

## TRANSCRIPT OF AUDIO FILE:

# EFFECTIVE REFERRALS TO SPECIALTY MENTAL HEALTH AND ADDICTION SERVICES RECORDING

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### **BEGIN TRANSCRIPT:**

(MUSIC) [00:01:00 – 00:16:33]

AARON: Good afternoon and welcome to the SAMHSA-HRSA (ph) Center for Health Solutions webcast titled three strategies for effective referrals (inaudible at 00:16:45) mental health and addiction services. My name is Aaron Williams (ph), Director of Training and Technical Assistance for Substance Abuse at the SAMHSA-HRSA Center for Integrated Health Solutions. I am joined today by my colleague Laura Galbreath, the Director of the SAMHSA-HRSA Center for Integrated Health Solutions. We will be your moderators for today's webinar. [00:17:05]

As many of you know, the SAMHSA-HRSA Center promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance abuse conditions (inaudible at 00:17:19) behavioral health in primary care provider settings. In addition to national webinars designed to help provide integrated care, the center is continually posting practical tools and resources to the (inaudible at 00:17:35) website providing direct phone consultation to providers and stakeholder groups. And directly working with SAMHSA's primary and behavioral health integration team and other (inaudible at 00:17:45) health centers. So before we get started, we have a few housekeeping items. To download the presentations, please click the dropdown menu labeled "Event Resources" on the bottom left of your screen. [00:18:01]

Slides are available on the (inaudible) website which is [www.integration.samhsa.gov](http://www.integration.samhsa.gov). During today's presentation, your slides will be automatically synchronized with the audio. So you will

not need to click any slides to follow along. You will listen to the audio through your computer speakers so please ensure that they are on and the volume is up. You may submit questions to the speakers at any time during the presentation by typing a question into the “Ask a Question” box on the lower left portion of your screen. Finally, if you need technical assistance, please click on the question mark button on the upper right corner of your player to see a list of frequently asked questions and contact info for technical support. Now I would like to introduce Nisha Patel (ph) from the Health Services Resources Administration Federal Office of Mental Health Policy to provide a big welcome to the webinar. Nisha. [00:19:03]

NISHA: Great. Thank you so much. And I am really pleased to be here to represent HRSA and thank you all for participating in this very important webinar on the importance of referrals and, you know, follow through for effective coordinated care around behavioral health. You know, the number of people on this webinar really tells us how timely and valuable this webinar is. A lot of the news articles, as I’m sure you all know, as of late are geared towards behavioral health and in particular, the epidemic that we’re facing as a nation around the increase in heroin and opioid abuse which has led to initiatives by both the secretary of the Department of Health and Human Services and the White House. And both have, you know, really emphasized the importance of referring patients to an appropriate treatment center to get help. You know, I really think that we’re learning a lot now about the health care system at large. And that we’re learning that the super utilizers who are often times, you know, patients who are uninsured and patients are Medicaid are accounting for a larger percentage of our health care spending. [00:20:05]

And there was a recent study that was published in *Health Affairs* that showcased that over 40% of the high cost patients with frequent hospital stays had multiple chronic conditions. Close to 40% of these super utilizers were related to a mental health issue. And this is just a huge concern and really emphasizes the need to integrate behavioral health into primary care. From the HRSA SAMHSA side, the topic fits very nicely into the collaboration between our two agencies on primary care and behavioral health integration that’s highlighted by the technical assistance resources available through the center for integrated health solutions. And as you all know, this resource really promotes the development of these resources to better address the needs. You know, and including a variety of resources on there. In particular, where I work, within the Office of Rural Health Federal Policy here at HRSA, we have a number of diverse programs that are aimed at meeting rural community need including behavioral health issues. [00:21:09]

Many of our grantees develop and implement successful programs targeted at implementing mental health into primary care such as providing mental health screenings and referrals and making sure that they’re providing this care through a coordinated approach. We also have a research center located here at the University of, located at the University of Washington that has done some research and even looked at DEA waivers to prescribe (inaudible at 00:21:33) percent of the primary care physicians which can, you know, comprises the largest group of physicians

in rural America have received waivers. And so most of these counties therefore had no physicians who had waivers to prescribe this medicine resulting in more than thirty million people who were living in counties without access to this treatment. Our office, the Federal Office of Rural Health Policy, we have received funds in 2015 to develop a rural opioid program which we are extremely excited about knowing that rural communities face tremendous challenges in providing care and that people in rural communities are twice as likely to overdose than their urban counterparts. [00:22:15]

And finally, we've even developed an evidence based mental health and substance abuse tool kit which is located on the Rural Assistance Center. And for those of you who are not familiar with the Rural Assistance Center, it's a one shot stop for rural as we call it and it's housed by the University of North Dakota. And the website is [www.raconline.org](http://www.raconline.org). And on that website, you will see a number of evidence based toolkits that we have had the privilege of developing with some of our researchers over the past few years, one of them around mental health and substance abuse. [00:22:59]

And these tool kits are organized by modules including information on how to be able to determine the community need, how to implement a mental health or substance abuse program, strategies that you may be able to adopt within your program and how to be able to evaluate the same measure mental health program. So all of this to say we're really excited to have you on this webinar and just to be able to hear from such a diverse range of experts. And with that, we will get the show started and I will turn it back over to our moderator.

AARON: Thank you Nisha. Before we introduce the presenters for today, I just wanted to provide you with a little information about the purpose and contacts for this particular webinar. So the purpose of today's webinar on effective referral relationships (inaudible at 00:23:49) identified as patient centered medical homes and providers who adopt (inaudible) referral to treatment protocols. After this webinar, participants will understand how effective referrals fit into patient centered medical homes and expert models and be able to identify four strategies for building partnerships with specialty mental health and addiction services for effective referrals also recognize practical tips and resources to establish appropriate referrals. [00:24:19]

LAURA: Hi, Laura Galbert here, your co-moderator. I really just want to take a moment to give you a little bit of a context for you to think about effective referrals. First, I do want to start by really underscoring that there's a high prevalence of psychiatric disorders and eating and substance abuse disorders in primary care and that a large number of those disorders can be successfully identified and treated in primary care with the right infrastructure and support. And so, you know, we're really excited in terms of early identification, the opportunity that that primary care environment offers. [00:24:59]

You know, but we really know that for a lot of, for some folks that have really higher needs, you're always going to need to have a link in to a specialty provider within the network. Just like any other provider or specialty provider organization. And that's what we really want to focus on is for those folks that really need more intensive services, how do you connect to those services? And I think it's really important just to kind of have a sense of if you're not very familiar with your partners in the specialty mental health and addiction providers, there's a couple things I think are important to recognize. You know, (inaudible at 00:25:33) specialty mental health and addiction providers, they're really addressing some complex issues. They're going to be... Treatment will really involve (inaudible) but involve looking at life stressors and clinical symptomology. And that treatment really looks, may include a team approach including a psychiatrist or psychiatric (inaudible at 00:25:57) case manager and other specialists in psychosocial rehabilitation, recovery support, and other social supports for employment and housing as needed. [00:26:09]

