case is the justification for integrating behavioral health into your primary care model
- Often a business case is self-evident and in other cases you have to craft a business case- concept of the Total Cost of Quality

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Reimbursement Environment

- The reimbursement environment continues to evolve
  - Screening
  - Direct Services and Treatment
- Many of you are in mixed reimbursement environments
  - Fee for Service
  - Capitation
  - Alternative Payment Methodologies
  - Value Based Models
  - Accountable Care Organizations
  - Pay for Performance

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Reimbursement Considerations

Many environments yet mature and have incorporated behavioral health in primary care reimbursement-changing as we speak

Understand your integration model options (e.g. fully integrated owned model versus integrated co-location model)

In general, reimbursement does require licensure (MD, PhD, LSW, Psychologist, Certified Counselor, etc.) and clear documentation

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Building Your Business Case

1. Understand your population- burden of illness and social determinant of health issues
2. Confirm the integration model you intend to deploy
3. Understand your true reimbursement environment-eliminate urban myths
4. Understand the total cost of quality (opportunity cost)
5. Model (pro forma) the financial impact of your proposed integration model

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Total Cost of Quality

Direct reimbursement for screening and treatment is relatively straightforward to model

What other revenue streams are in play? ACO or Pay for Performance

What is the opportunity cost by not providing behavioral health?

What impact does behavioral health have on clinical productivity? How much new revenue could you derive by warm handoffs of patients to a behavioral health resource? **THE SECRET SAUCE!**

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DISCLAIMER

"All models are wrong- some models are useful"

George Box- Statistician

BUSINESS CASE FOR BEHAVIORAL HEALTH PRO FORMA MODEL

Core Assumptions:

Panel size	1500	1500		Average Visit Scheduled Time		15	minutes
Encounters	4200	4200		Estimated time saved by diverting to a behaviorist		11	minutes
Payer Mix							
Medicaid		40%		Average visits per hour		3	
Medicare		12%		Transition training time		16	hours
Commercial		8%					
Sliding fee scale		40%		SBIRT screenings that triage for intevention		16%	
Average Reimbursement per visit		$135		Projected proportion that could be diverted Behaviorist		50%	
Medicare SBIRT Reimbursement							
G0396		$ 29.62		Slots created as a result of integration mode		246.4	
G0397		$ 57.69					
Medicaid SBIRT Reim H0049				Estimated Medicare SBIRT Screens		504	
H0049		$24.00		Estimated Medicaid SBIRT Screens		1680	
H0050		$48.00		Estimated Medicare Screen & Intervention		80.64	
				Estimated Medicaid Screen & Intervention		268.8	
Provider Hourly Rate		$ 72.00		Medicare encounters		504	
RN Hourly Rate		$ 27.60		Medicaid encounters		1680	
Medical Assistant Hourly Rate		$ 15.60					
Behaviorist Hourly Rate		$39.06	$81,250	$65,000 Base salary	25%	Benefits	
				2080 Hours worked a year			

Costs		Salary Resource	Time	Lost Revenue	Totals	
S	Screening					
I	Intervention	$40,625.00			$	40,625.00
T	Transition Costs	$ 1,843.20	16	$6,480	$	8,323.20
	Subtotal				**$**	**48,948.20**
Revenue						
X	Screening Reimbursement	$55,248.48			$	55,248.48
P	Gains in Productivity	$33,264.00				$33,264
R	Reimbursement for Screen and Treatment	$ 8,714.76			$	8,714.76
					$	**97,227.24**
Net Business Case					**$**	**48,279.04**

BUSINESS CASE FOR BEHAVIORAL HEALTH PRO FORMA MODEL

Core Assumptions:

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Medicaid		40%		Average visits per hour		3	
Medicare		12%		Transition training time		16	hours
Commercial		8%					
Sliding fee scale		40%		SBIRT screenings that triage for intevention		16%	
Average Reimbursement per visit		$135		Projected proportion that could be diverted Behaviorist		50%	
Medicare SBIRT Reimbursement							
G0396		$ 29.62		Slots created as a result of integration mode		246.4	
G0397		$ 57.69					
Medicaid SBIRT Reim H0049				Estimated Medicare SBIRT Screens		504	
H0049		$0.00		Estimated Medicaid SBIRT Screens		1680	
H0050		$0.00		Estimated Medicare Screen & Intervention		80.64	
				Estimated Medicaid Screen & Intervention		268.8	
Provider Hourly Rate		$ 72.00		Medicare encounters		504	
RN Hourly Rate		$ 27.60		Medicaid encounters		1680	
Medical Assistant Hourly Rate		$ 15.60					
Behaviorist Hourly Rate		$39.06	$81,250	$65,000 Base salary	25%	Benefits	
				2080 Hours worked a year			

Costs		Salary Resource	Time	Lost Revenue	Totals	
S	Screening					
I	Intervention	$40,625.00			$	40,625.00
T	Transition Costs	$ 1,843.20	16	$6,480	$	8,323.20
	Subtotal				**$**	**48,948.20**
Revenue						
X	Screening Reimbursement	$14,928.48			$	14,928.48
P	Gains in Productivity	$33,264.00				$33,264
R	Reimbursement for Screen and Treatment	$ 2,263.56			$	2,263.56
					$	**50,456.04**
Net Business Case					**$**	**1,507.84**

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Summary

- Appreciate the total cost of quality and the opportunity cost by not providing behavioral health in an integrated model
- Sometimes you have to craft a business case when one does not exist
- Do your home homework and do not rely on urban myths
- Develop a pro forma model for your integration effort

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Care Coordination and Referral Arrangements to Specialty Care

A Patient Perspective: My doctors, dialysis clinic staff, and mental health case manager are well connected. They take a team approach, and they each check on the status of my health... Today I have control over my health; it doesn't have control of me. The coordinated care allows me to feel like I can go out and be a part of the community.

