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>> AURORA: Good afternoon everyone, welcome to the SAMHSA Center for the Integrated Health Solutions task titled Workforce Development Part II. Making the connection through integrated behavioral. I am your moderator for today's webinar. As you may know, the promotion of developmental Center for integrated health including mental health and substance abuse services to better address the needs of individuals. Mental health and substance abuse conditions. Specialty and behavioral health or primary care provider studies. In addition to the national webinar designed to help providers in a great care, the center is continually posting practical tools and resources to the website providing direct consultation to providers and groups. Directly working with sensor primary education and grantees. They are a safety net provider and training education program. But before we get started, a couple of housekeeping items. Please click on the drop-down label event resources on the bottom of your screen. The slides are also available on the website located on the tab about us, \webinar. Today's presentation the slides will be synchronized with the audio so you will not need to flip through any slides to follow along. Listen to audio so your computer speakers, please ensure that they are on so the volume is up. You may submit questions to the speakers at any time during the presentation. By typing in the question it can be asked a question box in the lower left portion of your slide. Finally, if you need technical assistance please click on the? Button in the upper right-hand corner to see a list of frequently asked questions it and contact info for tech support included. The use of opinions and content expressed in the presentation do not necessarily reflect the views, opinions or policies of the Center for mental health services, the substance abuse and mental health services administration, the health resources and services administration, or the U.S. Department of Health and Human Services. Now I would like to kick it off to Andrew Phillips to discuss today's learning objective, Andrew.

>> ANDREW: Thanks Aurora, as the new director for the Center of Health Solutions I would like to welcome you to our webinar today, this is the second in the series that we've been doing on the training of behavioral health providers in our workforce. Today our presenters will be speaking on the kind of workflows and practices that are required for behavioral health providers to do their best. We will talk about some considerations for clinical training, we will talk about how to actually integrate best practices into your workflows and to make procedures flow nicely. These are the areas where we find people are requesting assistance the most. These are the areas where even if we've got everything else in place, even if we have a great financially sustainable model in place, even if we have a good flow of patient referrals and everything else we need to really make an integrated system work nicely, if we don't have the right kind of training and workflows and place it all tends to fall apart. The topic is just so essential and we are happy to have everybody in line with us. I will go through some of the learning objectives and keep in mind during the presentation today that here at the center, we also offer additional training support on any number of these topics and at the end we provide information on how to get that. Some of the key objectives are one, first recognize the role of the behavioral health providers play. Not truly as clinicians but leaders in their areas and agents, networking and bringing a disciplined integrated care environment. We also look at how do we involve staff in continuous quality improvement cycles. As we are doing the work, make sure we continuously do it well. Even better than we've done in the past. We will be looking at how do we use protocols, procedures to really make our clinic workflow more efficient but also maintain our staff making sure that they are not becoming so exhausted and burnt out and turning out their work. They want to head for the door. Finally, we talk about workflow processes and those are really there to support the best practices that we are doing with our clients. We have two really good top-notch speakers today, joining us from part one we have Doctor Virna Little. She is the associate director of strategic planning at the Center for Innovation and Mental Health at the University of New York. Virna is a part of a tremendous initiative that is happening in New York right now on training and retaining the best providers within behavioral health. We are so excited to have her here. Also, Doctor Jonathan Muther he is the Director of Behavioral Health and Psychology at Salud Family Health Centers. This is one of the largest organizations in this area and he

is also a professor and just a known individual in the field of primary care integration. So happy to have them both here. We have one question that we will go to before we get started. For everyone in the audience, if you will examine the question on the screen here and just let us know what is your role here, are you a primary care clinician, behavioral health provider primarily, that can include behavioral health provider functioning in a primary care environment. Are you more of an administrator, or are you in the leadership chain. As a director or the director within your system or something else. Let us know. Just a couple more seconds on the poll. The last couple responses here, then we will shift off and see the results. Closing up. It looks like we have a really interesting mix in the crowd here today. We've got a good number of behavioral health providers, a pretty even spread of administrators and directors or leadership chains. We also have a lot of folks in the other category and you have a small chat box on I believe it is the right hand side there of your screen. I am curious, let us know who are you, what is your role if you're in the other category as the speaker present that helps form the discussion. With that, we will turn over to Doctor Little. Take it away.
>> VIRNA: Good afternoon. Thank you so much, it is a pleasure to be here and to spend the next chunk of time with all of you talking about workforce retention. I think it is something for those of you center directors and administrators I think this is something that people struggle with every day and always looking for a creative way to try to keep people engaged in your system. I think one of the things I would like to really emphasize is that one size does not fit all. What I really mean by that is for many of us particularly in integrated settings, you have pretty complex systems so you might have primary care centers, you might have some satellite sites where you care for people in schools or homeless centers. You might have some community-based services and when you think about retention, I encourage you to think about those separately and what works in one group might not work in some of the others. The same with disciplines which really help in terms of retaining psychiatry providers might be very different for your community health workers. Speaking of that individuals of different ages or different career stages, if you are attracting new graduates, what are you going to do differently for them or if you are attracting people out of residency programs, what are you going to do differently for them. Thinking about each position, so what I used to like to do is literally listing every position that I had and then really think about individually