There's certainly a very different pace and work flow than a primary care environment and I think it's important to recognize that there's little reimbursement uniformity from state to state. Community mental health funders are regulated at the state level. So there's not a lot of consistency from state to state that you'll find. And so it's really important that you think about, you know, what applies... Take some lessons learned from what you hear today and think about what applies locally as you have those conversations with your specialty providers. And lastly just want to reinforce that your partners in specialty mental health and addiction providers are really there to kind of save lives and are a great partner for you, that there are folks at a community mental health center that are dying prematurely because of preventable health conditions and that on average, not seeing a primary care physician in five plus years. [00:27:05]

So that partnership can lead to lots of opportunities to really address the whole needs in your community. And then certainly we're seeing some real positive steps in how to develop solutions for sharing patient information, something we know that is a big issue. Also just to give you another context for specialties is to give you a sense of some of the services that you're going to find at a specialty substance abuse provider as an example, really pointing here towards the four quadrant model and that in a specialty, you know, you're going to... By building that partnership and referral network, you're really going to have access to things like specialty outpatient substance abuse treatment that may include (inaudible at 00:27:49) residential substance abuse treatment, crisis service, detox, sobering, lots of different specialty services that are going to be available to you to think about when you're having a conversation. [00:28:03]

Again, just to give you a context for your referral partnership. Also, just want to make sure, in terms of the context... I think this is an important webinar. Obviously, you're logged in because you recognize a need. But also think about how this helps you as you think, as you go forth with NCQA (ph) patients that are medical home recognition. We know that the new 2014 standards

have a much stronger focus on behavioral health. And if we look at requirement number five B (ph), referral tracking and follow up, it is a must pass element for NCQA. And by boiling effective referrals, you're going to have a great opportunity to really demonstrate how you're meeting that criteria. Again, here we take a deeper dive into that standard five and being able to really describe how you've been able to maintain and build upon agreements with behavioral health providers that enhance access, communication, and care coordination really thinking about all three. So I'll put it back over to Aaron to talk a little bit about how this relates to experts. [00:29:11]

AARON: Yeah. So those of you who are thinking about implementing an expert model, here's a bit of context about expert. Now as you know, many of the screening and different events and most of the work that you'll be doing will be around the screening and (inaudible at 00:29:25) intervention because only a small number of clients that actually need the referral to treatment portion of the expert model. However that referral to treatment component is critically important because clients who need our referral to treatment, you know, tend to be people who have more chronic health conditions, maybe have more other health needs and that really drives up the cost of care long term. So having a good referral partner and a very good protocol to get those folks the treatment they need as soon as they need will help some control costs and really create an environment that is more conducive to health, long term health outcomes. [00:30:09]

So that's really what we're here to talk about today is about how to establish those appropriate referrals and really, you know, move that forward as you begin thinking about building your behavioral health legacy (ph). With that being said, I want to introduce today's speakers, presenters for the rest of the webinar. First we'll have Les Burlin (ph) who is the CEO of Central Kansas Foundation which is substance abuse partner of (inaudible at 00:30:39) Regional Health Center in Kansas. We also have Linda Stone (ph) and Todd Cohen (ph) and they work with community health centers in Sarasota, Florida and the Florida Department of Health in Sarasota County. Also we have Stephanie Dodge (ph). She's a clinical psychologist with the west Hawaii Clinical Health Center. Without further ado, I'd like to turn it over to Les for our first presentation. [00:31:07]

LES: Thank you very much, Aaron and good afternoon everyone. It's good to spend some time with you. As Aaron mentioned the perspective that I'm going to bring today is of a behavioral health provider with a primary focus delivering substance abuse disorder services and our efforts over the last two years are to engage our medical partners and our other behavioral health partners in a rural setting in a rural state with integration. To give you just a little bit of background because obviously the state of integration differs greatly across the nation. We all have, in different states, very different internal and external constraints. So the framework for the state environment that we're currently working in to pursue integration is one that our political leadership has not embraced Medicaid expansion. So we don't have Medicaid expansion.

[00:32:03]

But we do... I'm thrilled. We just passed 100,000 people on the health exchange producing insurance. And we have health homes, person centers health homes. So a lot of ACA characteristics are moving forward. We are fortunate in Kansas to have S per (ph) treatment codes and screening codes and grief intervention in our Medicaid plan as well as all substance abuse levels of care in our Medicaid plan. While the state is pursuing behavioral health integration between substance abuse disorders and mental health, we still operate on a bifurcated system and that certainly will persist. I'm certain some of you have that same situation and that does present some significant challenges in terms of reimbursement and just work flow and getting through those things and I'll share a little bit of how we address some of those.

[00:33:05]

Everything that I'm going to show you today about the partnerships from our perspective we received no grant funds. It's all been built on a fee for service or global payment structure or a contract between non-profit organizations. That is exciting to me to be able to build that through the existing reimbursement framework and of course that's changing day by day. So we're certainly adapting our model to those constraints. And before, you know, you get to see some really nice models and workflow models. They're incredibly important to go through that process. It's time consuming but very valuable also to look at the patient perspective. But from our perspective as a behavioral health provider, when we began this work it was very important and maybe still today remains the most important thing is to earn the trust of the medical community. [00:34:03]

They don't know a lot about us. We have just been a referral source. And the way we've gone about that and what we've found important are, number one, that we can demonstrate that we're competent in our area of expertise, that obviously we do no harm to the patient, and the interventions that we engage in ultimately result in improved patient health. And we've been able to do that. And one thing we've really learned is as medical practitioners, recognize that we are (inaudible at 00:34:37) and do good work, they become great partners and beat us out for the services we provide. So the models that I'm looking at, especially on the screen now, we have a wide variety of partners which also includes acute care. And I'll do a little commercial for integrating with acute care as well as primary care because we really believe from the onset that to effectively manage patients across the full continuum of behavioral health and medical care, we needed to have a great relationship with emergency departments and hospitalists who see addiction every day there as well and to be able to connect a lot of these people who show up in an ED without a primary care physician to the resources that are available to them. [00:35:27]

So the Central Kansas Foundation offers a full continuum of substance abuse care in five locations across the state. We do adhere to medication assisted treatment. We have detoxification

services. We offer buprenorphine (ph) services. And we do have a medical director that is connected to our FQHC (ph) that also has thirteen family medicine residents. As you can also see, we have about 900 acute care beds in emergency departments. And then we have, right now, in a formal network across the state, eight providers who have signed onto the requirements that we established once we began this process that you'll see in a minute how important those characteristics were to develop a very healthy network and to try to address the breakdowns that occur between our systems. [00:36:21]

Obviously there was a lot of work done just understanding the different medical systems and training our staff to that and vice versa. I like to joke that I spent a year of bedtime reading reading (inaudible at 00:36:39) curriculars and I still don't know how the medical community gets paid. And I don't know that they understand how we get paid. But those conversations are ongoing. Our basic model is that a screening and brief intervention and referral to treatment. So we place (inaudible) specialists and behavioral health specialists into medical settings full time on site in the FQHC and also in the emergency department and medical surgical floors of our partners on the acute care side. [00:37:11]

These people participate in the screening and in the initial engagement of the patient and are readily available in our model to practitioners. We don't have fifty minute hours. As you'll see later in one of the models, if a physician needs help, he dings us through the electronic medical record and our staff shows up the office to conduct the consult and start the process. One of the most difficult things that we found as we were trying to attract additional SUB (ph) partners and behavioral health partners in community mental health centers is really the approach to care. [00:38:01]

