TRANSCRIPT OF AUDIO FILE:

2015-02-26 14.00 REMOTE YET RESOURCEFUL_ INTEGRATING BEHAVIORAL HEALTH IN RURAL PRIMARY CARE

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BEGIN TRANSCRIPT:

SARAH STEVERMAN: Good afternoon everyone, and welcome to SAMHSA-HRSA Center for Integrated Health Solutions webinar, Remote Yet Resourceful, Integrating Behavioral Health in Rural Primary Care. My name is Sarah Steverman, a consultant for the SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health, and I will be your moderator for today's webinar. As you know, the SAMHSA-HRSA CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance abuse conditions whether they're seen in specialty behavioral health or primary care settings. In addition to national webinars designed to help providers integrate care, the Center is continually posting practical tools and resources to the CIHS website, providing direct phone consultations for providers and stakeholder groups, and directly working with SAMHSA primary and behavioral health care integration grantees and HRSA funded health centers. [01:12] Before I introduce your speakers for today's webinar I have a few housekeeping items. Today's webinar is being recorded, and all participants will be kept in listen only modes. You can find the call in number for the webinar on the right hand side of your screen. Questions may be submitted throughout the webinar by typing your question into the dialogue box to the right of your screen and sending it to the organizer. I encourage you to submit your questions as you have them and we'll answer as many of your questions as time allows. If at any point during the webinar you experience technical difficulties, please call Citrix Tech Support at 888-259-8414. The webinar slides are currently posted online at www.integration.SAMHSA.gov under the webinar section. Lastly, at the end of the webinar, please take a moment to provide your feedback by completing a short survey. [2:05] To begin, we're pleased to have Tom Morris, the Associate Administrator for Rural Health Policy and the Health Resources and Services Administration of the U.S. Department of Health and Human Services with us today to provide a welcome. Tom will receive the work of the Office of Rural Health Policy at HRSA, advising the secretary on rural health issues as well as serving as the HHS representative on the White House Rural Council. Tom?

TOM MORRIS: Great, thank you so much, Sarah, for that introduction. And really, thanks to everybody for the opportunity to be on the call. I'd like to just give you a little bit of information about the federal office for Rural Health Policy for those of you not familiar with what we do. We advise the HHS and the HHS Secretary of Rural Issues. We're located at HRSA, the Health Resources and Services Administration, but we do a broad range of policy and program work that cuts across a broad swath of agencies within HHS. And really inherent in that is we do a lot of work with rural safety net [ph?] providers and it's focused around trying to find ways to address unique rural health challenges. Over the past couple of years we've really ramped up our work around behavioral health care issues generally, but on integration, more specifically, and Alicia O'Brien leads our efforts on that and so I'm happy for the opportunity to be here and take part in the call. Clearly integrating behavioral health and primary care is a need nationwide, but it's particularly important, I think, in rural communities given the limited infrastructure that we know we have there. And so we're happy to see the ongoing partnership with HRSA and with SAMHSA that is manifested in the work done by the Center for Integrated Health Services and their TA and the training materials they've produced, the webinars that go on, all of which are important resources for folks who are trying to figure out how best to do this. [3:56] Now the Center's not the only one focusing on this integration issue. It's a topic that gets a lot of interest broadly. It's something I hear a lot from the discussions we have with the state offices of rural health. And so for those of you who do work with your state office of rural health, great. If you don't and you're on this call, please reach out to them because they can be an important partner in this also. I should also tell you that this issue comes up a lot within a group we work with. The last year or two years ago, the White House Rural Council created the Rural Health Philanthropy Partnership. This is a group of about 40 foundations and trusts that support rural health activities nationwide, and they work with grant makers in health and the National Rural Health Association. And we get together with these folks probably once a year and then stay in touch throughout the year. And the one topic that always comes up for them is this issue of how best to promote the integration of these two sectors. And so there really is great interest in it. The other thing I would add is that when we look at telehealth as a tool to help with this, we know that there's a lot of potential there, and that if you look at the total number of Medicare billings or services under telehealth, far and away mental health billing is the leader in that. And I think it speaks to the great need that we have out there in rural communities. [5:23] We also fund, through our community based division, a number of grant pilot programs. And invariably if we fund 50 grants in a year, 10 to 20 of them are going to be around behavioral health care issues. And so I think that's an indicator of great need. For those of you who are interested in that funding I'd urge you to go to the community health gateway on the rural assistance center website. You can find out information about our programs, but more importantly you can see a toolkit that we're pretty proud of that's around rural mental health and substance abuse. And included in that is the notion of integration. And these toolkits are partly review, partly case study, part evaluation, and really a how-to manual on how to get started in these areas. And they're based on what we've learned from our own grantees and from the larger research literature. Now today you're going to hear from one of those grantees. This is a practice that has dealt with many of the challenges

and opportunities of integrating care in, I think, the Upper Great Lakes Family Health Center. And the work Don has done there is a great example, and I'm glad to hear they're on this call. You're also going to hear from a national policy expert to get the big picture, and that's JOHN GALE: with the Maine Rural Health Research Center at the University of Southern Maine, which is one of our federally funded rural health research centers. And they have been really the lead for us for years and years on mental health and behavioral health issues. [6:47] And I would also say that I think this issue is timely because of a recent announcement from HHS around delivery system reform and the need to really focus how we pay for services and how we organize services with an emphasis not so much on volume but on value. And none of this operates in isolation, and so if we can address some of the behavioral health challenges that often pop up in primary care settings, we're going to get better outcomes for those patients, and we'll also have a chance to control cost. And so I think as we continue to focus on this topic you're aligned exactly where the department's moving in terms of where we'd like to see… how we'd like to see health care design moving forward. So I thank all the speakers for their participation, and I thank Alicia and Alex Ross for allowing me to kick this thing off. So I look forward to the discussion.