some of the things that might be important to people in that job category. Around morale and retention. That was often really helpful because when you thought about it globally, you might not think about some of the things that as if you were brainstorming around with your managers or around individual job descriptions. I think one of the key points is how do you know that you are making a difference? I always like to ask how do you know you are successful. How are you measuring retention rates now? Generally a lot of organizations aren't doing something formal or the HR department doesn't put something out formal. Maybe think how you might be able to track that. I know when I was with an organization, we tracked it sort of separately, independently and then try to really get information about why people were leaving. Then thinking about being able to measure across different categories. Again, that one size doesn't fit all because you might see trends in one area. Maybe you're keeping primary care providers or you are keeping behavioral health providers but you're not keeping some of the people who may be our field-based as an example. Think about it as a quality improvement project, I think sometimes we tend to think of CQI only and our clinical areas. But the reality is, quality improvement should span all of our services. Thinking about whether or not something around retention could be a CQI project not only will that make your regulatory folks happy, but it would also involve different staff maybe in the CQI project. I would definitely encourage you to do that. Really encourage you to think about status, satisfaction surveys. Thinking about whether or not you are asking questions that are going to be actionable. Really trying to home in on that. Thinking about return on investment. A lot of times many of us talked about doing broad skill training, I know I've had a lot of conversations with my colleagues about doing broad skill trainings. Bringing someone in and I had a conversation the other day with a colleague and we were talking about she had a proposal for tens of thousands of dollars to train people in the organization in a particular model. We were really thinking about that in terms of retention and whether or not that would really have an impact. One of the things that I have I think learned over time, is that it's often better to select a few people that you really talked to about a trajectory in your organization or people that you are really trying to foster into leadership roles. Invest in them as trainers or in content experts or maybe specialized or specially trained supervisors. So that they are able to take on a leadership role, they are able to do something outside of their normal role. Often

what that does is retain that group of people in the organization and keep them engaged. Really thinking about rethinking some of your training efforts and trying to focus it in conjunction with your retention efforts. Thinking about wellness activities and whether or not they have an impact on your retention in trying to measure that. I know a lot of people are doing wellness activities in their organizations. Really thinking about which ones make a difference on your retention rates and how are you going to try to track that. I think one of the things that also comes up when we talk about retention is the evaluation process. I think one of the things we are learning and I know that this holds true for some of the experiences that I've had is one, it's really important to teach supervisors and managers how to do a evaluation and in the roles that they can play in retaining people in the organization. I know that I really come to make sure that I exercise the supervisors and do with my own stuff that you need to sit down and schedule a time to do the evaluation and it really is an important opportunity to be able to spend spend time with that employee.Thinking about that process and how to optimize it. I know one of the things that has really gotten some talk recently, I really learned what is helpful is to think of the evaluation process is really like treatment planning. Thinking about it as a living document. In other words maybe it is a shared document that gets populated throughout the year. So that if something or somebody has something that they are working on, it can get put in tractor. If somebody did something you really wanted to note, and evaluation, then it might go there and might be a document that you both populate throughout the year. As opposed to one that gets populated before you sit down with somebody to do an evaluation. If you think about how we get information now, or how we track things. We like to get things quickly, would like to keep track of things and I think that that mindset can get carried over into how we do performance evaluations. Really thinking about smart goals, I think smart goals really having things that are measurable or achievable. Most of you use smart goals and your evaluations. If you don't, and encourage you to. Often we do smart goals and I see them in an evaluation. They are talking about what might happen in the next 30 days, 60 days or 90 days. Really sort of forgetting that we want to try to work with employees to span the evaluation period of the year. That's how often we are doing them. So we are doing things to engage that employee to follow up with that employee and giving them something that will last across the time of the evaluation period. When

you think about that from a retention standpoint, you can see how that might be an important factor. I always used to say to people and I actually used to, people kind of made fun of it but I think that people would really value it was I always took the time to talk to people during that evaluation process. If you were going to spend your career here, what would that look like? Really talking to people about where they saw themselves going, opportunities. I think people value just having the conversation and also thinking about things that you might do in between the evaluation process to help people get notice. We talk a lot about caring and patient care, remembering that sometimes sending a letter to staff or a note from a manager about something that they might have done or a situation or being able to reach out. If they took initiative, it really can go a long way. It is important to do it sort of selectively so it has a big impact but also to do it as part of a process. So it is something that you might do as a team, part of a process. You have a way to identify situations or employees that might really appreciate getting some sort of a note. Thinking about staff development and training. Really trying to be very creative, again, talking body developing in-house expert. Really supporting people's ability to be trainers. I think what that does is gives people a little diversity in their role. Somebody who does patient care for their week as their job often really appreciates the opportunity to do some training or some supervision or to be a content expert. Really utilize some of the free evidence-based practices, people love to learn, they love to grow. One of the things that I've always encouraged people to do and a lot of managers sometimes get a little surprise when I say this, I encourage people to keep a resume or a bio sketch and to populated as they get new training and to put them on there because what it does is it really keeps people invested in their careers and you want to keep working with them to grow professionally. If people are in some place where they really feel they have the opportunity to learn and grow professionally, you are going to keep them. Often I hear from supervisors, we don't have any money. Or we don't have the ability to do that. There is a law of evidence-based practices out there particularly when people who know me know that this is there is a zero suicide effort. That there is a lot of even evidence-based practices on the zero suicide website that people can get trained and get a certificate. You might be able to do some of that work. To really look for some of those opportunities, but do it in a thoughtful way so that people can really grow in your giving people the opportunity to learn. I think it is really important to create