The fourth item that we had to learn was the, really the old ways of doing business in behavioral health were unacceptable. And there were a couple of key things there. So as you see in our MOUs that we have within our network, we have some fairly exciting to us anyway, minimum requirements for our providers, our SUB providers. By virtue of working in all these different environments, obviously we need to be able to get in touch with people twenty four hours a day, seven days a week. And that's, in many cases, an on call. But that availability has to be there. And I think that the most important thing that has led to great outcomes in our engagement of the patients that we refer has been the requirement that same day appointments must be available in the behavioral health community. We expect that to be happening on the medical side as well but on the behavioral health side, sometimes that is a challenge. [00:39:05]

We also really rely heavily and demand that we have a warm hand on in as many cases as well possibly can. Obviously in a rural environment, it's not going to happen every time. But it is not uncommon for our substance abuse disorder partners to physically come to the clinic or come to the hospital, visit with the patient if they have been admitted and arrange that first appointment

and get off on a good start really based on motivational interviewing and engaging that patient. I can't over emphasize in our experience how important that warm hand off has been. And it took some time to build this and to get that commitment. But one of the reasons or the motivators for that is we began to look at the data and what providers could earn by attracting new patients, we were very pleased to see that about 57% of the people that we screened and that needed referral to treatment were block (ph) grant eligible. [00:40:17]

But the other 43%, 16% commercial insurance, 22% Medicaid, and 5% veteran's administration were new patients for these providers that produced additional income. And once that was apparent that they could attract that, it really helped them to manage their block grant funds and also to help their bottom line by engaging those patients. And in addition to that, we built in some transportation via contract with peer mentor organizations to be able to deliver people directly from the clinic or the hospital to their treatment provider in real time and that has helped a great deal. [00:41:01]

The patient assisted treatment protocols, meltrason (ph) and bupinorphene (ph), not every provider offers all of that. But we at least want these providers to be supportive and not exclude someone who's on any kind of medication that may help them with their diagnosis. Unfortunately we still have some providers who may not be accepting of medications. And so we view it very important that medication assisted treatment is readily available. We have access to our behavioral health clinical staff in Kansas. That's a clinical license and they can diagnose. And then obviously the communication piece, which I think you'll see from all presenters is critical. We do have and do use electronic health records all the way with all of our health partners. That is also a requirement. They're not all the same and we obviously have to do some work for some common forms and common forms of communication and that's ongoing as well and we are working a lot with our state exchange to try to improve those outcomes there. [00:42:17]

We certainly, not requirements but aspirations, knowledge about esper (ph) training and motivational interviewing. And then a big piece that I believe impacts the success of a referral network is the training and the understanding on the part of the behavioral health staff of the medical environment. It's a different environment as was mentioned earlier. It is a different pace and we've learned a great deal. And that's a whole other webinar. But being able to select staff who can thrive in that environment and in that pace and again, build that trust with physicians and practitioners that they can hand off patients to us and know that they're going to get a quality service. [00:43:07]

And we are strongly encouraging bidirectional integration. We are working, as I mentioned earlier, our medical director is also one of our partners in the FQHC. We also have a thirteen family medicine residents that do a rotation through our substance abuse disorder facility. And



having medicine on both ends of the integration is our preferred model. We're not there yet and haven't quite found the mechanism to be able to pay for all that but we're certainly hopeful that we can do that soon. These referral outcomes are aggregate outcomes from all those partners which include 800 bed hospitals. So they are heavily skewed towards residential services. But you can see that we have a significant referral network built for every modality of care.

[00:44:11]

And this... The patient engagement is very exciting to me. Obviously if we're referring to bedded programs, the engagement rate is fairly easy to reach. But overall that 74.6 engagement as defined as making the first appointment or entering the facility if it's a residential bed. And then out of our primary care settings we're still at 58% which is not where we want to be but still is not too bad. And I'm really certain that the warm hand off and that engagement of being able to meet the person that you're going to be seeing in real time before you actually go there has a huge influence on that outcome. (PAUSE) [00:44:57]

This is our primary care model that's based on esper. I'm not going to spend a long time going through all these boxes except to emphasize that I would expect each partnership to develop a very different one with some more characteristic. In our experience, the best outcomes have been produced by real time consultations, a model that has behavioral health professionals available in that setting at, to either respond to a positive screen which... We screen every patient annually. And the other benefit of having the SUB staff or behavioral staff on site in the clinic is we catch them on every appointment. We're... Our electronic health record notifies us of the upcoming appointment and we are able to essentially meet them at the door, ask them how they're doing, "What else can we do to assist?" So it really establishes a great therapeutic relationship and keeps the information flowing. [00:46:01]

The physicians and practitioners are also obviously call on us at any time if they have a difficult situation, if someone is very depressed and maybe suicidal, we will show up right away. And we have a high ability to address those situations and then move through that crisis situation. Again, what we noticed is as physicians and practitioners saw what we can do with people and, frankly, are relieved some of the pressure and time in their busy lives, they became just our biggest champions, that every level in the community and support us and help us in many, many different ways. The acute care model is somewhat different. And I know this is hard to read. I might need to blow up that slide or print it up. The acute care model is based out of the emergency room or trauma center where medical staff screen every patient and then our staff are there. [00:47:09]

We have routinely providers on call to come to the hospital to meet in real time with the patients. Again, that's been very, very successful. We have had huge success reducing recidivism to the emergency department, just incredible numbers. Just simply engaging people in treatment and

getting them to the facility or making sure that they've arranged that admission. And so we'll be publishing that before long. It's just been a very successful operation. All of our work in acute care is handled by a contract with the acute care facility. So essentially we are paid to go in there and do that. I also forgot to mention we do provide level, regular outpatient and intensive outpatient on site at our clinics and FQHC. So that's really a nice dynamic that our staff in the clinic can just walk over to the treatment counselor and hand those people off and get that treatment going at the same location. [00:48:17]

So the patients are very familiar with their medical location and our attendance rates are better at the treatment because of our co-location than they are overall with all our facilities. I'm about out of time. There's lots more to say but I'll stop there. Sorry I (inaudible at 00:48:41) that. Thanks again. I really appreciate it.

AARON: Alright. Thank you Les. Now we'd like to introduce our next speakers, Linda Stone and Todd Cohen. I'll turn it over to you Linda.