SARAH STEVERMAN: Thank you so much, Tom. As Tom mentioned, we have with us today Don Simila, who's with the Upper Great Lakes Family Health Center, and JOHN GALE:, who is at the Maine Rural Health Research Center out of the University of Southern Maine. And we will… I'll introduce them with a little bit more info in a moment. [8:02] Next slide. So today, just to give you a brief overview before we kick it off and get into some of the [inaudible] you'll be introduced to primary care and behavioral health integration models that have been used in rural settings. We hope that you will be able to identify the components of these models and including what you might need to consider when you're planning, implementing, and financing integration. And lastly, this is a starting place for many of you, so we hope that you'll take the resources and information presented here, begin working on integration in your own communities, and utilize other resources that CIHS and HRSA have available to you. Next slide. We're going to actually start off with a couple poll questions. We want to get a sense of who is on the call today and who we'll be speaking with. So if you could identify your role in primary care behavioral health integration, whether you're a health center administrator, a clinician provider, a policy maker, a researcher, or some other stakeholder. So go ahead and select one now and we will show you the results in just one moment. All right, it looks like we're relatively evenly split between health care administrators, clinicians, providers, and other stakeholders, with a few policy makers and researchers on the line. [9:47] Great. And then our next poll question gets at where you are in the process. Are you just starting to think about this in a precontemplative mode, are you actively thinking about it, are you planning, in the planning processes, talking to people, doing more research, are you in the implementation mode, have you thought about this and planned it and are already starting to do it, do the work with integration, or are you in the maintenance model, evaluating and sustaining, perhaps expanding your program that has already implemented some sort of integration. We'll see the results. Again, pretty evenly split. We have some who haven't quite thought about it, know that you should start thinking about it, and then we have quite a few, actually, who

are in the planning and implementation mode, and some veterans that have… 14% of you have implemented and are working on this pretty actively and maintaining. [11:03] Great. Next slide. All right. And now I just want to introduce Don, Donald Simila, who is the President and Chief Executive Officer of the Upper Great Lakes Family Health Center. Don holds a Master of Social Work degree from Michigan State and is also a board certified… is also board certified in health care administration by the American College of Healthcare Executives. He's going to give us an on the ground example of what it looks like to do introduction in a rural area. So Don, I'm going to turn it over to you.

DON SIMILA: Thank you, Sarah. Okay, so let's go to the next slide. So allow me to provide you with an overview to help create a little bit of scale and context for you. Upper Great Lakes Family Health Center was originally known as the Gwinn Medical Center, A2 [ph?] provider, 20 year independent physician practice located near what was K. I. Sawyer Air Force Base, or affectionately known as K. I. Siberia in the military world. It was a large strategic air command base with as many as 10,000 service personnel. In 1995 the base was decommissioned, the area saw a significant population decline, increase in unemployment. Base housing was converted, too, and created affordable housing opportunities for low income residents in our community. The primary care practice, as a result, saw a significant increase in the number of uninsured and self-paid clients as well as an increase in the number of Medicaid patients that it was seeing. [12:54] In 2008 a group of concerned citizens, and I was one of those, got together to review potential options to sustain the rural clinics in those… in that county. We wrote for and received a planning grant from ORHP, which assisted us with exploring the possibility of creating a community health center. In 2009 we formed a 501c3 corporation, created an organization that essentially met all 19 federally qualified health center requirements. In late 2009 and early 2010 we submitted an application to HRSA for approval as a FQHC Look Alike. In November of 2010 we received notice that Upper Great Lakes was approved as an FQHC Look Alike. At the time of our grant proposal to ORHP in 2012 of the integrated behavioral health service project, Upper Great Lakes was a Look Alike with two clinic locations, 3.5 providers, and an annual budget of approximately $3 million. With the implementation of the ACA in 2010 and the opportunities it provided, the scale of our project changed almost overnight with approval of two major grant applications. Within about six or nine months in 2013 and 2014 we experienced over 700% growth, and so the challenge for our administrative team was to keep things focused and on track with our ORHP behavioral health integration project, and we've made sure that we've focused the integration project on the original two clinic sites in Marquette County with modest implementation across all of our new access point clinics. [14:51] Next slide. Next slide please. Next slide please. Thank you. I won't spend a whole lot of time on this. I really just wanted to make sure that we had a sense of the geography. The upper peninsula of Michigan is at the top of the map and bordered by Wisconsin and… on the south and Ontario on the east. Next slide. Provide a little bit further scale of the rural environment. The upper peninsula is approximately 7000 square miles… 17,000 square miles, with a stable but aging population of approximately 318,000 people, or about 17 people per square mile. Our integration project focused on two clinics located in Marquette County, Michigan, with a population of approximately 67,000. The Sawyer and Gwinn Family Health Centers are on the east

side of your screen. Next slide. So how did we know we had a need for integrated behavioral health services? Like many of you, let's jump to the next slide please. Like many of you we see the issues in our primary care clinics in our community every day. We have patients that have substance abuse problems, we have a number of at risk population folks in our community, we see a lot of folks with undertreated or undiagnosed behavioral health illness. [16:48] We reference several regional needs assessments. These uniformly identified a lack of access to behavioral health services in our community. In 2013, there were major funding changes in Michigan that impacted community mental health services, forcing mild and moderate behavioral health populations from the community mental health centers into primary care clinics for medication management. We did an internal audit or a snapshot in time. The data showed us that for this particular time period 60%, 60-70% of our patients had or have a behavioral health diagnosis or were taking a medication for a mild to moderate mental health disorder. We lacked consistent methods across all of our providers to assess and screen patients. On a routine basis our primary care providers complained to us as an administrative team about the time it takes to manage the psychosocial demands of their patient panel. Our regional health plan shared data with us on emergency room utilization rates for Medicaid beneficiaries, which showed us significantly higher rates for our patient population. And we all knew the lack of psychiatric outpatient services that… in our community, and often, required travel for a psychiatric visit was over 100 miles for our patient population. [18:16] We also conducted internal patient surveys in our clinics on… and really tried to determine what the patient demand and patient needs were. Next slide please. So as rural providers we all recognize the challenges of full vertical integration or full financial risk when adding services. Our clinics understood very clearly early on that as a small organization we were not in a position to financially take on a full scale behavioral health integration project without partners. We had a lot of positive existing relationships in our community of likeminded organizations, and that was key in developing a delivery model that met the organizational mission of each partner. Once the group got together mutual consensus across the consortium was easy to achieve. The consortium all had clients or patients in the isolated townships where Upper Great Lakes Family Health Care Center Clinics were located. Deciding on a best practice, however, or an approach took a bit of discussion, as often consortium members understood the challenges but each of them had tried and failed on numerous previous occasions to operate freestanding behavioral or co-located behavioral health services in our community. So our partners… Upper Great Lakes Family Health Center took the lead agency role. Upper Peninsula Health Plan was the Medicaid managed care plan in the UP. [19:55] Great Lakes Recovery Centers of Upper Michigan was a region wide outpatient substance abuse and mental health treatment center, and Pathways Community Mental Health, a four county mental health organization in our area, all got together as consortium partners. Next slide please. So how did we proceed? Upper Great Lakes Family Health Center convened a meeting of the stakeholder group to gather data and build consensus. The group began to develop a proforma or business plan based on what we knew to be the reimbursement rates available to Upper Great Lakes Family Health Center as a federally qualified health center. We formulated an outline of a response to the ORHP funding opportunity. We created formal memorandums of understanding between the partners outlining the accountabilities of each organization. We conducted