very clear trajectories for people. I always have a saying that what goes up doesn't come down. What I mean by that is often, I have learned that if you promote people which you definitely want to do internally but if they get promoted too soon and they are struggling or if it is not the right role for them. You often wind up losing them versus if you had waited or really try to create a trajectory where they can grow into that management role. One of the things that I know is often helpful is to create committees. So somebody doesn't get promoted into a management or supervisor position unless they have spent time on a committee or had the opportunity to lead the committee. So you get an opportunity to see how they did to see what kind of a leader or manager they are. Really be able to give them a chance to shine and a chance to grow. Also, be able to have a conversation with them of what some of the next steps might be. You can opportunity to see them, did they engage, are they a leader, did they inspire people around with the committee's mission is. Those are the folks that you want to be able to move into managers or supervisors. If somebody is struggling there, and to have a conversation with them about what might be a good fit for them long-term. I really encourage you to try to think about committees, one of the things I used to do was create committees on the site level or department levels that would mirror organizational ones like quality improvement. Environment of care. Emergency preparedness. Some other evidence-based practice, research, see give people the opportunity for some of those trajectories. Some of the things I think that we can learn, is to really create diverse positions. One of the things that I think was really helpful particularly for our psychiatry retention was that to create a position that did have some diversity. So that it was more worthwhile to have somebody do some teaching and training from collaborative care consultation, some research or some other activities outside of patient care for maybe a session a week or doing other activities intermittently. Because then they would stay longer. I know many organizations like psychiatry is often such a valuable resource that they get somebody in there and there immediately slammed into patient care and they don't stay. It's better to step back if you're having a high turnover in these positions, think about how you can refigure that position. Sometimes it is hard because you know, you do have a lot of patient care demands but if you're losing people, that creates a hardship for patients as well. What I often did was I figured out what FTE and patient care it would take to make someone self-sustaining. I would take that additional FTE so somebody had

to be in patient care 60 percent of the time to be self-sustaining with fringe and overhead, I might say okay you're really interested in this practice or you're really interested in this in informatics and doing something in our electronic health records. One day a week I will give you the opportunity to do that. Create some of these positions that allow people to do other activities to learn and grow. Taking leadership roles and yet still be self-sustaining. On the financial side. What that actually did was allow for us to do a lot of electronic health record work, a lot of quality improvement work, development of some of the evidence-based practices without creating new positions or financial hardships. Then thinking about often pulling people into Tiger teams. Sometimes I know some organizations and I know this is often a problem that for many of us, we are in meetings. Same things are on the agenda time and time again and they feel like you're not going to get past them. Creating a Tiger team and pulling staff people to participate in the Tiger team to fix this problem. We are going to give you some resources and some time. It really engages people with solutions and helps retention because they feel like they are able to make a difference in the organization and do something different. Then you make a deal of it. Put out an email or you recognize their work on that Tiger team. I would also suggest a lot of times people want to do staff satisfaction surveys, again, think about what is the purpose and what are you going to do. If you do a staff satisfaction survey, then you don't take any action or people don't see anything, you can often go backwards. I know that was sort of a very quick overview of some lessons learned and some thoughts. Again, I appreciate your time and I think we may be taking questions at the end. But I will turn it back over to the facilitators.

>> ANDREW: Excellent, a lot of good points there. Personally, some of you know from my clinical experiences given the opportunity for clinicians to become trainers and really enrich their careers it is so valuable and you are so right. We are going to hold questions until the end as we get more content to go through. I think some of the questions may also be answered as we go through. We will have kind of a combined question and answer. Towards the end here. We will move on to our second presenter here. Doctor Jonathan Muther. I will hand it over to you.

>> JONATHAN: Thank you so much, Andrew. Good afternoon everybody, it is great to be with you all today. I am the vice president of behavioral health services at Salud Family Health Centers and a clinician advisor at the University of

Colorado Denver in the Department of medicine. I'm going to ask you all to bear with me today as I really covered a lot of ground in a short amount of time and it's going to be a bit like taking a sip of water from a fire hydrant. There's a lot packed in here and hopefully I will leave you with some helpful resources at the end of the presentation and will have some time for questions as well. To get things kicked off I would like to talk to you all about what it means, what integrated care actually is and what our version or our interpretation of integrated care is here. It's an term becoming increasingly popular, increasingly utilized and therefore subsequently increasingly miss utilized. We think it is important to just kind of have a common ground from a linguistic standpoint and semantics standpoint, what integrated care is, what team-based care is. What is the difference between integrated and graded. Behavior health and so forth. We use lexicon to really ground us and our approach to integration and defining some of the terms in terms of what we use and what we utilize and how we define behavioral health as a team of practitioners working together, not only to address the mental health and substance abuse. But certainly the product conditions that come along and present most often in primary care. A quick overview of the model, at Salud Family Health Centers. Salue is an SQHC. We had some degree of integration for the past 20 years. Currently, if you look at the spectrum of levels of integration, BiPAP scores we typically break it's five or six so sort of on the higher end of integrated care services. We are not a co-location, we are beyond that. We also go beyond peer consultation. For example, we label our clinicians or term our clinicians as behavioral health providers. So just like the primary care provider, behavioral health clinicians are seen as providers sharing and having an equal responsibility in the overall health of the patient. Really just kind of emphasizing the team-based aspects of care and kind of promoting equality across providers again overall. The responsibility of the overall health of the patient. We are quadruple in team oriented, everything that we do is to ensure that we improve outcomes across the board. Of course we reduce the total cost of care. Improving not only patient satisfaction and the patient ensuring that the patient is satisfied with their care experience. But also that providers with behavioral health, physical health and all other members of the care team are also satisfied with the work that they do with the work that they are doing. As Virna pointed out, several characteristics of how to keep the providers happy as set forth in aim. I'm going to try to emphasize some of the supported interventions that we do as part of our