LINDA: Thank you. It's... We are also delighted to be here and I'm glad I had an opportunity to hear what Les had to say ahead of us because there are some similarities and there are some differences. [00:49:11]

The similarities are that we are in Florida and we are not expanding Medicaid either. (LAUGHTER) We have had the high levels, high rates of people who are being covered by the federal marketplace. However, we have lots of people who aren't because they fall through the cracks. And those are essentially the people that we're serving. We are a... We are also going through patient centered medical home recognition. We're smack dab in the middle of that. And so we have a lot of balls in the air at one time. We are a public entity, family (ph) qualified health center. That is that... I'm told I need to push my slides forward. [00:49:59]

That is we work with the Florida Department of Public Health in Sarasota and we have a private not for profit board of directors. And so we work under a co-applicant agreement between the two. Our service area is really bifurcated. We have a service area of north Sarasota which includes the city of Sarasota and some of our higher risk areas. And then we have one... We have two up there, a pediatric primary care site and then a full service primary care site. And then in the south part of the county, south Sarasota County and part of Charlotte (ph) County, we also have a full service site. We served last year over 30,000 patients. So we have a huge patient panel. And we provide onsite behavioral health services at two of our three sites and we're really working towards fully integrated model of care, primary care and behavioral health. We're engaged in the, one of the SAMHSA-HRSA learning collaborative to try to push that forward. [00:51:07]

I think we've made a lot of progress but clearly we have obviously a way to go. We also try to work under a brief therapy and medication management model. And that is interesting. We find the acuity of our patients is much more significant than we realized. We do serve a large number of homeless. And so they come to us with a multitude of obviously both substance abuse and behavioral health issues. And so we are trying to adjust how it is that we are delivering our care. We have a contract with one of the major behavioral health providers, (inaudible at 00:51:51) which just changed its name to Center stone. And they give us a licensed mental health counselor who really goes to two sites and then two psychiatric ARNPs (ph). [00:52:01]

And they work with us on the psychiatric assessments and the medication management and they work under the auspices of a psychiatrist. We also have a memorandum of understanding with (inaudible) Sarasota which is a behavioral health (inaudible) provider. And we get this person at no cost. That is really funded through state funds with the goal of... They are focusing in on primary care patients who tentatively need substance abuse. Many of them are either pregnant women or parenting women but suddenly other target audiences and he works to, he works with motivational interviewing to try to get them into treatment. And so that's a perk we have and it's extremely successful. We also have three psychosocial case managers. Todd's going to talk to you a little bit because he's the one who handles and oversees referrals. [00:53:07]

The target population that we see is low income uninsured adults and they must be primary care patients at our federal qualified health center. And the idea is that it has to be a mind body integration that if there is a contract that if you come here for primary care and want behavioral health you have to be engaged in both areas. So as I said earlier, we do a lot of case management. We do psychiatric assessment and medication management with the goal of our primary care providers taking over the medication management once the patients are stabilized. And then we have a brief therapy model that is really problem focused, goal focused. We try to keep it to successions (ph). We obviously have to extend it every once in a while or more than every once in a while. But we really try to make it, as I said, goal focused therapy. [00:54:11]

Todd's going to talk to you about our external referrals and essentially they're for our high acuity patients and also individuals with insurance coverage. We cover the uninsured and then we try to help patients who have another payer source to get in with a community agency. We do not, as yet, have Medicaid contracts but we are working on them. They are taking forever for us to get. We seem to be at the end and once we have those in place, as all of Medicaid is under managed care in Florida, and once... And they're carve out arrangement with the... They're called Medicaid managed assistance plans. And they carve out behavioral health and that is who we are engaging for contracts. The advantage of that is once we have... [00:55:09]

Under those contracts, we can ask for perspective payment wrap around, payments that will help to underwrite some of our underinsured. That's a whole other conversation. But I know financing

is a big issue. It's a big issue for us. And we have collaborations with a number of community agencies. And I'm going to let Todd take over from here.

TODD: The next slide is kind of a referral flow chart of how we kind of deal with referrals here at the health department here in (inaudible at 00:55:41) county office. You can kind of look at that. We're going to touch mainly on external referral process. But we also have an internal referral process and we've referred to our psychiatric nurse practitioner and our licensed mental health practitioner and substance abuse within our contracted people within our agency. [00:56:03]

You can kind of look at that. But we're going to touch more on the external referral process. And how we get the external referral is that they come from our primary care providers here in Sarasota. We screen each patient with a very quick depression screen. We use the PHQ2 (ph) model. When they test positive for that, a three or above on the score, the primary care provider then refers that patient through a referral process to the social services case managers which is myself and two other individuals. We usually... What we try to do is do a warm hand off with the patients as well. We're not always available to do that and it's not always. It's not always available to be able to do that. So usually what we sometimes have to do is we get paper referrals from the providers or through our EHR, our electronic health records and then we contact the patients through the, through telephone. [00:57:05]

So what we do is when we get the referral, we try to obtain a written release of information from the patient, either verbal... First we try to get verbal. That is what kind of gives us permission to contact the outside agencies. And the reason we get verbal is a lot of our contact is through telephone with the patients. And then once we refer that patient, we follow up with written consent as well with them. And there's a universal release of information that we use that all the agencies that we've met with... And how we've done this external referral process is we've met with all our local agencies that provide mental health services for all the Medicaid, Medicaid managed care providers, Medicare, and all private insurance agencies except private insurance. So that's what we did is we met with all those agencies and went through a universal release of information that they all agreed upon. [00:58:01]

And then the next step we do, once we get that, is we sent... All the agencies in our office have agreed upon is a universal referral. So we send that universal referral to the selected agency of the agent's choice. So we meet with the patient or we talk to them on the phone and give them options. Mainly we try to set them up with agencies that are close by where they're located. A lot of the patient population has trouble with transportation, so on and so forth which I'm sure every (inaudible at 00:58:27) that we deal with has issues with that. So we try to get it close to where they're located. And then what we do is we send a universal referral to that agency and we include both the current medication of the patient, current labs, and also the name of the treating

primary care physician. And what we've agreed upon with the other agencies is this gives them permission then to process that referral and contact that patient to set up services through their agency. [00:58:57]

So once we do send the referral to the external agency to set up behavioral health services, we add that patient's referral form to our EHR. And we have a follow up list in our EHR that we can set up that gives, you know, two to four weeks of when we need to give basically, kind of a little e-mail that says, "You have a follow up to that." So what we do is we add that to the follow up based on acuity. If it's... If they're... When we see the patient, when we do a warm hand off and they're, you know, suicidal, they're, whatever may be the case. It depends on what that is and what the acuity is and how we measure that. We document the status of that referral in our EHR progress notes that the primary care physicians have access to. We basically document within the primary care physician progress notes. So they know what's going on. And we also close the loop in the referral tracking form to let the doc, the primary care physician know that we've referred the patient to this agency, what agency we referred them to, when we referred them, and then the patient knows and the doctor knows where we referred them to and when. [01:00:09]

We facilitate, the case manager and myself, my two other coworkers facilitate the communication between that outside agency and the patient's primary care provider. So what... If there's any... When there's follow up from the outside agency in regards to medication, you know, contact, progress notes, any kind of concerns with the patient, we facilitate that communication between that outside agency and the primary care provider. Per our agreement with all the agencies that we've met, you get updates on the patient's progress on a quarterly basis or more often as indicated if the patient needs. And it's sent to us and then it's sent to the patient's primary care provider for review and coordination of care. [01:00:55]

So basically what we do, we get that... We get the progress notes from the outside agency or medication or anything that they're receiving from that agency and we attach that to our records so the doctors here can actually see specifically what's being done with that outside agency, what kind of medication they're on so they don't, you know, obviously prescribe medications that they're already on, you know, so on and so forth. So the external referral form that we use is attached to here. It's basically straightforward demographics, a little brief history of maybe what has been diagnosed in the past with anything, if they've ever seen a provider in the past that diagnosed them because we have a lot of patients that have received services in the past. They go four or five years. They don't get any services. They don't get any treatment. Then they come to us and they need our services. So we go on and give them kind of a brief, the outside agency a little brief update on what's going on with us here and then also obviously, you know, what kind of insurance they have and then our contact information and our three locations and where they get referrals from. [01:02:01]

And then the next slide is the universal release of information that we use to send to the outside agency. So it's a work in progress. We're always tweaking what we need and we're always trying to figure out what best serves us and what best serves the patients and what best serves each outside agency. We try and accommodate each outside agency the best we can. Like I said, we met with all of them face to face and went over all this and reviewed this with all of them and tried to get the best process we could to benefit the patient because we reason we wanted to do this is to make sure the... A lot of times when patients come in... Before we were just giving them information, giving them a number because not every agency had a referral process. It was more... Some of them just said, "Here's the number. Call them." And we wanted to kind of circumnavigate that and have the, make sure that the patient's following up by referring the patient directly so the agency gets that information and can contact the patient directly.