surveys of Upper Great Lakes Family Health Center patients. Again, we conducted small focus groups, we surveyed providers, we surveyed Medicaid managed care members and community mental health staff to determine the lead. Next slide please. Per business model assumptions that we began with, we really had to focus on a number of issues. In particular, from an administrative perspective, I was concerned about what our break even analysis would be and what a cash flow analysis would be. [21:39] What was some of the questions that had to be answered, or what is the actual number of patients per day that we need to have to cover costs, or what is our minimum breakeven point based on the available reimbursement we have. How do we cash flow the project? In particular, it's a bit of a challenge. As an FQHC we are serviced on the front end but have to file a year end cost report to receive reconciliation payments from the state Medicaid office. That means that some of our payments lag up to 18 months. Could we recruit a behavioral health provider? We weren't sure that we were going to be able to find the appropriately credentialed folks in our rural community. One of our partners agreed to lease us a licensed clinical social worker as part of their contribution to the project. Another question we had to ask and answer was are we prepared to learn the coding, reimbursement requirements, complete the required prior authorizations and ongoing authorizations for behavioral health folks. And unfortunately, while we all talk about value based health care, the reality is, is that as primary care clinics we still live in a fee for service revenue world. Medicare, Medicaid, commercial insurance all have limits on who can see patients, how often they can see patients, and how often we need to certify or recertify those folks for service, and could we find the properly credentialed staff to provide billable services. We were a little concerned about the effort and training that was required for our revenue cycle team as well, in learning the coding and the authorization process. [23:29] Another assumption or a question that had to be answered was is it safe for us to assume that we will increase the medical throughput of our primary care clinics, and do we have sufficient demand to fill the open clinical appointments if we shift some of the psychosocial patients that are currently on our primary care providers' schedule over to behavioral health folks. Our original two sites had highly productive providers. We saw significant increases in demand for medical services based on our sliding fee program. Shifting those BHS patients over to the appropriate provider should increase medical visits. We also anticipated Michigan's expansion of Medicaid, and it also played a role in our business matrix. Are there other community resources that might be financially helpful in the development of a project like this or could provide in kind support to our project? We had to consider what other opportunities there might be for us to help fund this project. And is it possible for us to share risk with another organization by contracting for, in this case maybe, completed billable encounters rather than taking on the full wage and benefits of an unknown service center or provider? [24:54] Next slide please. So we ended up with an annual funding formula assumptions that included $150,000 on an annual basis for three years from an ORHP grant that we were very fortunate and grateful to receive. It provided us with the startup funding for our project. Our historically positive relationship with our Medicaid managed care plan brought in in kind care management support and services to our project in which they embedded a case manager in our clinics that assisted us in working with their client population. As an FQHC we received reconciliation payment, as I mentioned earlier, after filing a year end cost report. So on an accrual basis the revenue

looked quite manageable, but we still had to cash flow the service over the course of the year. And we also assumed that our… on an average our collections on medical visits plus the projected increase in volume, if managed to plan, would provide additional income for our project and help support the increased cash flow needs. [26:18] Next slide. Our current staffing model as it sits today for the two sites in Marquette County in year two of our project show us a total of 4.1 actual FTEs that are employed. One FTE is in kind by our health plan partner. We have approximate total costs of $217,000. Last year we had billable revenue of approximately $140,000 with increased medical service revenue of about $25,000 that we were able to apply to the project. And so we're really running into a situation where we're about $50,000 deficit on the project. Our board, as well as our consortium feel that the benefit to our patients and to the community is, at this point, something that we're able to shoulder, but we do have plans to help identify other funding resources to continue the project. Next slide please. A little bit on the clinical model that we use. So we modified the four quadrant model and used it as a framework to determine the level of care based on screening and assessment of all of our patients. Quadrant one indicates a low need for behavioral health and a low need for physical health support. [28:02] The primary care team, really this is a routine patient and somebody we work with on a as needed basis. If a patient is screened and qualifies in quadrant two, it indicates a high need for behavioral health services, a low need of physical health services, which really determines the interventions by the behavioral health folks on our staff. Quadrant three has low need for behavioral health but high needs in physical health with a lot of chronic conditions, which drives that patient into our care management interventions. Quadrant four is a high level of behavioral health needs and a high level of physical health needs, which really determines a wraparound service with all three specialties working closely with the patient. Providers from all three specialties: behavioral health, primary care, case management, have been trained in motivational interviewing and use motivational interviewing skills to assist with… patients with solution focus and self-directed care planning. Our case managers have been trained in the stages of change in how to use their motivational interviewing skills with patients who are in different stages of change. They've also been trained in dialectic behavioral therapy. They use these skills with patients at different stages of change, both over the phone and in person, to provide care and assist patients with improving compliance with care plans. [29:29] Behavioral health providers use… utilize stages of change and motivational interviewing as well as DBT skills and therapy to teach skills to patients through improved quality of life and reduce symptomology. The clinic became aware of how stigma of counseling was alive in our community real early on in our project. We had numerous patients decline seeing a counselor for services. So one of the things we did internally was to change the name or nomenclature of our project from a behavioral health practitioner to a health coach, and we also had patients called back into the clinical areas by a nurse, just like they would be for any other primary care visit, rather than having the behavioral health therapist come out to greet them in the waiting room. Next slide please. And one… there we go. Thank you. The clinical interventions that we put into place, we implemented a policy and procedure to complete evidence based screenings for all patients at annual visits, any new adolescent patients, and all sports physicals. Screenings help in identifying patient needs and quadrants of care. [30:48] Integration training for all of our staff, regardless… regarding fears, myths,