model. In terms of clinicians and who we see or who we see as best fit for our program. We really want people to have a strong foundation as generalists. They have strong assessment skills and strong backgrounds in CBT, motivational interviewing. The other evidence-based and more common practices for clinical interventions, then we really kind of seek to them later training them further in their skills or what it looks like to work and integrated fashion. Everything we do is to design a culturally appropriate, being mindful of cultural sensitivities, linguistic sensitivities. Other considerations contribute to a lack of access or seeking care. More specifically the behavioral health, our overall approach is based on the fact that there is an access gap in behavioral health services. Unfortunately the demand for behavioral health services far exceeds the supply or availability of clinicians. Again, mentioning the barriers of the access to care the previous slide. Everything we do is designed to address those barriers and increase access to behavioral health services. Not for the sole purpose of improving or addressing the mental health or substance abuse concern. But a need to address the concerns as a mechanism to improve overall health. Again, unfortunately at this light, details of significant limitations across the health system, mental health, primary care and everything in between. There is a severe gap in access to quality behavioral health services. To the extent that as more than half of patients with an identified behavioral health concern do not receive care. For kids, it's as high as one in five. Children experience mental health disorders in any given year and unfortunately only about 10 percent of those kids actually receive services. The bottom table on this slide is numbered specifically related to the state of access as I would like to call it. Here in Colorado. That is specific to the Medicaid population. These are the access or penetration rates to care services in the state of Colorado in recent years. We know that unfortunately while maybe 20 percent, 25 percent of the population may receive care, the number of diseased states or rather the presence or mental illness is far higher than that. With Medicaid populations than other populations that experience limitations as it relates to social determinants of health. What are the barriers about or what are the specific factors contributing to this lack of access to behavioral health. The Colorado health Institute did a survey specific here in Colorado in our population. They asked Coloradans why are they not getting access to care, of course there is this common characteristics of insurance, cost related variables or what I would like to call more logistical side of variables. But then

there is also a stigma related variable and perceived variables. That contribute to a lack of access to care. If you are concerned about their neighbors seeing them walking in and out of a mental health center or a therapist office. Most importantly, that the common denominator of all of these things, all of these barriers to care is that an integrated model is able to address these. Whether it is offering services like this skill or offering extended hours of availability, providing real-time referrals and immediate consultations. Or offering services where a patient can see in our waiting room and not be concerned about whether a neighbor, friend or a stranger is aware that they are here for a diabetes follow-up or a depression follow-up. Moving on then to quality, what this slide points out is that even those who should be trained in quality and aware of quality initiatives aren't always very adopt in addressing quality concerns. We do a lot to try to keep our clinicians very mindful of quality initiatives. Making sure that we are on target in terms of really monitoring our program. Having an ongoing CQI process and ensuring that we are at the top of our game in the delivery of care. This is the model of measuring outcomes. I will just give you a few examples. A structural measure would be something like our emphasis on space, shared space between the behavioral health provider and the physical health provider. They are often literally standing shoulder to shoulder at the station. Passing each other in the hallway, bumping into each other in the hallway. That is what we consider the structural measure in terms of the space and physical layout of the clinic. Also, the behavioral health provider having the technology like an accessible laptop that they can take with them and carry easily in and out of exam rooms. So that they can quickly and easily access records and ask questions from the record and document during the actual appointment. Process measures, I can discuss further on the next slide but again it gets back to for us mostly around access. Providing access to care and again trying to be mindful of reducing that gap in terms of the demand for services availability. Then further outcomes or specific change to level a function or severity of symptoms. Something that I will get you a little bit further as I present a case later on. But we use the outcome rating scale or from the partners, excuse me, partners for change, outcome measurement system. Which again I will discuss here in a little bit. Another specific quality measure again, this is how we detail out and try to pin down access rates. Both for our total population, we want to make sure that the behavioral health team is penetrating so much into the population

that it's meaningful and patients are getting adequate access. Right now, unfortunately well fortunately and unfortunately I think we are doing better than most. We are at about a 20 percent of some type of behavioral health encounter for our entire population. We are working to increase that up to 30 percent. Then likewise, for each individual behavioral health provider we are trying to be very mindful of each individual caseload, turnover rates, how frequently patients are getting seen. Really pushing our outcome measure and emphasizing with all of our clinicians that they be very mindful of treatment planning and goals, objectives to meet those goals. Really assessing and discussing with the patient the progress towards those goals. So that they can be mindful of not only meeting the needs of the patients sitting across from them but also ensuring that their time to achieve a clinically significant outcome is such that it opens up availability to other folks who otherwise aren't getting seen by our clinicians see beyond 12 sessions and so forth. What makes this work? In large we are talking about a cultural shift. Really getting everyone to adequately buy into our model. Again, truly having medical providers also seeing the behavioral health provider as really truly sharing that responsibility for the overall health of the patient. We see this as a shift from a traditional biomedical model or a traditional psychotherapy model to a more holistic biopsychosocial approach. Those two identifying it as the disease state and responding with medications whereas emphasizing prevention and wellness. As opposed to traditional hierarchies with the physician sort of dictating who gets to see their patient. Again, we emphasize equal responsibility as opposed to telling the patient that they need to exercise and eat better, we asked the patient what they think is best. What are four motivational interviewing standpoint for example, we elicit from the patient what are their sort of priorities in their overall health and their initial steps or their own recommendations for how they can acquire better health status. Again, I like to see moving away from the traditional fern in the lamp therapy our two quick assessments and brief episodes of care. It is also important to be mindful of the spectrum of services that a behavioral health clinician can offer. Of course we are most often thought of and utilize to address mental health and substance abuse concerns but it's also important to make clear to not only medical providers but certainly the patient's as well that we can do a lot of behavioral management with chronic illness. This slide nicely lays out the spectrum of services that can be offered from a behavioral health provider. Be it