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Presented By:

Jeff Capobianco, PhD, LLP
Senior Integration Healthcare Consultant,
National Council for Behavioral Health

Jeff Capobianco has 20 years of clinical and administrative experience in healthcare, with extensive background in primary and behavioral healthcare integration, evidence-based practice implementation, use of learning organizations, and Lean Six Sigma methodologies. He ran integrated health and family psychoeducation implementation learning communities and chaired the Michigan Family Psychoeducation implementation steering committee. He was a research investigator at the University of Michigan School of Social Work and the director of research and new program development for the University of Michigan Health System-based Washtenaw Community Health Organization, a four-county behavioral health managed care organization. He is a co-author of Implementing Evidence-based Practices in Mental Health: A Field Guide published by the National Council. Capobianco consults with behavioral health organizations on using evaluations and performance measurements in integrated health efforts.

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Care Coordination/Referral Arrangements for Specialty Care Presentation Overview

1. Understanding specialty behavioral health – overview of services, culture, language
2. Practical steps for working with specialty behavioral health – overview of successful approaches to building the relationship, managing/sharing data, and coordinating care
3. Core Competencies for Care Coordination (referenced in your grant application)
   - Shared Patient Scheduling
   - Shared Treatment Planning
   - Shared Service Provision
   - Shared Record Keeping

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Understanding Specialty Behavioral Health Services:

- Billing supports longer appointments & length documentation
- Strong community/person in context biopsychosocial model approach
- Don't assume all BH providers do S/A treatment you may need to find a S/A treatment provider
- Same/Next Day access to specialty BH is becoming the standard however wait times remain considerable in most areas
- State Medicaid office regulates funding & documentation requirements
- Some BH providers have county staffing requirements &/or unions

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Understanding Specialty Behavioral Health

Culture: (defined as, "this is how things are done here…")

- Tends to be "process oriented" vs. "timeline focused"
- Strong consumer voice & advocacy
- Physical health screening & follow-up on referral for PH tx becoming more common but often still not seen as what "we" do
- Treat to target and use of treatment metrics limited
- Strong commitment to working with community social service & business community

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Understanding Specialty Behavioral Health Language:

- "Consumer or Client" vs. "Patient"
- "Person-centered plan of care" vs. "Treatment Plan"
- "Rehabilitation & Habilitation"
- "Medical Necessity"
- "Huddles" & "Mid-level" are not used

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Successful Care Coordination: Required Components

Shared Patient Scheduling:

- Same/Next Day Intake is becoming the standard
- If using referral model "rapid referral" process should be developed which requires partners develop referral agreement & associated policy/procedure (e.g., dedicated appt. times, single point of contact staff in BH and PC clinics)
- Time to first appt., 1st & 2nd appt no show data should be monitored regularly

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Successful Care Coordination: Required Components

Shared Treatment Planning:

- Goal is for all providers to work off one tx plan
- Real-time sharing of CCD elements & Crisis/ED/Inpt. Data must be goal
- BH Org & CHC/FQHC should use same screening tools to facilitate data sharing & tx planning/monitoring
- If co-locating, contract should detail vendor/purchaser requirements for treatment
- Workflow analysis is required to understand which staff do what when it comes to treatment planning/service provision

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Successful Care Coordination: Required Components

Shared Service Provision:

- BH interventions at the CHC/FQHC should be conducted briefly in the exam room w/ long-term therapy a referral service
- Important that the teams include PC or BH staff in all meetings/huddles
- “BH/PH whole health” & “wellness” must be responsibility of all staff
- Team & Clinician Dashboards should be used to drive tx planning & services continuous quality improvement

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Successful Care Coordination: Required Components

Shared Record Keeping:

- Clinicians need at minimum are CCD elements
- Clinicians & administrators need registry level data aggregation to do population management
- Partnership agreements should detail how data will be shared in order to address HIPAA & 42CFR requirements
- Combined HIPAA/42CFR consent is acceptable in many states
- Creativity is required if EMR's can't "talk" to one another

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Practical Keys to Successful Integration

- Leadership - Shared Vision between Partners
- Use of Change Management Technology
- Communication Plan
- Clear Statement of Work/Charge
- Work Plan: Tasks, Accountability, Measures, Timelines, & Resources
- Focus on data use & sharing to drive care coordination & cost efficiencies

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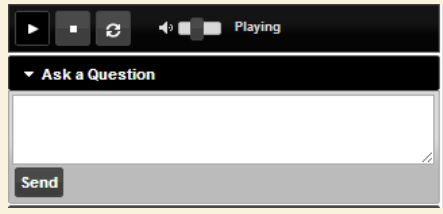
Questions ?

- You may submit questions at any time during the presentation by typing a question into the “Ask a Question” box in the lower left portion of your player.
- If you require further assistance, you can contact the Technical Support Center. Toll Free: 888-204-5477 or Toll: 402-875-9835



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For More Information & Resources

Visit www.integration.samhsa.gov or
e-mail integration@thenationalcouncil.org

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CIHS Resources for HRSA-Supported Safety Net Providers

- Patient-Centered Medical Home
- Integration Models
- Financing & Billing
- Clinical Tools
- Operations Practices & Resources
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Resources…….Email CIHS at integration@thenationalcouncil.org
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