attitudes, beliefs, and biases. Mental health first aid training was the beginning step towards cultural change within our organization. Personalities of the organization staff, whether they are providers, receptionists, nurses, or [inaudible] affect the culture and willingness and ease of integration. We found that even with education and skills training, willingness and openness of individuals is directly linked to how much integration actually occurs. This includes working with providers and their willingness to integrate. Many staff believe that the additional screenings in this project have created additional work for them. They didn't necessarily on the front end see the benefits of the screenings, the motivational interviewing and understanding the complexities of behavioral health billing, and passively avoided changes within our project. The integrated clinical intervention training included motivational interviewing, as mentioned earlier, stages of change, implementing DBT skills, multidisciplinary team meetings or morning huddles, and clinical reviews, reviewing providers' patient schedules on a daily basis for behavioral health needs of our patients, and actually practicing the learned skills in the office on an ongoing basis. [32:26] Cultural changes with clinical interventions were based on age and education of providers and nurses. So our project management, we expanded our initial development consortium committee into a formal project management committee, which meets monthly. Participation by all of our stakeholders have been quite exceptional with one of the Upper Great Lakes Family Health Center board members chairing the committee. We had a physician champion who's been with us throughout the project. Our health plan has active participation by at least two members of the regional health plan. Our community mental health representative is an active participant as our clinic serves a number of mental health clients in our community at several group homes. Our quality team is also present, as well as senior leadership within the project management team. Next slide please. [33:32] So what were some of the outcomes? 76% of our patients have been screened for depression, 68% of our patients were screened for substance abuse, another 68% improvement in depressive symptoms. We've seen a 51% reduction in substance abuse symptoms in the patients we've surveyed. We've had 381 patient referred to case management; 955 of our patients are compliant with treatment plans. 58% of our patients surveyed reported improvement in wellbeing as a result of the integrated care. Next slide please. And some of the outcomes. Further, Upper Great Lakes Family Health Center surveyed our entire organization using a evidence based tool that measured the level of communication between behavioral health and primary care within our clinic, the actual physical proximity of the behavioral health services, the temporal proximity or time to see a patient from referral to execution, the availability of behavioral health expertise services, elimination of the behavioral health stigma in our clinic. [34:55] The scale is 0-20. At the onset of our project we scored 11.9. At the end of year one we had an overall rating of 14.2, and at the end of year two, at our last survey, we were at 15.5. Next slide please. Some of the challenges that we have run into, and I think all of us maybe knew these but really they've become more evident as we have been implementing the project, as a small rural clinic our EMR is shared with a large regional medical center, and a cost for standalone EMR record is quite prohibitive. Providers are dependent on the ability to link with regional hospitals for lab results that populate in discreet fields, inpatient records, referral activity, consultative reports. So right now we're not exactly sure the direction that we'll take with moving towards a standalone in a medical record. State and federal privacy laws also restrict, in our case,

the ability to really do good cross communication and provide solid continuum of care for patients that migrate from our clinic maybe to an emergency room for service. The sustainability model for BHS is not only a financial challenge but also an integration challenge. [36:38] Sustaining a behavioral health provider in our clinics is really dependent upon volume and executable visits. It doesn't leave a lot of time for our behavioral health staff to focus on integration with other staff members, physicians, nurses, or reception staff. And our behavioral health model care really hasn't kept up with the requirements for billing service codes, and it really, in a sense, forces us… based on our fee per service model it forces us into a traditional model of outpatient service or traditional psychotherapy rather than a fully integrated service. Recruitment and retention is a big challenge in rural communities. The current median compensation in Michigan in health centers for an MSW is approximately $25 an hour, as compared with hospital MSWs that are running about $32 an hour. A full time provider with benefits costs us about $63,000 to $67,000 plus additional costs for technology billing and additional support staff. New graduates that are coming out of graduate school are limited licensed course and can only see some of our Medicaid clients but are excluded from Medicare and third party payments. These are the students that… and folks that are, at the current time, being trained in integrated behavioral health services. [38:21] Many of the folks that are of my generation who are MSWs that came out of school were… and available to work are trained in the old traditional psychotherapy model. And really, when we advertised and interviewed for our positions, many of the existing MSWs that have been in practice for a long time were uncomfortable with this new model. So I think this is going to be a generational or a kind of service that's going to take a little bit of time for our education and training to catch up. Medicaid in Michigan limits the number of visits we can do with patients on the behavioral health side. We're limited to 20 visits on an annual basis. The case rates that were paid for by Medicaid and Medicare help with cash flow, but they're insufficient in really keeping a viable project in place. No show rates for us are… and you'll hear, I think a little bit later on, are really significant. We had a... have a 36% no show rate, and we've done a number of PDSAs, or Plan, Do, Check, Act, activities that are ongoing within our clinics to make sure that we're addressing the no show issues. We've done things as offering transportation, providing gas cards, bus tokens, reminder calls, scheduling appointments on the same day as the physician appointment, just to be able to make sure… just to reduce the number of no shows that we have. And we really yet… we're yet to really fully actualize the potential, I think, of our service as we're in the early stages of making this happen. [40:08] And I think next slide please. Culture change, I think we can't be understated. Existing primary care physicians are really trained to function independently. They really have no experience in team based care, and integrating a behavioralist into the clinic is really something that's new to them. Many of the physicians that we have in our practices have been… they're very seasoned and have been in practice for 15 or 20 years so they've they read about integration but really haven't experienced it in the residency programs. Community awareness of the full scope of services that are available are still necessary. Accessibility, longer travel distances, and higher rates of insurance. I think you skipped one of those.

SARAH STEVERMAN: Sorry, Don, we got you off track.

DON SIMILA: Yeah, you did. I wasn't sure if that was one of my slides or not so we can wrap up with that… maybe two slides back.

SARAH STEVERMAN: Two slides back. Yeah, thank you. [41:27]

DON SIMILA: Traditional clinic staff required training on privacy and confidentiality of behavioral health patients. They're in a clinical… medical clinic setting. The state and federal privacy laws are really very important to train your staff on because rules are very different for them. Integrated services within a clinic setting really reduces the potential for patient avoidance of behavioral health services, so it's a positive thing. Reframing and renaming our services as health coaching has been really beneficial in reducing stigma in our practices. And the question that really has to be answered on a regular basis and at our morning huddles is we challenge each other to define and viscerally understand what bi-directional or integrated care really means in our practice so that we're maximizing resources for our patient population. And that with that I've finished my slide deck. Thank you.

SARAH STEVERMAN: Thank you very much, Don. We have several questions, and if you have questions and you're on the line, you can type them into the question box on the dialogue box on the right hand side of your screen. And we're just going to take a couple of questions now and then we're going to move on to JOHN GALE: from University of Southern Maine and his presentation, and then we will have a bit more time at the end for questions. [43:08] So question for you, Don, on your presentation. What does leasing an LCSW mean? There is a participant who is in a rural integrated mobile clinic and they only have one LCSW. But what would leasing versus hiring a regional LCSW look like?

DON SIMILA: Well for us as a federally qualified health center it becomes somewhat synonymous with what's called an affiliation agreement. But our local and regional behavioral health organization had a number of staff; they had capacity to share a proportion of that MSW's time with our organization. So we were able to work out a part time lease agreement to bring that person into our clinic on a for cost basis. So we rented that individual for the actual cost of employment from Great Lakes Recovery Center.