related to psychosocial stressors, again, social determinants of health. But also the behavioral management of chronic disease. What is typically thought of as physical health concerns, diabetes, hypertension, chronic pain, sleep disorders and so forth. Of course, when a patient has for example diabetes is far more likely that they or as a member of chronic conditions were physical it increases the likelihood of the presence of mental health illness. So of course we are addressing those physical and behavioral comorbidities. Whether it's appropriate or not, primary care is still likely the most frequent place that somebody with SPMI is likely to present their concerns. Again, often we are requested for doing a brief assessment there on the SPMI population more often than not referring them out to a more appropriate level of care. Now I will do kind of a quick deeper dive into the clinical roles of the behavioral health providers at Salud. So we do behavioral health screenings with the purpose of recognizing a mental or substance abuse behavioral health concern prior to someone else recognizing it. Or prior to hopefully it presenting the time of it presenting higher severity. We try to identify behavioral health concerns that previously has not been identified. These types of encounters are initiated by the behavioral health provider, they are not requested by the PCP and are most often not expected by the patient. Just like a blood test or any other type of screening. We are trying to do some routine screenings from a primary prevention standpoint or secondary prevention standpoint to address the needs as early as possible. With that process works, which again with the use of the outcome rating scale is sort of a four-part question. Broad overview of it gets sort of a broad sense of level of functioning, a level of distress or wellness. Then we asked what we call the screen for life stressors which is a series of questions involving essentially the PHQ four on depression and anxiety. Questions on substance abuse. The PTSD which is a four-part question on trauma. If anything is positive on that initial screen, we will follow up and do a more in-depth screen measure to get the severity of symptoms. The second and most common type of encounter that the behavioral health provider offers is of course a consultation. The difference between a consultation or what we term consultation and a screen is that it is requested by the PCP or some member of the care team and the BHP is requested to respond to an existing or an identifying concern. In our model we don't treat the PCP as the client. Again, that sort of equality and responsibility for the care of the patient we are not seen as an adjunct or ancillary staff that is invited by the PCP. In fact, a consultation is just as likely

to be initiated by the behavioral health provider. Again when the need is recognized. It is not therapy although we are often seeing patients in concession with follow-ups for appointments just for brief assessments and brief interventions. I wanted to give a quick case example. This example is of a behavioral health consultation. In which the patient presented, this gives you a glimpse of the EHR to and how we track the screening measures and also the outcome measures and some of the documentation of the coding processes. So this patient was referred to our behavioral health consultation. She had been endorsing depressive symptoms in addition to anxiety and was told her depression symptoms contributed to her mismanagement of depression. Excuse me, depression was contributing to the mismanagement or poor management of diabetes. The symptoms had been going on for a few months, she also had significant difficulty sleeping. Also had a history of trauma. As we know from the work done in case studies and so forth, trauma history can greatly impact the physical impact or the physical outcomes of a patient as well as a case with this woman. We code this despite the presence of symptoms we typically don't do a full diagnosis. After just a brief consultation, it wasn't a deferred diagnosis. Again, our outcome measure is the outcome rating scale we actually track in our EHR as a lab. Essentially it's the behavioral health version of a blood test. Again a four-part question on how the patient is doing. At this point she was below the clinical cutoff so she wasn't endorsing symptoms of a clinical severity and warranting follow-up. We also code this procedure as a H0031. A lot of times how to code screenings versus consultations versus therapy can be very very difficult. But we code this as a CPT code as a H0031 brief assessment. A follow-up which was two weeks later, following the initial consultation that took place in the context of the medical appointment the patient was already reporting improvement. Certainly in the management of her diabetes. Yes, some of the symptoms of depression were still there. She had significant familial stressors and the trauma history and so forth. But she felt already even after the initial consultation that she was doing better. You don't seen in the documentation here but the intervention here involves a lot of motivational interviewing around again, eliciting from the patient what they thought was the best approach in managing their symptoms or diabetes. Also involving the referral to a CBT I sleep group. To help address the sleep concerns to help resolve both the depression and the mismanagement of diabetes. Again, a follow-up use the already a clinically

significant change in the outcome measure. There's about 12 or 13 points on the outcome measure which is the clinically significant amount of change and putting her above the clinical cutoff or out of the range of clinical severity. Again, that would have been a 90837 or psychotherapy follow-up. I think this case just kind of is a nice example of again our approach and providing that real-time access to care. The clinically significant amount of change that can occur just in one brief intervention and can really be further solidified upon a follow-up with just one therapy encounter. The last thing I want to emphasize here is the core competencies for behavioral health provider working in primary care. These competencies were in part developed by the Farley health policy Center. I won't go through these in depth in the interest of time. But there is a reference there that with a link to the website at the Farley health policy Center that has a report on how these core competencies were developed. Also, there is a link that will show you here on the resources to a brand-new campaign that was launched a few weeks ago really which is make health hold.org. It's a wonderful website that has videos highlighting the core competencies for behavioral health and primary care. Some other interesting videos and tidbits and so forth. Specifically if you are just new to the area, if you're looking to adopt training modules for your clinicians and for several other reasons this can be a very useful resource. With that, I will go ahead and stop. I know we covered a lot. In a short amount of time. But I am certainly happy to follow up with anyone individual at a later time. Andrew and Aurora, I think you might be ready for some questions.

>> ANDREW: Thank you so much, excellent. I really appreciate the use. Hopefully folks can see for a full standpoint how you were coding to what the screenings are doing to even just looking at the documentation may look a little different from traditional behavioral health documentations that might be pages and pages longer. These are also important for the integration to consider when we are thinking about training or designing current documentation systems. Things like that. I really appreciate that. Excellent. We did get quite a bit of questions so we will start going through some of them and we will see how many we are able to get through. To start with, I think we had an interesting one about coding. Somebody asked, I have come across so many different approaches to CPT coding for behavioral health conditions. Can you suggest a resource that clarifies which CPT code to use for each type of behavioral health prevention and integrated setting? Jonathan or Virna?