[01:03:03]

And it kind of takes it a little bit out of the patient's hands as far as follow up and putting it in the agency's hands to follow up with the patient and making sure they're receiving services because a lot of times, these people, you know, depressed, very depressed, depression and anxiety and they have a hard time following up with our appointments, let alone going to outside agencies. So we found that this is the best method to go forward with helping our patients.

LINDA: So one of the things that, just in terms of lessons learned... I know our time is almost over. I just want to reinforce that everything is written in a common electronic health record so that our onsite behavioral health providers write in the record and the information from external referrals sources is also in the record. We are working on changing the culture. We... The referrals are... They come. I think the providers understand that it is a value and that it's not just... It's viewed as the same as asking for a cardiac consult or a nephrology consult. This is as important and I think that's taken us a little bit of time. [01:04:17]

The next step is really making them comfortable with managing medications once they're stabilized. I talked about two way coordination and documentation. We use... Again, you heard motivational interviewing. We use motivational interviewing to help determine if the patient is ready for services. I know our substance abuse interventionist does it, Todd does it, all of our case managers are engaged in that. If the patient's not ready, they're not going to... Even if you go through all the steps, they're not going to follow through. And we try to clarify what services the patient thinks are beneficial and again, that's part of the motivational interviewing process. So thank you. [01:05:03]

AARON: Okay. Thank you Linda and Todd. Now we'll have our, turn over to our next speaker, Stephanie Dodge. Feel free to type in any other questions you all might have. Some of them we can answer now. But there will be some time at the end where we can answer some of those questions as well. But now I'll turn it over to Stephanie Dodge. Thank you.

STEPHANIE: Thank you. I'm very pleased to be here. My focus is going to be a little bit different. Although there are many similarities between West Hawaii Community Health Center and the places that the others providers have worked in regards to adult treatment. But I'm going to focus a lot on trying to do early intervention and trying to prevent those problems in the adults by intervening early on with the kids. [01:05:59]

So West Hawaii Community Health Center is a federal qualified rural health center. We serve a primary (inaudible at 01:06:05) the vast majority are on Medicaid. We have a very wide variety of ethnicities because we're in Hawaii. And we have limited community resources. So particularly psychiatric care, there are... There's only one adult psychiatrist who will take Medicaid in our community. We don't have a psychiatrist at our health center and there's no child psychiatry anywhere closer than Hilo (ph) which is 200 miles away. So just to show where we are, we're on the big island which is the southernmost island and we're on the west side. We have five different clinics that are spread over a distance of about 90 miles and we service the entire west side of the island which is, I don't know how many square miles, but 200 miles in length. Our original clinic, the main Koahkini (ph) clinic... We usually have about six or seven primary care physicians on the floor at any time and two behavioral health that are specifically there to take any warm hand off from the primary care. They're not seeing any patients during that time. [01:07:11]

We also have a part time (inaudible) specialist and most recently, we hired a social worker who is mostly there to help us with our referrals to inpatient substance abuse because there is no inpatient substance abuse on our island. They will have to be going either to Oahu or Maui and we were finding that the behavioral health providers were spending up to four hours trying to get somebody into inpatient. So we hired somebody specifically to deal with that. We have four other satellites clinics, one up in Wai Kaloa (ph). That's the northern most one. It has one primary care physician. We only have integrated behavioral health part time there. Our (inaudible at 01:07:53) clinic just opened and that's two primary care physicians, one behavioral health, and two dentists. [01:08:01]

We have then in our southern location, we have an adult clinic and a kaki (ph) clinic. Kaki means child in Hawaiian. And that's the clinic that I'm going to talk the most about. We have two pediatricians there, one behavioral health provider which is me, and a couple of dentists that work specifically with kids. Our external collaborator is the Department of Health Child and Adolescent Mental Health Division. So when we're collaborating with providers in the community that are non-governmental organizations or for profit, it's a lot easier for us to do our coordination. But working with a large government agency that's very set in their ways we found to be more challenging than some of our other external referral sources. So child and adolescent mental health division, we call it CAMD, serves the very high end kids of our community, most

of whom on Medicaid. And they have places called family guidance centers throughout the islands. There's one in west Hawaii. [01:09:03]

And they generally at family guidance centers have a psychiatrist, a child psychologist, a mental health supervisor, and then care coordinators. The actual services provided to the child and family is done through contracts. So these are all kind of supervisory people. And we can get all kinds of services if we can get a kid into the family guidance center including intensive in home services, multi-systemic therapy, and even therapeutic foster home. Now prior to our starting to work together CAMD was created out of a consent decree. So they really were created to address a specific problem. And because of the way that they were developed, they tended to get older teens. The average age at intake was 14 to 16. They tend to have severe mental health or behavioral problems. They're often involved in CPS, Child Protective Services. They're often court involved, substance abuse problems. [01:10:01]

And there's a very strict or there was a very strict criteria in order to be able to get into CAMD. First of all, you had to be on Medicaid insurance. So if you had good insurance, it's very difficult to qualify. Don't worry about what the case is. It's a measure that they use to exclude people and you need a score of 80 and above and the only thing that's important on that is in order to get a case a score of 80 or above you pretty much have to be a teenager who has substance abuse problems, who's run away from home. So it's very, very difficult for a five year old to get a case score of 80. And then there's a carve out for autism and CAMD used to serve kids with autism but the Department of Education took that away about eight or nine years ago. So they do not serve kids with autism. I'm actually going to skip this slide for just a minute and come back to it. This is the slide of what we went through, our process in order to make this coordination a better thing. But first I want to show kind of what it turns out looking like. [01:11:01]

Again, I did provide a hand out. Hopefully there's some way for you to download it so that you can see this larger. But we have integrated behavioral health in our federally qualified rural health center. So the first thing that would happen if a family came in, let's say for a well-child visit, they would be screened in the waiting room. We have screeners for children two and above. We just do the developmental screening two and below. So they would be screened and if it turns out to be a positive screen, then the behavioral health person who is right there on staff will be called and told about it. The behavioral health staff will work with the doc and they'll meet right in the exam room with the family and the patient to find out what's going on. Usually, we'll set up... Unless there's an obvious referral right there... For example, if they have great insurance and it's not at the level that we would want to send it to CAMD, we may want to refer it to an outside community behavioral health provider. But if it's not obvious for that, then the behavioral health person will meet the family, possibly do an intake right there or prevention right there or set up an appointment to do a more thorough evaluation. [01:12:07]