SARAH STEVERMAN: Great. One more question. You mentioned the $50,000 deficit that the project currently has. Did you take into consideration any of the savings on the primary care side when you came up with that deficit, and if not, do you think that you saved financial resources on the primary care side with efficiency or less frequent primary care visits for patients, that sort of thing? [45:04]

DON SIMILA: Well our assumption was that patients with a number of semantic and psychosocial concerns often frequented our offices and killed our schedules of our primary care providers. They were consuming sometimes one hour blocks of a physician's schedule, and again, we're living in a fee for service world where those physicians, in order to cover overhead and maintain their own income, needed to see at least two patients an hour. Moving those patients into the appropriate specialty service created more room for our physicians to see actual patients with chronic disease states

such as diabetes or hypertension or asthma or annual physicals that were backing up within the system. So we did anticipate and have been able to kind of measure the increased volume of our providers as noted in several of my slides. [46:19] I don't know that we necessarily saved resources because we pushed more patients through the clinic and consumed more resources, and that was calculated into the additional cash flow that we thought we'd generate… we generated from the increasing number of patients, medical patients.

SARAH STEVERMAN: Great. Thank you John. We have several more questions and I will kind of triage those as we listen to JOHN GALE: speak. He's going to give kind of the bigger picture. And he is a research associate with the Maine Rural Health Research Center at the University of Southern Maine, and he focuses his research on behavioral health, primary care, emergency medical services, and the rural health care delivery system. He's a past president of the New England Rural Health Roundtable, a member of the Board of Trustees of the National Rural Health Association, a senior fellow of the Health Research and Educational Trust of the American Hospital Association, and is also a former board member of the National Association for Rural Mental Health. We're really pleased to have John with us. I'll send it over to you, John. Thank you.

JOHN GALE:: Thank you, Sarah, and thank you, Don. That was a great lead in and I trust and I'm confident that a lot of what I will talk about… talk with you about will reinforce many of the lessons learned from the Upper Great Lakes experience. [47:53] So if I can have the overview, we're going to talk a little bit about the opportunities, and I believe the opportunities for integrated care in rural communities. There are many, many opportunities, some guiding principles, some challenges. I really want to talk to you about what's different about rural in the state of integration, and then we'll discuss some dimensions and models and where to begin. So if I may have the next slide please. So up front, I want to be very clear, I think that integration can make significant contributions to improving access to behavioral health service and enhancing quality of care and reducing stigma for rural residents. When I talk about rural I would like to suggest that in terms of the actual clinical practice of delivery primary care services or behavioral health services in rural communities, there's not much difference between what a primary care provider or a behavioral health specialist will do in an urban or rural setting. What's different is the context. And think of rurality as disparity condition in some ways, that you have fewer resources, you have fewer providers, you have lesser volume to manage the practices. So you're operating in a constrained resource environment. Next slide please. [49:26] In working here with our group called the Maine Health Access Foundation, in Maine, which is one of our conversion foundations, we… in working on a project in integration, we came up with some guidelines, and we want… and I think it's helpful to review them because at the end of the day integrated care really has to be patient needs. It needs to be patient centered, has to target at least one of the following goals of either expanding access, increasing the burden of illness, or optimizing the care that's delivered. It should be in a setting preferred by patients, which relates to stigma and/or reductions in stigma. It should be evidence based. It should be driven by clinical and care issues and functions and not so much focused on integrating within only… within facilities and practices but also across practices and settings because you're operating in… an

integrated system is operating in a larger environment. [50:30] And it has to look at both medical and behavioral health settings. There's reasons to integrate in both directions. Next slide please. So continuing in… there's continuous interests in integration by… evidenced by the fact there were 550 to 560 some odd folks on this webinar today that we have models, and they're… one of the issues that always struck me is that there's a focus on the models of integration rather than the functions. Models are very important but there is no one perfect model for every situation. We're making progress on reimbursement, as Don mentioned, but we're not out of the woods yet, and even though there has been parity around behavioral health reimbursement, it's still a struggle. And then finally integration of behavioral services is… really makes an important contribution to reducing stigma by letting people be seen in a much more comfortable setting that is appropriate to their needs. Just as not every patient who sprains an ankle needs to go to an orthopedist, not every patient who is struggling with depression or anxiety or a behavioral health issue needs to go to a psychiatrist or needs to go to a specialty mental health setting. This is really about delivering services in the most appropriate setting. So let's talk about… a little bit about models. If we can move to the next slide please. [52:00] You've all… you've heard a great deal of information from Don and the Upper Great Lakes… upper peninsular, actually, sorry, but there are other rural models, and this is just a sampling. There are many across the board. There's a couple of programs that we've seen and studied, and the Sierra Family Medical Clinic has been doing this since 2002. It's a service based and a federally qualified health center. Another system that was started with federal rural health outreach grant funding in Montana is the two site FQHC system. We have a couple of different models in rural health clinics, one in Sonora, California, and another in the Swift River Family Medicine Clinic in Rumford, Maine, which is a provider based partnership with a community mental health center, and probably what is the gold standard of integrated models, the Cherokee health system in East Tennessee. And they've been doing this for a long, long time. And so we will return to these models as we go through the talking points. Next slide please. [53:11] In thinking about integration we really want to… don't get too hung up on integration versus collaboration. They're two sides of a coin. So we tend to use them interchangeably, and I think that's fine, but we're looking at models essentially that talk about how patient… where the providers are located. Are they co-located in the same facility or are they fully integrated, located in the same facility where the staff are employees of the practice. So if you're looking at collaboration without co-locations, which is… we consider horizontal, there is really a focus on integrating services across practices and providers. It requires a great deal of negotiation. It requires some sensitivity to the barriers which includes communication, sharing patient information, as Don talked about, lack of integrated IT systems, and available referral sites. Now if you have the resources to develop a fully integrated practice, the vertical integration, you're really focusing on how it… how the providers work within that system. The barriers are funding and reimbursement. This is not an inexpensive activity. Staffing and workforce, billing and coding, as Don mentioned, space is an issue in a lot of practices, culture and viability issues. Next slide please. [54:40] So I want you to think about it. I'll talk a little bit about the evidence because I think it's important to understand where and what the evidence tells us about developing integrated systems. The evidence, I think, is very, very encouraging and promising, particularly related to depression. Now the big study has been done by AHRQ.

