Workforce Development Part 2: Making the connection through integrated behavioral health workflows

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SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderators:

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Roara Michael, Senior Associate, CIHS
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Learning Objectives

After this webinar, participants will be able to:

• Recognize the role of behavioral health providers as leaders and key agents in working with other disciplines
• Examine methods for involving new staff in continuous quality improvement cycles and monitoring
• Identify commonly used protocols and procedures for effective and efficient clinic workflows while also avoiding provider burnout
• Map workflow processes to support key evidence-based practices such as motivational interviewing and cognitive behavioral therapies
Today’s Speakers

Virna Little, PsyD, LCSW–R, MBA, SAP
Associate Director of Strategic Planning,
Center for Innovation in Mental Health at
City University of New York

Jonathan Muther, PhD
Director of Behavioral Health and
Psychology, Salud Family Health Centers
Poll Question 1

1. I am a:
   a) primary care clinician
   b) behavioral health provider
   c) clinic administrator
   d) health system or health center director/executive
   e) other
Creative Workforce Retention

Virna Little, PsyD, LCSW-r, SAP, CCM
Workforce Retention

- One size does not fit all!!
- Different disciplines
- Different ages and career stages
- List positions and brainstorm individually
How Will You Know You’re Successful?

- Do you measure retention rates?
- General satisfaction surveys “yes I am satisfied“ vs. using a scale for different questions
- Be able to measure and review different categories
- Is this a CQI project?
Return on Investment

• Does a broad scale training for all staff (DBT) have the most ROI or would you be better to select a few and invest in “trainers”?

• Wellness activities – how will your measure impact on retention?
The Evaluation Process

• Similarities to “treatment planning” as a living document
• Training supervisors to a lot time and to complete evaluations
• SMART goals that last throughout evaluation period and including events from across evaluation period
• Taking the opportunity to talk about career “if you were going to spend your career here what would that look like?”
• The caring letter-its not just for patients anymore!

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Staff Development and Training

- People love to learn and grow
- Not everything costs – utilize free sources for EBP’s
- Develop in house experts and trainers (play therapy)
Create Clear Trajectories

- Committee membership to leader to manager as a stepped process
- What goes up does not come down!
- Repurpose, repurpose, repurpose
- Committees such as compliance, EBP, environment of care, emergency prep, research etc.
- Secondary gain of committees – interactions, experience to see staff engage (or not)
- Coordinator (limited)
Some Lessons Learned

• Training professional skills
• Create diverse positions - Psychiatry
• Calculate sustainable patient care % and utilize FTE for staff as opportunity for special positions like informatics
• Don’t do a survey unless you have an action plan first
• Tiger teams to solve biggest staff “problems”, engaging stakeholders as a “special” selection
Questions ?
Behavioral Health Providers on Behavioral Health Integration Workflow

Jonathan Muther, PhD
Vice President of Medical Services – Behavioral Health, Salud FamilyHealth Centers
Clinical Integration Advisor, Eugene Farley Jr. Health Policy Center, UC-Denver
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Definition

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. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, ineffective patterns of health care utilization.

Value of Integration:

Physical/Behavioral Integration is good health policy and good for health.

Behavioral Health Overview

Salud Family Health Centers

Integrated Model of Care
- ≠ Co-located, consultative model
- = Behavioral Health Provider; shared responsibility; team-based care

Quadruple Aim Oriented

Scientist – Practitioner
- Empirically-supported interventions; Generalist clinicians treating broad spectrum
- Measuring outcomes; Evaluating team-based model of care

Cultural Competence & Awareness of Health Disparities
- Bilingual BHP’s, awareness of barriers to treatment, reducing stigma
BH Access Gap

Demand for services

Supply of clinicians

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Significant disparities exist between the need for BH services and access to BH care

- In 2016, 47% of adults with a mental illness and 89% of adults with a substance use disorder did not receive treatment

- 56% of adults with a behavioral health disorder do not get behavioral health treatment

- “An estimated 13-20% of children in the United States (up to 1 out of 5 children) experience a mental disorder in a given year…”

APPENDIX FF Behavioral Health Penetration Rates

<table>
<thead>
<tr>
<th>AGE_GROUP</th>
<th>FY 13/14 Penetration Rate</th>
<th>FY 14/15 Penetration Rate</th>
<th>FY 15/16 Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult 21-64</td>
<td>17%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Child Under 21</td>
<td>8%</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>Elderly 65 and older</td>
<td>5%</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

https://www.colorado.gov/pacific/hcpf/accphase2

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# Patient Variables:

## Why Aren’t Coloradans Getting the Mental Health Services They Need?

<table>
<thead>
<tr>
<th>Reason</th>
<th>2013</th>
<th>2015</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured*</td>
<td>77.5%</td>
<td>65.2%</td>
<td>72.4%</td>
</tr>
<tr>
<td>Concerned about the cost</td>
<td>75.6%</td>
<td>57.3%</td>
<td>56.1%</td>
</tr>
<tr>
<td>Didn’t think health insurance would cover it**</td>
<td>55.3%</td>
<td>43.3%</td>
<td>43.1%</td>
</tr>
<tr>
<td>Difficulty getting an appointment</td>
<td>30.5%</td>
<td>34.0%</td>
<td>35.2%</td>
</tr>
<tr>
<td>Don’t feel comfortable talking about personal problems with a health professional</td>
<td>31.0%</td>
<td>40.2%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Concerned about someone finding out you have a problem</td>
<td>19.8%</td>
<td>27.6%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>

* Asked of uninsured during the past year  ** Asked of those insured during the past year

Quality

- Only 30% of behavioral health quality workers report skills in both basic research and quality-specific skills (McMillen & Raffol, 2016)

- Behavioral health quality professionals may be ill-prepared to help their agencies achieve the kinds of quality targets necessary to survive in a transition to a value-based payment environment (McMillen & Raffol, 2016)
BH quality measures

- Access - Penetration rate into total Salud population, percent of unique pt’s seen by total BH staff (e.g. what % of primary care patients have been seen by BHP?)

\[
\% = \frac{\text{Seen by BHP (any visit type)}}{\text{Total Salud population}}
\]

**Goal:** baseline, then work to 30%

- Access - % unique patients in BHPs schedule, by individual BHP

\[
\% = \frac{\text{Unique pt by BHP}}{\text{All pt’s seen by that BHP}}
\]

**Goal:** quarterly, want to see 30% new patients. This shows a positive level of flux in the BHP practice – they are not just seeing the same patients over and over again.

*Acknowledgement: Parinda Khatri, PhD & Jean Cobb, PhD. Cherokee Health Systems*
Allow for the Blending of Cultures

BioMedical/
Psychotherapy

Disease Response w/ Meds
Traditional Hierarchies
Telling the Pt what to do
Fern & Lamp Therapy Hour

BIOPSYCHOSOCIAL

Prevention & Wellness
Equal responsibility for HEALTH
Asking what they think is best
Rapid Assessment & Brief Episodes of Care

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The Range of Needs that BH can Address

I. Psychosocial barriers to care
II. Medical health problems requiring behavioral or psychological intervention
III. Mental Health and Substance Use Problems
IV. Multimorbid Mental and Physical Health Problems
V. Severe Mental Health and Substance Use Problems

Services We Provide

- Routine Screening
- Screening Follow up assessment and treatment
- Consultation
- Brief therapy & BH Intervention
- Psychological Assessment
- Shared medical appointments
BH Screening

- To identify and address Behavioral Health issues that would otherwise go unidentified and unaddressed

- It is an encounter *not* requested by PCP/care team and not *expected* by the patient

- Tests that look for diseases before you have symptoms. Screening tests can find diseases early, when they're easier to treat (NIH)
BH Screening

Screen for Life Stressors & Outcome Rating Scale

- Depressed mood
- Anhedonia
- Nervous/tense
- Worry
- Marijuana
- Illicit drugs & Rx misuse
- etoh abuse per episode
- etoh abuse per week
- Trauma (PC-PTSD)
- Domestic violence

Follow up Measures

- PHQ-9
- GAD-7
- DAST
- AUDIT
- PCL
BH Consultations

What consultation is:

• At the request of the PCP or other member of the care team
• Responding to a concern that has already been recognized
• Both assessment and intervention-based encounter
• Designed to respond to aspects of overall health, not just mental health

What consultation is not:

• Treating the PCP as the “client”
• An “adjunct” or “ancillary” service
• ….the only thing we do
• “Therapy” though can take place in succession, e.g., follow up at next med appointment
Consultation example:

History of Present Illness
- Depression Screening:
  PHQ-9
  Thoughts that you would be better off dead, or of hurting yourself in some way Not at all
  Total Score 14
  Interpretation Moderate Depression

BH Visit Details:
Pt is a [redacted] y.o. English-speaking woman referred for a BH consult d/t endorsing depressive sxhs in her medical appointment as a reason for why she is not effectively managing her diabetes. Pt states she has felt depressed for '2-3 months' an [redacted]. Pt endorses sleeping 1-2 hours a night, eating once per day, feeling unmotivated, anhedonia and hopelessness. She denies SI/IH, anxiety sxhs and reports no substance use. Pt states she had therapy once in the past with a male BHP and "didn't feel a connection." She endorses a trauma hx from childhood that does not cause current PTSD sxhs. Notes she is recently married to a "very supportive and kind" husband and he is concerned about her mood. Pt cites when she is at work as the only time she is "happy and able to not worry about my children." Pt works part-time.