We'll try to treat inside our clinic if the problem level is low with a brief intervention or refer to community. But if the situation is such that, you know, we're thinking that Department of Health is really what we need, the CAMD services really are appropriate, then we'll start working with the family to get them through their intake process. And we will get them referred over there. We'll help pave the way so if it's the five year old who can't get a case score, they can get in and then they'll do their evaluation, decide whether or not they should remain in CAMD services. We will coordinate throughout while they're in CAMD. We sign releases of information or have the parents sign releases of information both ways so that we don't let go of this patient. We're still their primary care physician and we're still going to see them periodically. We're still going to check in with them. [01:13:03]

We also have monthly meetings with the care coordinators to talk about our families that we both see and see if there's any ways that we can coordinate better. Some examples would be that maybe the family has not come in for a well-child visit for a long time. I've noticed that. And I talk to them about having their service provider encourage the family to come in. And that works in the other direction too. Sometimes families have disappeared from their services and we can catch them in the next time they bring in the kid for the cold and find out what the barrier is to the family continuing services with CAMD. When the child improves enough to be stepped down from CAMD services, they will come back to us. And so we have that continuation of care instead of CAMD ending services and the family sometimes then not having anything and get lost. We also will be able to monitor the child as they grow and to see if they need additional services later if something in the environment changes or their symptoms become worse again. [01:14:05]

It's also a bidirectional referral process. So if CAMD has a family that doesn't have a primary care physician, then they will, you know, encourage them to come in and see us. And it's a lot easier in our direction because we don't have any restrictions. We take anybody. So they just refer them over to us and then they'll become some of our shared clients. I got a question here. Are you services for kids under five for evaluation of behavioral disorders or possible ASD? Yes. Actually, I do evaluate for those. So we would do that within our health center. And then sometimes if they have an ASD then I'm going to be referring them to another avenue of resources, not to CAMD because CAMD has an exclusion for that. So I want to go back to kind of what did we do in this process of trying to get a large government organization and a federally qualified rural health center to coordinate better. [01:14:59]

And some things that happened... First of all, it came from CAMD wanting to. They saw who they were treating. They were spending a lot of money on these high end kids and they really, really wanted to start getting some younger referrals and kind of intervene earlier. And they realized that their exclusion criteria was a barrier to this. So they were open to relaxing those criteria. They were also very worried though that if they relaxed the criteria that this flood of kids

would come in because we do live in a rural area with limited resources. And so there was some fear on their side. On our side, I had pretty much stopped sending kids to family guidance center because I didn't think they were bad enough to get and if they were bad enough to get in somebody else would usually refer them, usually the schools. So I had made no referrals to CAMD in the six months prior to this project getting started because my perceptions was, "Well, they just try to turn away kids." [01:16:03]

So there was some funding. CAMD and, believe it or not, Kaiser (ph) actually put some money into this. And then they hired the Hawaii Primary Care Association to kind of be the facilitators for these meetings. That was a really, really good move on their part because the federally qualified health center behavioral staff and the family guidance center staff, they all have so much going on already in their busy days that really to have them try to do this as an add on, I think it would have failed. So having somebody who's actually hired to facilitate this process made a huge difference. And Kristy Grey (ph) was our facilitator and she's just amazing. We put together a steering (ph) committee that include CAMD, the Hawaii Primary Care Association, family guidance staff, and the federally qualified rural health centers. [01:16:59]

And the reason that CAMD and family guidance center are separate there is CAMD actually sent their top people. We had the director of (inaudible at 01:17:07) committee. This really had high up support on the government side. And then they hired some consultants to help us within training and learning what the other states were doing and some things that we could possibly do. So we had the, brought in some experts, consultants. The first thing under activities they did is they decided some potential sites. And I kind of wandered into this by accident. My boss came to me and said, "CAMD's looking for sites. Would you like to do it?" And I said, "Sure." And we ended up being one of the two sites. Identifying, provide training or needs for the sites... So trying to figure out what everybody needed in order to work better together, utilizing the consultants as part of that, facilitating communication between partners and agencies... This was the hugest lesson learned. They actually... Because we're all on different islands, they actually paid for us to fly to get together once a quarter for all of the (inaudible) committee people to meet. And that is how those barriers got broken down, how we started to say, "Okay, they say they're willing to take kids earlier. I'm going to send them ones that I really think are heading to be their clients in the future." [01:18:11]

And they in turn started to trust that I was meaning well and that I wasn't going to try and send everybody to them. I was only going to send the patients that were really going to benefit from their services to them. We implemented routine screening at primary care. So that was part of what came out of this. More recently, we... We started by screening everybody just to kind of learn what was going on and what our population was and who we really wanted to send to CAMD. But more recently we've identified a sub-population to really focus in on and that is children with externalizing behaviors, ADHD, behavioral problems, oppositional defiance

between the ages of four and eight. And those are the kids that we want to really focus on coordinating better with. So we did that not too long ago. [01:18:59]

We're working on shared health info and data. With a large government organization this is really challenging. But they (inaudible at 01:19:09) support of the director of CAMD and they started to bring into our steering committee the actual IT people. So they're working on that. It's a work in process. And then also figuring out how reimbursement is going to work for this. Some of the outputs... I'm not going to go down that but our outcomes in the short term is that we've really increased our PCPs knowledge of what CAMD can do and also as we... One of the things that we got out of this was we were allowed to have our PCPs start calling the child's psychiatrist for what they call curb side consults. And we don't do a whole lot of those. But it has made our PCPs feel much more confident in what they're doing when they can check in with that specialist. Again, remember there's two sites. There's us and there's one on Oahu. [01:20:05]

The family guidance center, that psychiatrist of Oahu kind of refused to do this. He was worried about the liability and that was one of our major barriers. Our one in west Hawaii was much more open to it and so eventually our west Hawaii psychiatrist became the curb side consult for the entire center. And that's how they got around that barrier. We've increased the collaboration between the two sites. Like I said, we have our monthly meeting to do coordinate just on our shared clients. We also have the quarterly meetings of the steering committee and then (inaudible at 01:20:37) telecommunication we do the steering committee meetings on the in between months when we are not actually meeting face to face. We've decreased the time and the eligibility requirements. CAMD really came down... When I initially started this I had to fill out a 13 page packet of paper work in order to refer a family over to CAMD and, like I said, the requirements were really strict. Now it's a one page referral plus the release of information so it's three total and they're letting me let in kids who are four or five years old who have significant behavioral problems that are likely to end up being their patients in the future. [01:21:19]

And so we've increased the referrals from me to them. We've increased the referrals from them to us. We've definitely increased the coordination and I think the biggest thing in the building. I now feel that I can just pick up the phone and call DeAnne (ph) if I've got a case that I'm not sure whether or not should be sent to them and we can just kind of talk about it especially if I've already gotten a release of information or I can do a hypothetical. In the medium term, we're increasing the number of shared patients. I think we have about 25 now. We're increasing access to CAMD for our entire community. We're improving patient symptom scores. So we are seeing that both the treatment that we do with behavioral health in our clients, we're getting kids better without even having to refer to CAMD and we've also been going on long enough that we've had a couple of kids who were improved enough in CAMD that they were able to be stepped down back to us. [01:22:17]