They have… in their work they said that integrated care achieves positive outcomes, and they define that as improvements in symptom severity, treatment response, and/or remission response so that integrated care systems, they really find this to be a very positive and… improvements in the healthcare system. But what they did not find was improvements in outcomes as the level of provider integration or integrated care processes increased. So they found that it was the attention to behavioral health issues and depression and a greater awareness on behalf of providers that made a difference rather than whether they were in a fully integrated model or they were at a… the earlier stages of the horizontal integration. So it's important to say… to know that there's room to start where practices are comfortable and then evolve. [56:12] Clinicians and consumers, the clients both were very satisfied with integrated care. Looking at another collaborative initiative relating to homelessness funded by HUD, the Health and Human Services and the VA, neither the use of evidence based practices nor measures of trust or collaboration among network agencies were associated with client service use or outcomes during the first year of the program. And finally, work that I've done with a colleague of mine, David Lambert, we find that small rural providers may not have the resources to develop fully integrated systems of care but can begin at a lower level and evolve. So the evidence tells us there's no need... there's a huge need for integration. No single model is right. It's a work in progress. Begin when the practice is ready, assess the readiness for integration, and implement an appropriate model. With time and experience trust and collaboration builds, and you can move up the continuum as appropriate. So thinking about integration, we really need a framework that recognizes the functions and the importance of integrated services regardless of location of the providers on the continuum. [57:34] We can't… we don't need to push everyone to the highest level of integration right away. It has to make sense for the funders and payers and consumers and providers, and it has to facilitate sustainability through adequate reimbursement for all components of integrated care. Next slide. Let's talk a little bit about the barriers. Next slide please. So I'll talk a little bit about the issues of practices and providers, the barriers for practices, their different practice styles, cultures, and languages. They're not all the same and they don't often talk the same language. If you think about coding, which Don mentioned earlier, behavioral health providers use the DSM 5. Primary care folks use the CPT and ICD 9 coding languages. They're different, and it's important to understand that and use the appropriate model. Integration models, you should select where to begin based on context and resources and think about the services. And Don touched on this earlier. Their direct care services, evaluation of patients, psychotherapy, medication management, directly reimbursable by many third party payers, but the integrative services are not necessarily reimbursable. This is where we struggle. [59:06] So the need for the hallway consult, the need for warm handoffs, and the ability of the providers to meet and discuss and learn how to improve care isn't always paid for, and that can be a challenge. Licensure and reimbursement, state licensure and scope of practice regulations limit the pool of providers. I mean the licensures, the scope of licensures, doesn't make a difference urban and rural, but the way it plays out means you may have fewer providers… fewer types of providers to choose from. So for example, Medicare will only directly reimburse for a licensed clinical social worker or a doctor or level psychologist. Many Medicaid programs and third party payers will use a broader definition of licensed and master's prepared clinicians. You need to fit the type of provider that most addresses

the needs of your biggest payer mix. You may not be able to find the right provider that can do all that you need to, and it's something to be aware of. And there are administrative and access restrictions imposed by third party payers. Can you join the provider panel? Are there restrictions on settings? These are things you need to be aware of. And finally there are the economic challenges. It's, yes, these services are reimbursable, but developing an integrated practice is subject to the same volume of or the same issues as the primary care practice or stand-alone behavioral health practice. You're talking about low patient volume, high standing… high sunk [ph?] costs in terms of staffing costs and space and investment in the program. You have high no show rates of patients who don't always come in when they're supposed to, and you have low rates of insurance coverage. [61:03] Other challenges, recruitment and retention. If we can step back one, I'll move through this quickly. As I mentioned, limited scope supply of specialty behavioral health providers, retention issues. This is not an easy area of practice for a clinician that may be the only behavioral health clinician in your practice. They have the inability to specialize, they see whatever type of patient comes through the door. In an urban area you may have a clinician who specializes on women's issues or eating disorders, men's issues. That's not likely to be the case in a rural area. You have professional isolation. They don't have the chance to get together with colleagues as much as you would like. And you have boundary issues. I mean in a small community a behavioral specialty mental health provider is likely. The clinician's likely to see their patients on the street, in the local grocery store, at little league games, at community events. And this can be a challenge. And then recruitment and recruiting. When you think about this, you really have to understand where your providers are coming from. If you recruit a provider for your integrated practice from an existing community mental health center, you're not really improving the resource capacity; you're really just rearranging the deck chairs. So it's necessary to think about how you get providers from outside of the community to expand capacity. Moving a provider from place to place doesn't change things. [62:34] Payment, productivity, and administrative issues, although we now have parity so that third party payers can't really reimburse differently for behavioral health versus primary care services, what we are seeing under the ACA is a great growth in the types of plans that carry high out of pocket costs, so the patients are absorbing a greater portion of the costs. You see higher rates of insurance and underinsurance. I mentioned the no show rates and the administrative burden of enrolling your providers in multiple… often multiple panels for behavioral health. Next slide please. So we think about collaboration; I'm going to move quickly through some issues with collaboration and then get back to what we mean by this. The Heath, Wise, Romero, and Reynolds, through the Center for Integrated Heath Solutions, has this collaborative framework that talks about minimal collaboration where there's separate systems and facilities, minimal communication, separate practices, essentially sharing patients back and forth. Then you have collaboration at a distance. This may be where a lot of rural practices are, separate systems and facilities. They may work together with providers but it's not integrated in a way… they're not… it's not systematic sharing of information, certainly not enough to influence patient care. [64:03] Next slide please. Basic collaboration on site, and Don is talking about this, and this is where they were starting with hiring a clinician or leasing the clinician to come in. You can bring… we've also seen this, the example I mentioned from Rumford, Maine. They were sharing a staff, the local community mental health

center, which is probably 30 to 40 miles away from Rumford, just placed a staff person in the clinic. So while it's an improvement in access and local services, it improves regular communication, there are still are some barriers and challenges to sharing information and records. Number four is close collaboration with some system integration. You begin thinking about shared sites, shared systems, having some process for regular communications. You do tend to have some tensions between systems and roles, but you're beginning to get agreement on the screening tools to be used and some collaboration on treatment plans. Next slide. And the next two are moving up. You see greater collaboration on an integrated practice, and they're moving along the lines of these clinical functions of sharing space and site, coordinated treatment plans and models You still have some of the tension with role influence but there are active efforts to seek solutions to problems or develop work-arounds, and there's a more consistent team identity between the primary care and the behavioral health staff. [65:47] And finally, this is the Cherokee model. You have full collaboration in a transformed/merged integrated practice. This is very highly evolved with shared systems and sites, regular communications, expectations around shared treatment plans and models. They understand roles and culture. The balanced team… there are regular team meetings and balanced power. So next slide please. So thinking about all of this; these are not discreet levels. You seem some blurring of those boundaries and that's okay. But I think it's important to really think about what drives the level of collaboration. It's very complex. What are the available financial human resources administrative resources to develop integrated strategies? They're going to vary from community to community. Those resources are unique, and the balance of resources are unique to each setting. You have different… you have trust and rapport issues between primary care and behavioral health organizations. It can be good; it can be bad; it may need nurturing, but I think you need to understand and assess accurately where that level of trust and rapport may be. What are the provider and patient needs? The fact that patients need the services, if providers are comfortable screening for behavioral health issues, are there substance abuse, depression, anxiety, and don't refer to the service; it can undercut it. How willing are providers to put aside cultural and practice differences and begin to see how each other… each of the two areas can supplement one another and help, at the end of the day, improve care for patients? [67:34] Is there reimbursement? Are there grant funds to fund and sustain integration activities? Do the… does the organization have the administrative and billing capacity? As Don mentioned, behavioral health billing is very vexing to the… to most medical coders and billing staff. It's a different world. It's a different language and different systems, and I think it's important to really honestly assess how well your organization is prepared to begin to adopt these changes. You have the space. You can't put… you can't expect a clinician to function in a back room in a closet. Is there adequate space that provides the privacy that's necessary and allows the team to function together? What are the local market and competition issues? And how willing are the providers to share control and management of their patients? Next slide. And we're just going to talk a little bit about some of the functional aspects. So some of these… and I think in terms of where a practice may be that it's exploring integration. In the clinical side this is the… probably the easiest and the lowest hanging fruit in terms of functional aspects of integration if the providers are willing to do so. [68:56] Can they arrange for regular communication; can they talk to one another?. It doesn't have to be an everyday meeting,

