HRSA Behavioral Health Integration Grantee Training Webinar

Thursday, September 11, 2014

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

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
Seiji Hayashi, MD, MPH  
Chief Medical Officer  
Bureau of Primary Health Care  
Health Resources and Services Administration

Setting the Stage/  
Some Guiding Assumptions

In order to succeed, your desire for success should be greater than your fear of failure. — Bill Cosby
“The Body must be treated as a whole and not just a series of parts.”

Hippocrates 430 BC

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
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

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

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

<table>
<thead>
<tr>
<th>LEVEL 1 Minimal Collaboration</th>
<th>LEVEL 2 Basic Collaboration at a Distance</th>
<th>LEVEL 3 Basic Collaboration Online</th>
<th>LEVEL 4 Close Collaboration Online with Some System Integration</th>
<th>LEVEL 5 Close Collaboration Approaching an Integrated Practice</th>
<th>LEVEL 6 Full Collaboration to Integrate Health and Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>In separate facilities, where they:</td>
<td>In separate facilities, where they:</td>
<td>In same facility not necessarily same offices, where they:</td>
<td>In same space within the same facility, where they:</td>
<td>In same space within the same facility (same shared space), where they:</td>
<td>In same space within the same facility, sharing all practice space, where they:</td>
</tr>
<tr>
<td>▶ Have separate systems</td>
<td>▶ Have separate systems</td>
<td>▶ Have separate systems</td>
<td>▶ Have separate systems</td>
<td>▶ Have separate systems</td>
<td>▶ Have separate systems</td>
</tr>
<tr>
<td>▶ Communicate about cases only rarely and under compelling circumstances</td>
<td>▶ Communicate periodically about shared patients</td>
<td>▶ Communicate regularly about shared patients by phone or e-mail</td>
<td>▶ Communicate in person as needed</td>
<td>▶ Collaborate, driven by need for each other’s services and more reliable referral</td>
<td>▶ Collaborate, driven by need for each other’s services and more reliable referral</td>
</tr>
<tr>
<td>▶ Communicate, driven by provider need</td>
<td>▶ May meet in person</td>
<td>▶ Meet occasionally to discuss cases due to close proximity</td>
<td>▶ Meet occasionally to discuss cases due to close proximity</td>
<td>▶ Meet occasionally to discuss cases due to close proximity</td>
<td>▶ Have in-depth understanding of roles and culture</td>
</tr>
<tr>
<td>▶ May have limited understanding of each other’s roles and norms</td>
<td>▶ Have limited understanding of each other’s roles and norms</td>
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</table>

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

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 healthy 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.
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

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

SBIRT Implementation
A Framework for Integration & an Evidence-Based Practice
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

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)
SBIRT: A framework

Screening

Brief Intervention

Referral to Treatment

Alcohol Use in Primary Care:

30% Abstinence
48% Low risk use
9% At-risk use
8% Abuse
5% Dep

Manwell, Journal of Addictive Disease, 1998
Universal Screening

Ideal: All patients should receive an annual screen

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

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.

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?

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
**Brief Risk Assessment/Full Screen**

- **AUDIT**
- **CAGE**
- **ASSIST**
- **DAST**

- **CRAFFT** (youth)
- **Alcohol.screening.org**
- **T-ACE/TWEAK** (pregnant women)


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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?
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.)
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
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


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
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

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
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

Questions?

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Primary & Behavioral Health Integration: The New Standard of Care

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.”
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.

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”

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

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

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
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.

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.
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.

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
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

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
Integrated Care Workflow
Usual Care vs. Integrated care

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

Usual Care
January 3

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.
• 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.

• 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.

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

• 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.
Individual returns to clinic.

He's still depressed and is not taking any meds.

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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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.”

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

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
Translating PHQ-9 Depression Scores into Initial Planning

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

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

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

Performance Measurement Goal for SBIRT

**Complete SBIRT Checklist**

<table>
<thead>
<tr>
<th>Screening</th>
<th>Correct</th>
<th>Incorrect</th>
<th>Absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asks the Inlight three question screen</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Provides supportive statement</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Positive Screen</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Uses AUDIT, DAST, CRAFTT correctly</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Provides results and feedback on score</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

**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**

| Uses readiness ruler to assess readiness for referral | ✗ | ✗ | ✗ |
| Makes appropriate plan/referral with patient based on readiness | ✗ | ✗ | ✗ |
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.
“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


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
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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Contact: Communications@TheNationalCouncil.org 202.684.7457
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.

Collaborative Care Model

Effective Collaboration

- Informed, Activated Patient
- Practice Support
- Measurement-based Stepped Care
- Caseload-focused psychiatric consultation
- PCP supported by Behavioral Health Care Manager
- Training
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.”


Elements of High Functioning Teams

- Outcome Based
- Formal & Informal Team Development
- Effective Communication
- Shared Vision
- Team Values

Lardieri, Lasky, Raney, SAMHSA-HRSA CIHS 2014

HEALTH MANAGEMENT ASSOCIATES COMMUNITY STRATEGIES

www.integration.samhsa.gov
Core Competencies

- Interpersonal Communication
- Collaboration & Teamwork
- Screening & Assessment
- Care Planning & Care Coordination
- Intervention
- Cultural Competence & Adapting
- Systems Oriented Practice
- Practice Based Learning & Quality Improvement
- Informatics

Health Management Associates Community Strategies
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

Cross-Training is Essential

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

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
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.
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

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?
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

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
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.

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
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
- Encounters: 4200
- Average Visit Scheduled Time: 15 minutes
- Estimated time saved by diverting: 11 minutes
- Payer Mix:
  - Medicaid: 40%
  - Medicare: 12%
  - Commercial: 8%
  - Sliding fee scale: 40%
- Average Reimbursement per visit:
  - Medicaid: $335
  - Medicare: $24.00
  - Commercial: $57.69
- Estimated time saved by diverting: 11 minutes
- Estimated Medicare and Medicaid SBIRT Reimbursement:
  - Medicare: $29.62
  - Medicaid: $57.69
- Estimated Medicare SBIRT screenings: 504
- Estimated Medicaid SBIRT screenings: 1680
- Estimated Medicare Screen & Intervention: $8,714.76
- Estimated Medicaid Screen & Intervention: $268.8
- Average Reimbursement per visit:
  - Medicaid: $48.00
- Average visits per hour:
  - Medicare: 3
- Estimated Medicare SBIRT Reimbursement:
  - Medicare: $335.04
- Estimated Medicare Screen & Intervention: $8,714.76

#### Costs:
<table>
<thead>
<tr>
<th>Component</th>
<th>Salary Resource</th>
<th>Time</th>
<th>Lost Revenue</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>$40,625.00</td>
<td></td>
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<td>Intervention</td>
<td>$1,861.20</td>
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#### Revenue:
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<tr>
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<tr>
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#### Net Business Case:
- $1,507.84
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

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.
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
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

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
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

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
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

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
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

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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For More Information & Resources

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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
- Health Behavior Change
- Workforce Development
Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.