And we're trying to standardize procedures. We're struggling still with that. CAMD staff initially just wanted us to get their typical reports that they use to turn in for the (inaudible) consent decree. Those are not very useful on the ground if you're trying to figure out what the provider in the home is doing versus what you're, you know, what you're talking to the family about when they come in for their medical appointments. So the monthly meetings were much more practical than having those old forms go back and forth because they didn't provide much information. And we're still working on the combined integrated health. And if I have just a few minutes left, I do want to talk about some of the other integrated care things that we have going on on the adult side. [01:23:07]

I would have put slides in if I realized there was going to be so much focus on that. Some other ways that we've coordinated with some of our other external resources is one of our main substance abuse treatments is called (inaudible at 01:23:21) substance abuse counsel. And we used to just try and send clients over there for an assessment if they needed to go a higher level of treatment. And they wouldn't follow up. And some of the problem is the transportation. So one of the most recent things we've done is worked with (inaudible) so that they have a van that goes and picks people up. They always did. And they made our clinic, our main clinic one of their stop off points. Also once or twice a month they are willing to send someone over to do an assessment at our clinic if we schedule that. So somebody who is used to coming to our clinic, yes, they'll have to come back to our clinic but at least they're not having to go to somewhere new that might be a little frightening. [01:24:05]

We also, as I said, hired a case manager to specifically help us get patients into inpatient on another island because that process is still prohibitive. That would definitely be an area we should work more on is to work with those centers off-island about trying to get a fast track for our patients in because sometimes the wait list for those is months which, you know, with substance abuse you kind of have to strike while the iron is hot. More recently, because we don't have inpatient detox anywhere on the island but certainly not on our island, we worked within our center with our primary care physicians to come up with an outpatient detox program where the physicians felt supported by the behavioral health staff and that we were not going to be putting them at risk. We also chose to use primarily segretol (ph) for that instead of filigriam (ph) and that kind of cut down on the people coming to us just for meds to feel good. [01:25:03]

And then one of the problems we found when we started that program... It worked great for people who actually had a partner or had someone who could watch them overnight in between the days that they were coming into see us to get their medications each day and to be evaluated each day. So we worked with a nearby sober living house and they are now dedicating two beds that we can use where they will at least have somebody living with them and being able to check on them overnight as they're doing their sober detox for the five days that we do that. And then

also... Right at the beginning you mentioned that you had very little ability or nationally they have very little ability to do subaxone (ph). We don't do that in our clinic but we are lucky enough to have two community providers who can do that. So we have very close relationships with them to be able to refer some of our opiate abusing clients to them. [01:26:01]

So I know I tend to talk fast so I guess I'm done. Maybe we can open it up for questions early. Thank you again. (PAUSE)

AARON: Hi. Thank you for that Stephanie. So thank you for that. So we decided to try to do a little, do something a little unique with this particular webinar. So now we have all of our presenters available for what we call sort of a group discussion. So probably for about the next ten minutes or so we have a couple of questions that Laura and I would like to ask that are open to the group for a discussion. But first we have actually one question for our HRSA partner and that's Lisa. Lisa, in many rural parts of the country, on site partnerships might be difficult due to the availability of providers. Are there any programs or resources at HRSA that are available to support such activity as telehealth? [01:26:59]

LISA: Yes. Thank you. That's a great question. And, you know, we do have a number of resources here at HRSA and specifically within the office of rural health policy. What's really great about the programs that we have here within the office are that they're very diverse and they're really focused in on what the need is in the community. We have a program called our rural health network development program which is a three year program we have where funding is up to 300,000 a year for three years. And it's really focused in on infrastructure development and capacity building for rural organizations. And so bringing in network together to be able to strengthen the infrastructure and connect the dots sort of administratively, clinically, financially, and administratively. And so we've got a number of branches who have used those funds to be able to build up their capacity and get that together so that they're ready to start providing some telehealth. [01:27:57]

We also have program, a rural healthcare outreach services program which is directly focused in on providing direct healthcare services. So through that three year program, we've got a number of programs that are actually specifically focused in on sort of telepsychiatry, telebehavioral health sort of services and are doing great things through that. And we have some success stories that we would be able to share there. What's also great about our office is that we actually have an office of advancement of telehealth and so this office focuses specifically on telehealth activities. And there are some funding resources available there. But there's also a telehealth resource center that we fund through the office that has been established to provide assistance, education, and information to organizations who are really looking to provide telehealth services. And so they're sort of a technical help assistance vehicle that's out there. We've got fourteen telehealth resource centers. So there's regional spread out and we fund them and so it's great

because we're able to work with entities as they're looking to implement their programs and sort of provide technical assistance on some of the areas that maybe be of challenge to them.

[01:29:09]

So those are just some, a few of the resources that we've got within HRSA that may be of interest to people.

AARON: Okay great. Thank you, Lisa. Now we have a question that actually came in through our question box (inaudible at 01:29:25) as well. This goes to the other presenters. What are some of the suggestions of items that should be included in your MOU, memorandum of understanding in your agreement with your referral partner? So if you guys could briefly just speak to (inaudible) items you put into your referral agreements or you think should be in the referrals agreements (inaudible at 01:29:49) with these kinds of (inaudible)?

LES: Let's start with Linda and Todd. [01:29:57]

LINDA: We have... We actually don't have memoranda of understanding. We have a behavioral health stakeholder's consortium that works together and it's more or less through the consortium that we begin to develop these agreements. And more gentlemen's agreements... Sarasota's really a wonderful place for collaboration. That is one of the things they've been doing for a very long time. So they... This actually started with the homeless. We're working with a huge homeless population here. And the idea was how do the agencies working with the homeless collaborate? And from there we began to look at it on agencies that have behavioral health. How are they going to collaborate and then how are they going to collaborate with ones for homeless? We do have MOUs but they don't happen to be for this. We have MOUs for our public hospital here, for services. We work with a place called Senior Friendship where we, they have our sovereign immunity and we... They help us provide specialty services. With this particular piece we don't have any MOUs right now. [01:31:15]

We do have an MOU for... Let me back track and say. We do have a memorandum of understanding with HRSA for our substance abuse interventionist (ph). And it's really outlined... The idea is the purpose of the collaboration or the memorandum of understanding... There's sort of a template. What is you're trying to do? What are the mutual obligations of each of the partners? And questions about termination... So we can certainly send you a template on that if that's helpful.

AARON: Okay great. What about Les? What about you?

LES: We have some formal MOUs. And the content includes HIPPA and CFR42 (ph) requirements, credentialing requirements, and, as I mentioned on the slide, some performance

expectations as far as same day service available and the willingness to come on site to do some of that clinical work. So those are all included in our MOUs. [01:32:29]

AARON: Okay and Stephanie?