although those… the morning huddles that Don talked about can be very effective if you're in the right site and you have the time. But some regular communication. Are there critical pathways or practice guidelines? Can the behavioral health team help the primary care team understand the issues and vice versa? Do you have an effective internal referral process and scheduling process? Are there screening tools that everyone agrees on and is comfortable using? Can you share medical information? And this is a challenge across sites. It can be done. I will say that in the behavioral health world we have tended to use sharing of information as a red herring to avoid collaboration, but I think that's starting to break down. And what's the need for consultation and education? Can some of the primary care folks manage some of those complex patients with support from behavioral health specialists? The less easily addressed, because they're more resource intensive, are issues of co-location, how do you share space, do you even have the space, can you create a fully integrated staff where you have one organizational structure and all are employees, single medical records, electronic health records, shared billing and scheduling systems, and shared risk. [70:28] These are things that take more time and resources and can be very complex. So it's worth thinking about that. Next slide please. So let's talk a little bit about models here and the models of integrated care. So these models are useful for understanding the issues. This is a work done by Collins, Hewson, Munger, and Wade, and we can provide you with some of the links to these resources. But this is very important to look at these models because they suggest settings, particularly small rural practices, where collaborative care being lower on the level of collaboration integration may be more feasible. So you have improved collaboration between separate providers. Thinking about how you do that, this is pretty low hanging fruit. Can you improve how patients move across… and clients move across those settings and the providers [inaudible] You have behavioral health care rendered by medical providers, you can have the primary care folks doing more screening, can do more work around medication management. I have co-located services, disease and chronic care management, reverse collaboration, which… co-location, which is very important because we know in many behavioral health settings and community mental health centers that their clients are much more less likely to get the primary care they need. [72:08] On average we've seen studies that say that behavioral health clients with very acute conditions that have serious and persistent mental illness die 25 years younger than other patients because they just don't get the care around chronic diseases: smoking cessation, obesity, diabetes, that other patients do. You're going to have a unified system of primary care and behavioral health system and hybrids. So it's all… we'll talk a little bit more about these if I can get to the next slide. And here's a quote that I like, and I know some of the physicians that I've worked with around this issue have resonated with them. George Box made this statement. He was a statistician. That essentially all models are wrong but some are useful. Now I don't want you thinking that I'm dismissing models because they are useful in providing a contextual and a theoretical framework that can help guide practical action. So you want to target your population. Can you… are you focusing on the general population, thank you, of primary care patients or specific populations, and what type of services. Are you doing brief intake, traditional behavioral health services, patient education in self-management, referrals, referral in acute and emergency care settings, crisis services and the like. [73:37] Next slide please. So here's… we have… we're running a little short on time so I'll move through some of

these quickly. This preparatory training, both types of providers need to think about types of patients to prefer, what to say to patients we're referring to improve the likelihood that they'll enroll in the system, how to integrate behavioral feedback in a team medical plan, co-managing patients, integrating services, and population health management. For behavioral health providers it's the other way, understanding and adapting to primary care mission and role. They it's a different work pace, it's much faster, you don't have the 20 visit system that some traditional behavioral health providers are used to. There's an interruption in workflow, which is a shock for some of them. So providing curbside and written consults, charting for medical records, and evaluating patient… population specific treatment for managing patients. Next slide. This… I won't spend a lot of time, but this will give you… if you want to go back and look at it some of the real distinctions between primary behavioral health care and specialty behavioral health care, it's a much faster, lower intensity service where you're likely to be seeing patients two or three times that than over the long haul. Next slide please. So here's… and again, some of the issues to keep in mind. We talked about the coding languages, the difference between the ICD-9 moving to ICD-10 in the fall of 2015 versus the DSM-V. [75:22] They diagnose differently. There's a difference. Behavioral health tends to diagnose with greater specificity after multiple encounters. Primary care you're really focusing on symptoms, so you're not… primary care, a physician isn't going to diagnose mixed depression, atypical depression with mixed features. They're going to diagnose depression. And that's a challenge in terms of thinking. Thinking about which services you need and are reimbursable, and not… and how to balance the challenge and the demand for the direct services with integrative care. Next slide. We've talked about some of these along the way. There are differences in the limitations on what types of licensed providers different plans will reimburse for. You need to be aware of these, spend time on it. You may have challenges enrolling, and provider panel's one of the ways that managed care organizations limit that cost by limiting the access to the panels. In two specific types of rural providers, federally qualified health centers and rural health clinics, there are limitations. They both allow for cost based reimbursement. One of the challenges that we're seeing is that there are limits on the ability of the sites if they employ a psychiatrist or they employ a social worker or psychologist to service the distance telehealth sites. [76:55] So where to being? Next slide. And I will wrap up with these two slides and open up for questions. Where do you want to begin? What are your goals for developing an integrative service? Is it… and all of these can be important. Are you expanding access to traditional behavioral health services, providing direct care versus consultative services for your primary care providers? Are you talking about improving primary care provider productivity by reducing the time that they spend with patients with depression and anxiety? Are you looking to improve the treatment of patients with chronic diseases because there's a whole scope of behavioral health activity around behavioral health and assessment, helping patients with diabetes or chronic illnesses comply with their medication routines with weight management. Are you improving coordination of care and reducing primary care utilization? You should… then need to think about the best way to achieve each goal. Start simply and evolve with experience. There's a tendency to think… we always tend to focus on these very integrative systems. This is not a… one isn't inherently better than the other. The goal is to start somewhere and move with experience and avoid competing for necessary resources. And last slide please. Finally,