>> VIRNA: I think there is several and I would actually direct people to the Center for integrated health solutions website because there we have taken great strides and are actually updating it to do something that goes state-by-state because the coding recommendations can change state-by-state. Also, could even change based on the licensure of the provider or the kind of organization you are in such as an SQHC. I would encourage you to look at that resource because I think it breaks it down and might be the most helpful. Then you could certainly ask questions of that team. There's an opportunity to do that through the website.
>> JONATHAN: I agree, the only thing I would add is also you might want to check with your peers. In Colorado for example, the Medicaid agencies produce a lovely 300 page document --.
>> ANDREW: The website is actually at the bottom of the slide. Integration.SAMHSA.gov there is a tab under financing and billing tools that is there that you can reference. Let's see, another one here I think this is another interesting one. Also practice related. In a SQHC how do you avoid generating an additional copay for patients who have been provided a consultation in an exam room. So initial consultations it sounds like.
>> JONATHAN: The way to get around that is we don't charge anyone. We track it, we code it. But it never translates to an additional copay for the provider regardless of insurance. Essentially, in our system it is a co-pay for the total visit. What they may have paid upfront for the initial medical appointment is covered in the cost of behavioral health providers. We have some kind of workaround on the backend so that those encounters don't trigger billing to send a bill to a patient. There is a couple mechanisms in our EHR that help do that. Which is by visit type and again how the CPT code is put into the record.
>> VIRNA: I would second that to think about your organization processes and think about for integrated settings, how you manage visits like pressure checks, sugar checks, if a provider calls in a diabetes educator. That you have some consistent processes and policies. Many of the same issues arise.
>> JONATHAN: Not to totally switch gears to talk about and open up a can of worms of payment reform, but in the existing most often service system these considerations unfortunately have to be made and have to be kind of really mindful about each individual encounter. But to the extent possible advocate with your state stakeholders, policymakers and payers about some type of capitated system or

permit per month mechanism that allows you the flexibility and again to take a team face approach to care as opposed to needing to count each individual account or each individual person.
>> ANDREW: Thank you. We are actually getting quite a few questions around the codes and billing. I think we will probably hold off on taking too many more of those as the presenters mention. These are pretty stay independent. I will let those know in addition to the website, we offer a one-on-one assistance and technical assistance on these topics. Shoot us an email at integration@thenationalcouncil.org. We will have the information at the end of the presentation. There's other areas for questions. Another question that we got is here's a good one. Patient engagement is such a critical part of improving health outcomes, what kind of engagement strategies do you use things like peer services or other techniques?
>> JONATHAN: For us, it's really not too much more beyond what I already said. As it relates to operating behavioral health services basically we just try to set a tone that hey, we know you may not be here for behavioral health and we know you're not asking necessarily for behavioral health services and we are going to offer them to you anyway. Or we are going to screen you for mental health symptoms whether or not that is your reason of presentation anyway. Something I didn't mention is that it also takes the form of PHQ screening as completed by the medical assistance and if that initial screening is positive then they will call a behavioral health provider in. But essentially our effort is to really try to mobilize behavioral health as a part of one's overall care. Really, anytime somebody comes to Salud it is in hopes that it PHQ screening rep is across the board. More often than not a patient gets exposure to some aspect of behavioral healthcare. I hope the answers the question.
>> VIRNA: I am also going to jump in and think about patient engagement and sort of tie into the workforce retention. I like to think of it as our patients tell us a story and to try to use data to really look at your engagement. When we think about engagement and we talk about our behavioral health providers, what is the average length of time, how many or what is our cancellation and show rates for new appointments or second appointments. Using that data to try to design our services to help engage patients. Thinking about using 30 day action plans for engagement strategies or engagement groups. So I encourage people to really look at some of

the data around engagement. Listen to what patients are telling you and think about how you can engage in your providers in some solutions.
>> ANDREW: Great. Another one I think this one, I can guess the representative said it. This individual as we are struggling with having primary care and behavioral health in two different electronic health records. How do you address that barrier?
>> JONATHAN: Oh gosh. This is a tough one. This is like where EHR starts the blessing and the curse. We do face that as well. We have an integrated health home and collaboration with local community mental health centers, the community reach center. We have a PCP in their practice and do have that integrated health home. They still operate on EHR2. We are working to build centralized data warehouses and so forth. In the end there is a lot of workarounds, there's a lot of unfortunately a lot of paper trading. There is a lot of use of our care coordinator. Who has access to both records. So she is able to print off records from the PCP and get it to a psychiatrist and vice versa. The other thing is we've trained front desk staff in at least the scheduling of both records. So the scheduling can sort of happen on either side and in either record. There is a lot of manual labor really, there is a lot of creating a list in EHR and scrubbing that up against another list in the EHR to get a true population metric and hiring out the attribution and so forth. Unfortunately I don't have a great answer but we are in the process of trying to develop a more enhanced health information exchange process.
>> VIRNA: I think there is no easy way around that, perhaps read-only access to the other system or some other similar.
>> ANDREW: Next one, we have some a couple of questions about like arranging visits and balancing different types of visits. I want to combine a couple of them. Basically, how do you divide up your visits particularly like what kind of time increments are you using in your clinic and how do you like what is the kind of ratio of follow-ups versus initial visits. Can you talk more about how you arrange your clinic that way?
>> VIRNA: I think that whenever we talk about appointments like this or scheduling, I've always found that what works in one clinic works in one clinic. Just because populations are different, systems are different, services are different. So to really try to take some of those things into consideration, I think at this point in time that most centers could or should be operating with some sort of open access

with some sort of same day next day scheduling and then the ability to really think about what your time frames are from that. In integrated settings most appointments unless you are working with some different populations in 30 minutes. I think again to really go back to what your data says that if you're having a hard time getting people in for initial appointments. Then thinking about how to reconfigure those appointment slots. Maybe doing some same day next day shorter engagement visits. I think that there is no set prescription that is going to work in all but there is certainly some best practices that are out there that you might be able to learn from.