Pt appears cooperative in session. Her mood is "down, I have no motivation" and her affect tearful. She exhibits good judgement and reality testing and fair insight into her condition.

Pt endorsing several depressive sxhs (see above) and appears to meet criteria for MDD though more thorough assessment should be conducted so dx deferred at this time. Depressive sxhs and diffuse boundaries with her daughters appear to be affecting her sleep and ability to care for her physical health. Pt is amenable to BH therapy and arranged to meet with this provider on 9/5 for a 1st session. She was also referred to the BH Sleep Group and asked to get out of bed when she notices herself worrying at night. Dr [redacted] (her medical provider) was informed of the plan and my impressions.

Session Start Time --- 8:45am.
Session End Time --- 9:10am.
Duration of Encounter --- 25 min.
Session Setting (Place of Service) FQHC.
Type of Contact: ---, Requested Consult.
Mode of Treatment ---, Face-to-Face.

Assessments
1. Illness, unspecified - R69 (Primary)

Labs
Lab: BH - Outcome Rating Scale (ORS)  BH - Clinical
Individually 2
Interpersonally 9
Socially 7.5
Overall 3
Total 13.7

Procedure Codes
H0031 MENTAL HEALTH ASSESS NON-PHYSICIAN

Follow Up
2 Weeks
Case example: Therapy follow up

BH Visit Details:
Pt is a y.o. English-speaking female who presented to the clinic in the morning after a BH consultation for a medical appointment as a result of her mood and degree of mania. It is noted that her mood has improved significantly since her last visit, with her mood and energy levels down from 260 to 140. Pt reported that she has been putting up better boundaries in her personal life and social interactions. She also endorsed some improvement in her sleep patterns.

Assessments
1. Major depressive disorder, recurrent episode, moderate - F33.1 (Primary)

Labs
Lab: BH - Outcome Rating Scale (ORS) BH - Clinical
- Individually: 7
- Interpersonally: 4.8
- Socially: 9
- Overall: 7
- Total: 27.9

Lab: BH - Session Rating Scale (SRS) BH - WNL
- Relationship: 10
- Goals and Topics: 10
- Approach or Method: 10
- Overall: 10

Procedure Codes
90837 Psychotherapy, 60 minutes

Follow Up
1 Week
Core Competencies for Behavioral Health Providers working in Primary Care

- Identify and assess behavioral health needs as part of a primary care team
- Engage and activate patients in their care
- Work as a primary care team member to create and implement care plans that address behavioral health factors
- Help observe and improve care team function and relationships
- Communicate effectively with other providers, staff, and patients
- Provide efficient and effective care delivery that meets the needs of the population of the primary care setting
- Provide culturally responsive, whole-person and family-oriented care
- Understand, value, and adapt to the diverse professional cultures of an integrated care team

Resources

- Essential: http://integrationacademy.ahrq.gov/
- Essential: https://www.samhsa.gov/integrated-health-solutions
- Value of Integration & Competencies: https://makehealthwhole.org/
- Case study: http://www.advancingcaretogether.org/
- Webinar: http://www.youtube.com/CUDFMPolicyChannel
- National organization: http://www.cfha.net/
- Outcome Measure: https://www.heartandsoulofchange.com/
- Policy: http://farleyhealthpolicycenter.org/
Questions ?
Poll Question 2

1. Following this webinar, I plan to:
   a) review my current workflow/procedures
   b) revise or make changes to existing workflow/procedures
   c) Share this information with others involved in workflow practices
Additional Resources

Workforce: Recruitment and Retention of Behavioral Health Providers

November 20, 2017

Presenters: Vima Little, PsyD, LCSW-R, SAP, Associate Director of Strategic Planning, Center for Innovation in Mental Health at City University of New York; Craig A. Kennedy, MPH, Executive Director; Association of Clinicians for the Underserved; Daniel Do, LICSW Clinical Director, Lynn Community Health Center

- Presentation
- Recording
- Transcript

Workforce Issues Related to Physical and Behavioral Healthcare Integration Specifically Substance Use Disorders and Primary Care: A Framework

Abstract: Builds on a number of recent papers and reports about the integration of substance abuse treatment into primary care and other health care settings.

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CIHS Tools and Resources

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- Core Competencies for Integrated Behavioral Health and Primary Care
- Primary and Behavioral Health Integration: Guiding Principles for Workforce Development
- Building cultural competence in healthcare
- Sample Job Descriptions
Thank you for joining us today.

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