understand, and I can't stress this enough, understand the clinical dynamics and how they're translated in behavioral health reimbursement policies. [78:32] You've got to take… do the best to maximize reimbursement within the rules. Learn to use behavioral health procedure and diagnostic codes. They're not easy; it requires a different thought process. Work with the clinicians to make sense of this. Understand the policies implemented by your third party payers. Do they require prior authorization, limitations on the number of visits, paperwork requirements? Don mentioned this earlier. This is a huge issue that can sink the… sink an integrated service. Recognize which types of providers are reimbursable. Hire the provider you can that makes… that can get reimbursed by the number of patients who are your most common payer source. If you have a heavy Medicaid population, very low Medicare population within your payer group, focus on what Medicare will… Medicaid will allow. Excuse me. You can do the best you can within your resources. And then understand the different treatment modalities. What is… how and what are the mental health conditions, evaluations, psychotherapy, med management, med evaluation, management services? Then there's the cognitive, emotional, and social issues affecting the management of physical health intervention. These are the health and behavioral health assessment intervention codes. How do you help a patient with diabetes deal with depression or with a… a patient with cancer or other chronic illnesses. [80:04] And finally, to the extent that there might be some reimbursement available through different payers, care management codes, and how you can take advantage of that. So these are the key things that I think that are worth looking at. And here are some resources. One resource that I will say up front that is incredibly helpful is the Center for… the website for the Center for Integrative Health Services. They have a phenomenal number of resources on the Center. Please take advantage of that.

SARAH STEVERMAN: Thank you, John, very much. And as John said, here are a few resources that are available to you. I've also sent some other resources throughout the presentation. Hopefully you've all been able to see those regarding some more specific information that, as John mentioned, CHIS has available. There is a lot there so please go and check it out. If you would consider your questions, and we have about 10 minutes, 9 minutes, to answer some questions. So for those of you who would like to ask a question, you can type it into the dialogue box on the right hand side of your page, and we also have contact information for Don and John if there's any follow up questions that you're looking for. You can always also ask questions to us at the Center at Integration at the National Council.org, and someone will get back to you. Our first question that has come up… there's questions… many questions about various types of providers. Do either of you have any experience with working with certified peer specialists in rural communities? What is the potential for the use of or the engagement of providers that are not necessarily licensed social workers or psychologists? [82:08] Either John or Don, if either of you have anything.

DON SIMILA: Well I'll just touch briefly on it. From my perspective as an administrator, a non-billable provider is a cost that has to be calculated into your overall budget. And if it's not going to generate revenue it's going to be hard to sustain the service unless you have excess capital to do it.

JOHN GALE:: And I completely agree, Don. You may want to check with… there are peer counselors and peer support services available through some community mental health centers, and they have funding for that. One of the things that we do see in rural community is the use of indigenous healers, lay personnel, and peer counselors to provide supportive services. They're certainly not going to diagnose and treat patients but they can provide a very supportive context, and for patients who are struggling with behavioral health issues. So we've seen them used in rural settings quite effectively. I think part of it is they're not likely to be employed in a primary care setting, but there may be opportunities through working collaboratively with specialty mental health services, community mental health centers, and it's worth exploring because it's one aspect of providing care management and helping to support individuals that have needs that… beyond the strict treatment of their illnesses. [83:53]

SARAH STEVERMAN: Great, thanks to both of you. We have a few questions also about crisis services and the relationship between the primary care specialty behavioral health and any crisis services or sort of community treatment teams. Do either of you have experience with engagement of crisis services and integrating those into the model?

DON SIMILA: Let me just mention that Heidi Snyder on… my behavioral health director is on the line, and Heidi does crisis intervention with a number of her folks. Heidi, do you want to pick that question up?

HEIDI SNYDER: Yes, we work with our… locally we work with our regional dial health program, and they provide us 24 hour support for our patients for text messaging, calling, live chat. So we have a regional dial health that we connect with. Also, we are crisis providers for our hospitals, so we have referred patients to our hospital because we have a regional psychiatric service there for inpatient adolescents and adults.

JOHN GALE: One of the other points to think about in terms of crisis support and referral for patients beyond the capacity of the integrated team is despite developing the service you really need to think externally as well. So it's helpful to think about, just as Heidi and Don were saying, developing linkages and relationships with the more specialty oriented providers so that you have the ability to refer patients. [85:48] So if you have someone who is in crisis or very, very acutely ill beyond what your service can do, how do you link not only to provide some support until such time as they can be enrolled in the other service, but… so you need consultative support, but moving them across settings and to develop those relationships. And one of the ways of sort of encouraging that is thinking about what the practice can offer to some of these other programs in terms of their patient's primary care needs. So certainly working across settings is critical in this regard.

SARAH STEVERMAN: Thank you. Thank you Heidi. I think we have about… we have time for, I think, just about one more question, and I thank you, for everyone who wrote in and asked their questions. We had a few participants who were interested in the potential of integrating primary care into behavioral health specialty care. Obviously your

model, Don, in Upper Great Lakes, is in the primary care setting, and I'm just wondering if you consider that, Don, and John, if you know of any rural providers who have integrated primary care into behavioral health specialty care. [87:14]

DON SIMILA: Well coincidentally we are just completing an agreement with a… one of our local community mental health organizations that operates a network of about 12 foster care group homes for severely mentally ill and developmentally disabled folks in our community And we have a provider who will be doing rounds in all of those group homes for primary care on that patent population. So yes, we have considered it and the reverse of integration for us is something that meets with our mission.

JOHN GALE: We've… I've also worked with groups here in Maine and the Maine Health Access Foundation and Tri County Health who, I mentioned earlier, was the group in Rumford. They have begun to place, through some of the primary care sites, clinicians in mental health settings. Now it's a bit of a challenge. You're talking about a very different service site, and it's as much of a challenge for them as the other way, which… because they don't typically have the same sort of space. You need a fully equipped exam room and the ability to handle blood and medical products and equipment. [88:39] So it's not inexpensive but it is doable, and certainly it's one way I think of solidifying the relationships so that there becomes a more integrated system for both sides. So it's possible but you start have… have to start thinking about what type of space they have, what can you… can they provide the clinical equipment. You need nursing staff; you need the primary care providers to be willing to do that. So it's doable and there are examples in rural settings and… that are working. It just requires a different level of discussion.

SARAH STEVERMAN: Great. Thank you. Thank you both. That is all the time we have today. I have 1:29. Once again, a recording and transcription of this webinar will be available on the Center for Integrated Health Solutions website. Once you exit the webinar you will also be asked to complete a short survey. Please be sure to offer your feedback on today's webinar and also any suggestions you have that would inform the development of future CIHS webinars. I would like to extend a thank you to our presenters, Don Simila and JOHN GALE:, for joining us on today's webinar. And thank you all for participating in our webinar. Please stay tuned for more CIHS webinars in the near future. Have a great afternoon.

END TRANSCRIPT