>> JONATHAN: I agree with a lot of what Virna said, absolutely. As an example, a brief overview of our expectations is typically between eight and ideally 12 encounters per day, divided across to clinical sessions. Our screening process usually takes 10 to 15 minutes max. A consultation process usually takes 15 to 20 minutes max. Of course there will be exceptions to both and we will go over in the event of safety concerns and so forth. Also we very intentionally cap our therapy slots per day per BHP. Three slots per day. We really want to emphasize that the BHP isn't co-located or just down the hall doing therapy all day. For our model and what works best for us is two thirds of the time and two thirds of their encounters are either a screen or a consult taking place in the exam room. In our case also, it's about as twice as many consultations or responding to an identified need as it is. A screening.

>> VIRNA: I think also one good point that you sort of brought up where the different types of visits. I think more and more to look at only productivity. I'd like to see what a provider does every day is like a painting and productivity is one color. To think about the different types of visits into think about the amount of time in patient care or doing other activities as part of how you're measuring providers. It doesn't mean you don't need to know how many patient visits somebody has to do in order for somebody to be self-sustaining but to think of it just because of the diversity of types of visits. People are running groups, they are doing warm handoffs. They are seeing emergencies and all of those are very different requirements and very different time frames. So someone could see quite a few patients and only in the first part of their day. Really thinking about what the total picture looks like or what providers are doing in their role.

>> JONATHAN: I think that's a great way to put it and the last thing I will say tying back to your presentation really Virna, is that exact variability and that no two days are the same and it helps with a behavioral health provider retention and job satisfaction. I really feel like for that need. For that matter we see people that are doing well and they see people that are it's kind of a relief to see a negative screen or see people with some stresses of course but not a clinical severity. Seeing that full spectrum and different types of encounters helps with the satisfaction and engagement from day to day.
>> VIRNA: I agree.
>> ANDREW: Great. Also, to the point I think you both mentioned we really have to always consider leadership support as well. Thinking about as we are taking into account which way and where to kind of add an extra time in people's schedules for consultations and stuff like that's important to understand that. There is a number of questions about EDP and treatment legalities using evidence-based practices and protocols. I think one person summed it up pretty well and it's pretty common some curious what your experience is here. We had difficulty incorporating brief interventions done by behavioral health provider to a regular 20 to 25 minute appointment or visit. Do you have any suggestions for that?
>> JONATHAN: Virna, I will let you take a stab at it initially. I'm getting another call on this phone line. I missed some parts of the question. Sorry.
>> VIRNA: I think that a lot of times the incorporating's of brief intervention, it really becomes a training issue. I know many times when organizations are sort of transitioning to using brief interventions or shorter appointment times there is often a lot of conversations about the inability to fit what needs to happen into a session. I think there's a couple of things that are often really helpful. One is to really give people some focus around the practices. Really what also they need to document. The reason that someone is there and the assessment of systems, tools that are really helpful and a clinical intervention provided and with a providing the documentation and to be able to use collaborative documentation. So that the first five, last five around collaborative documentation to really help focus the session to review. That is one of the things that I love about some of the tools like the PHQ or the GAD because it allows you to start with a patient to see you were here last week and now you're here, what changed. That really gives a good foundations for a focus

session and to help clinicians work within that shorter timeframe. It really becomes I think a training issue.
>> JONATHAN: I would echo that and focus on the measure and be able to demonstrate some type of clinical outcome. Whatever it is. In our case, we use the again the outcome rating scale which is standardized and invalidated in every mental health setting. With primary care being the exception running a RCT to validate. That works for us, it is brief and easy. It is certainly not the end-all be-all. But having some strategy to demonstrate with data is a change.
>> ANDREW: Thanks. The next question again I think speaks to the importance of getting support within the organization to make change. This question is phrased and referenced to an FQ but I think this is pretty much any organization. How do you get the administration to understand the difference between providing traditional mental health services in the primary care setting versus providing integrated behavioral health and primary care services. I think we are talking about deeper levels of integration.
>> JONATHAN: I was fortunate enough that a lot of folks that came before me laid the groundwork again, we had some iteration of an integrated model for about the past 20 years. One reason why that has worked is that we have had provider champions and mainly medical provider champions. We've been able to demonstrate over the years support from not only all or many PCPs. But also, clinical leadership or our chief medical officer. Farley is a huge advocate and proponent of behavioral health and primary care. Just getting that buy-in and again the culture change and getting the buy in for medical leadership and other clinical leadership is important. The other thing I think is really helpful is patient stories. Explaining say to the CEO or the CSO, here's the benefit of wellness. Here is yes, we do depression and here is how the behavioral health provider can make a difference in addressing diabetes. Then lastly, come up with a business model. At the end of the day if it helps, if it helps the bottom line that is tough to argue with. So again, provider champions, patient stories that tell a pretty compelling impact on a patient. Making a business case.
>> ANDREW: There is another question I think fits in nicely. That is now on the patient angle of this. Let's see the question is essentially about how do you talk to a patient who maybe if they are coming in for maybe a primary medical visit they are not necessarily expecting to have a behavioral health provider in the room. How