STEPHANIE: So yes. I agree with Linda. Most of our are more gentlemen agreements. Really having that close coordination and that steering committee meetings... We've solved things without having to do much formally. The one time that we were talking about having a formal MOU is when that psychiatrist in Honolulu was very worried about legal concerns of doing the curbside consult. And we had been putting something together and trying to work that out. And then, as I said, he pulled out and the other psychiatrist stepped in. [01:33:07]

There's a lot of research nationally showing that there's almost never been that, a legal lawsuit or a problem about that. And also, we are not experiencing, number one, many curbside consults. We're doing maybe two a quarter. And our pediatricians are very clear that they write in their note that they made the decision to use that medication after a consult with a specialist and they don't even list the specialist's name. So we didn't really end up having an MOU for that in the long run. (PAUSE)

AARON: Okay great. That's helpful. We have another question here. Many of you talked a little bit about finances. I just wanted you to touch a little more on the issue of financing. So, you know, thinking about your sort of referral model and referral services, how are those providers and services being financed? Are you still using block (ph) grant funds or (inaudible at 01:34:05) funds or fee for service? How are you sustaining your models currently? How is that working? I guess we can start with Les. [01:34:19]

LES: Sure. We do, as I mentioned, most of our work by contract or within the fee for service existing system with codes. A combination of esper code billing and also on site services generates enough revenue to support the staff. That was our premise when we first began. As I said, we really don't have any grant money so it is within that fee for service realm and then we also contract on the acute care side directly with the acute care facility for the services so that labor costs are covered there. [01:35:03]

And then the next thing we're really doing is working with managed care organizations around that are managing Medicaid to look at global payments and I think, ultimately, this will be wrapped up into this global payment system. I should say we did run into some issues with the encounter rate and same day billing and some other things as we were rolling out our screening and intervention services at the FQHC. So... But we were able to resolve those.

AARON: Okay great. Thank you. Let's see. How about Linda and Todd?

LINDA: well, one of the things that the Florida Association of Community Health Centers, which is our trade organization, our primary care organization, was able to pass through our legislature was billing three services a day. [01:35:59]

And so we are planning to take advantage of that. Once we get our Medicaid contracts in place and we have subcontracts for our behavioral health services, we will be able to (inaudible at 01:36:19) the appropriate codes passed, pay our contractor, and hopefully realize the difference because you get a perspective payment system which is a flat rate and there will be a difference between what we pay out to the people we contract with and what we receive. And then obviously because of who we are and what we do we would rotate that money back into services for the uninsured. The other piece that we just received is through the Department of Children and Families. We're receiving a small stipend or contract that's going to go through our behavioral health provider that's going to be targeted for those patients they serve who are in primary care and behavioral health. That's the target audience for that group. [01:37:09]

And the other way in which we do it is it comes out of our FQHC grant. We are trying to have less of that and more of a way to at least break even on the situation.

AARON: Okay great. Stephanie, what about you all in Hawaii?

STEPHANIE: So the... CAMD is a state organization. So they're state funded. At our FQHC we are primarily fee for service. So all of our behavioral health fees we can bill for that. And we are more than self-supporting in our behavioral health department. So that's how we pay for our case manager who is the only person who cannot bill fee for service. Almost all of our patients are insured. Hawaii has a really good Medicaid system and did even before Obamacare. But we also have one position at the main clinic. It's an insurance specialist. So if someone does come in and they are uninsured, that person works with them to get the Medicaid or whatever appropriate insurance. [01:38:17]

We do have a small grant to cover uninsured but that's only for that interim until we can get them insured. And then the only grant money as far as I know on this project was the grant for Hawaii Primary Care Association to facilitate the development of this project which I think was money very well spent.

AARON: Okay great. Thank you all. Those were sort of the major questions that we had (inaudible at 01:38:45) discussing time. Now before we go into our open it up to questions from our audience, I just wanted to show you guys a few resources that are actually available on our (inaudible) website that are related to this particular webinar. [01:39:05]



There are a few things there in our (inaudible at 01:39:07) section of the website under clinical practice, esper (inaudible) sample contract business agreements and also some sample referral forms. So that is a good place to go if you're looking for those kinds of forms related to partnership development. Also within your, you know, the (inaudible at 01:39:33) resource center, you have a number of different work flows and documents that were cited today on the call. And also once you get in those memoranda of agreement that were cited here on the call, you can definitely make those available on the CIHS (ph) website. So now what we want to do is open it up to questions. So if you had questions, you can submit them at any time by typing them into the "Ask a Question" box. I know a number of you have submitted questions already. We have answered some of them. But if you have other questions related to the content that's been presented to any of our speakers, you can put those in the question box mail. We'll try to... We'll go through a couple of them before we end the call. [01:40:21]

So you've got some time if you've got some other questions you want to ask. Put them in the question box and you can do that now. (PAUSE)

LAURA: Hi. Laura here. We have somebody who dialed in and asked about the advantages and disadvantages of kind of bidirectional integration (inaudible at 01:40:49) substance abuse specialist and primary care versus having a primary care provider embedded in substance abuse treatment. And really I think they're very different in terms of you really could think about both, thinking about the needs of the specialty population and the substance abuse treatment, making sure that while they're there getting their recovery support services that their primary care is being addressed. [01:41:11]

And then certainly substance abuse. We know there's such a large component of folks in primary care that have substance abuse, be it alcohol, certainly those with opioid addictions. Any of our presenters have any thoughts they want to share on that?

LES: This is Les. We are certainly trying to get the other half of our integration to include primary care providers in our facilities. We believe that that has just great possibilities. There are some barriers but we are actively working to do that so that hopefully our people can have great access to primary care. [01:41:57]

(PAUSE)

LINDA: I think... This is Linda. I think, in some ways, there are different populations. We did work with one of our behavioral health providers and had, and stationed a primary care provider there. And it worked very, very well. But they were... They seemed to be a different population and higher acuity population who were coming in for their outpatient treatment and then received the services that day when they were in. Our (inaudible at 01:42:29) is a little bit different.

Obviously we try to attend to anybody who has a problem that needs immediate attention. But it's much more of... They see their primary care provider. They receive a referral and then we work with them, you know, the next day or the day after. So it seems a little bit different and I think there are just... A lot of the patients that we see... They won't go into treatment unless we provide it. [01:43:03]

I mean, it's not like they're going to go to an outpatient mental health facility. They're here and they come in and... (PAUSE) It just... It's hard to quantify but it's a different type of population that we see.

LAURA: Great. Thank you.

STEPHANIE: And this is Stephanie. I don't... We don't have any primary care embedded in our substance abuse. But one program that we do is we have a homeless shelter called the Friendly Place. And we do send both a behavioral health provider and a primary care physician over there for two hours once a week so that if that population doesn't, you know, isn't comfortable except at the family shelter, sorry, Friendly Place, then at least they can get introduced to primary care and behavioral health there. And then hopefully eventually because the Friendly Place is not too far from our main clinic, eventually once they're more comfortable, they'll be able to come over and get their primary care needs met at our clinic. So we've done it with that population but not embedded in our substance abuse treatment places. [01:44:09]

LAURA: Thank you so much. We want to go ahead and begin wrapping it up. This is Laura. I just want to say thank you to our presenters and to all of our participants. We hope that you were able to get some good ideas on how to build your referrals, relationship to specialist (inaudible at 01:44:29) mental health and addictions, to support good care coordination, access to services, and certainly to help you meet your criteria around NCQA patients and medical homes, esper. And thank you again to our presenters. I'll turn it over to Aaron.

AARON: Thanks. That's all the time we have. Just as a reminder, there is a recording and transcript of this webinar that will be available to you on the CIH website. Once you exit the webinar, you'll be asked to complete a short survey. Please be sure to offer your feedback on today's webinar. Your input is important to us and the development of future CIH (inaudible) webinars. I'd like to extend my thanks to our wonderful presenters today and thank you all to the audience for joining us on this webinar. That is all. We will talk to you next time. [01:45:33]

**END TRANSCRIPT**