can you kind of anticipate this and be accepting an understanding of the purpose of these shared visits?
>> VIRNA: I think it is really again the training issue in terms of how you really have a chance disciplinary team and really practice in the centers. And to say I work with Virna, she is a part of my team and helps me care for my patients who are feeling anxious. I'm going to have her come in and finish up with you today. So really, really working with providers and sort of communicating to patients that there is a team. The people from the team care for them and really being very comfortable in doing a handoff having a process in place. I am sure you have something to add from your practices.
>> JONATHAN: I would just say I mean semantics, language, how you present your purpose to the patient is really critical. Using kind of less alarming verbiage like terms like mood and stress as opposed to depression and anxiety can be really helpful. I think it is just a lot of psychoeducation with patients on what therapy is, normalizing symptoms. Explaining that given your trauma history, a reaction like this or these types of panic symptoms are not uncommon. Here's what we can do about it. Again, in our system, it is not just the PCP doing kind of what is typically called the warm handoff or introducing the provider. Although a diverse point on how that happens is critical. Also, we just have the behavioral health providers go in and we say they are part of the overall healthcare team. "Mark is here to check in on mood and stress and I'm cooperating with Doctor so and so". Then we can go in quickly and efficiently getting the psychosocial history, if we can do it in a way that does not interrupt the flow of the medical provider than that helps get their buy-in as well. In fact, it can increase their efficiency. If I come out of a room and I give a rapid psychosocial history that means the PCP doesn't have to get into that with the patient, there's already a plan for a follow-up that I can ensure with the PCP. That sort of efficiency helps get the provider a buy-in and their support from the team aspect it's really critical.
>> ANDREW: We will make this the last question. We have quite a number of questions that continue to come through. People are again welcome to submit their questions through email. A couple more slides to get there. We will wrap up with this one and it's actually another combined number of people asking about similar things here. Can you tell us a little bit about staffing ratios, for example for any given PCP teammates or maybe a physician, practitioner, RN, how many behavioral

health providers do you typically recommend or based on patient caseload size. Also, any comment on the use of peers in the mix?
>> VIRNA: I think what that sort of national standard is for every 3.5 to 4 primary care is one behavioral health provider. Again, I think that it depends on your model. Whether or not we are doing a more consultative model or people are seeing more ongoing. It does depend a little bit on your model in your population but that is often a general rule of thumb.
>> JONATHAN: I would say literature is also very mixed. I agree that the 3:1 or 4:1 is a standard. That is the minimum that we have here. The number varies by clinic. I would also encourage people to think about it by patient population. Not just the provider ratio but also the behavioral health provider per patient ratio. Developing an algorithm for the number of behavioral health providers that would be adequate. Again, if you look at the full spectrum of behavioral health services and you move beyond the typical kind of mental health depression and anxiety, getting into the behavioral management of the physical illness, the need for behavioral health services really rises. If you look at Community Health Center Incorporated of Connecticut, Cherokee Health Systems in Tennessee, some of the most progressive models and integration, they have a 1 to 3 ratio with one PCP to every three behavioral health providers and certainly managed to keep everybody busy. I think different ways to look at it there for sure.
>> ANDREW: In clinical work as well it seems the more we offer the more need there is. It's a rising tide. We do have one last question that we would like people to look at and think about, as you are answering the question which is asked after this webinar, what are you doing with this information? Are you going to look at your current staffing strategies, maybe making changes to your current workflows or clinic procedures. Are you going to share the information with others? How you answer the question helps think of a plan sort of an action plan if you're watching this with other members of your team. What might you like to start doing different when you look at your staff ratio issues. Looking at different trainings that are available to people on your team or how you're advertising services for patients who come in for medical visits. Any number of these things. You really think about what strategies you want to do to make the time you spent on the webinar today useful for your work. We can do the poll here. We have a good number of people who are going to spread the word here. We are happy to see that. In just a moment

we will talk about how you can download these slides and have them available. I think we have just a couple of more resources that we wanted to share. Again, we have these are all on your screen here and we will have these slides for download. These are links that are available to you, we have some current articles through folks from elsewhere. Best practices, training behavioral health providers in this area, links to a couple of different resources available on our website. In particular, with the framework for integrating primary care and behavioral health services, identifying who in the workforce is really required for integrated healthcare systems. How you can recruit and retain folks in your area. They are on this webinar on this topic. The bottom left I will highlight another center that is valuable that is the National Clinician Consultation Center. They offer clinicians to call on any number of topics from substance abuse to HIV prep and other screening tools. That is a great resource that's available and also through email that folks definitely should consider if you're not familiar with it in your organization. Of course our website, Integration.SAMHSA.gov and as I mentioned, we offer at no cost training and assistance to you folks out there who are doing integration work with primary and behavioral healthcare. All you have to do is send us an email to integration@thenationalcouncil.org. We are happy to work with you on any topics we discussed today or anything else. A couple of key website resources have links including things I write like job descriptions for folks out in the field who are successful in filling these positions. With that I will hand it back over to Aurora.
>> AURORA: Thanks Andrew, you can find the first part of the series Workforce Development Part I and Recruitment and Retention on our website at Integration.SAMHSA.gov\webinar. You can scroll down to the section where you can hear the recorded presentations, click on "Workforce" and will be linked to Part I. In 48 hours you will have access to Part II, focusing on training the workflow.
>> ANDREW: That's it.
>> That is all the time that we have today, once again, we are recording into the description of this webinar it will be available on the SAMHSA website. If you want to access the webinar you will be asked to complete a short survey. Be sure to offer your feedback. Your input is important to us as it forms the development of our future seminars. We would like to send a huge thank you to our presenters for joining us today. Thank you for joining the webinar and please stay tuned for more webinars in the future. Have a great afternoon everyone.

>> VIRNA: Thank you.