National: BHI With Virtual Site Visits

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Hello everyone. I'm Krystal Gomez from TMF Health Quality Institute. Welcome to our national CPC webinar entitled IT Behavioral Health Integration NO with virtual site visits. I'd like to start things off today with a few announcements. The slides for today's presentation will be available for download on the collaboration site. You can also download the slides directly from the WebEx environment today by using the top tool bar and selecting file which will open a drop down menu. Then select save as and then document. Today's program is being recorded and will be posted on the collaboration site once transcripts have been completed. We appreciate the presenter's time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products or vendors are expressions and opinions of the person speaking and not an opinion of nor endorsement by The Center for Medicare and Medicaid Innovation nor TMF Health Quality Institute nor the host of the program.

As a reminder, all the lines will remain muted throughout today's session. To submit questions click on the question and answer tab on the right-hand side of your screen and please remember to submit all questions through the Q and A tab and not the chat tab.

I am delighted today to introduce today's speakers. I'd like to introduce our subject matter expert for today's presentation Dr. Benjamin Miller. Dr. Benjamin Miller worked as a post-doctoral fellow in primary care psychology at the University of Massachusetts Medical School in the Department of Family Medicine and Community Health. Currently Dr. Miller is an assistant professor in the Department of Family Medicine at the University of Colorado Denver School of Medicine where he is responsible for [inaudible] involving integrating behavioral health into primary care. We will also have three practices here that we'll be sharing on today's webinar. We have Vanguard Medical Group out of New Jersey, Tilley Diagnostic Clinic in Arkansas and Yampa Valley Medical Associates in Colorado.

Now I'd like to hand the presentation over to Dr. Laura Sessums. She is the Division Director of Advanced Primary Care at the Centers for Medicare and Medicaid Innovation. Dr. Laura Sessums.

Thanks Krystal. Today's webinar as you just heard from Krystal is going to be really practical as we're going to get to listen to practices talk about their work on behavioral health integration into primary care. I'm really looking forward today to hear about some of their struggles and also about some of their early successes. In the beginning of my medical career I practiced with a group in an inner city setting where our patient population had significant mental health issues including schizophrenia and bipolar

disorder, substance abuse and the like. The psychiatry group who saw many of these patients was located nearby, but it was extremely difficult to communicate with them and them with us, and of course there was no shared medical record and the rare collaboration that occurred only happened with a lot of time and effort.

We had other patients at that practice site that suffered with more common diagnosis such as depression and anxiety along with severe life stresses like physical and sexual abuse, exposure to violence, and that really limited these patients' ability to focus on and achieve the goals of their medical care. Of course we in the general internal medicine group had no special training in addressing these serious problems, no education on community resources that we might access for the patients and certainly no behavioral health resources in our clinic. I, along with the other doctors, I was just overwhelmed with the chaos and we all just did the best we could for the patients, but we certainly knew it was never enough.

In my more recent practice, my patients were elderly with a large percentage of patients with cognitive impairment or dementia. Similarly, there many of us felt overwhelmed with the practical issues that we were confronting. What was the best way to screen for and then treat these issues? How did we deal with the family and caregiver concerns that these diagnosis generate? Well, we decided to get additional training from a nearby group of geriatrics docs who were more than happy to give us lectures on these and other geriatric issues, link us with available community resources and then to be a resource for us when we needed them. As a result we increased tremendously our ability to diagnosis and manage these problems within our own practice making our primary care even more comprehensive and of course our patients safer and better cared for. Yet we really still struggled with the time that we spent doing cognitive testing on patients and talking to patients and families about our concerns, their concerns and the options that we knew of to deal with progressive cognitive decline. Ultimately though one of our RNs with a special interest in geriatric patients decided to undergo additional training which we supported and really became a tremendous resource for our practice in caring for these patients. So finding the right behavioral health training, processes and resources for your practice in your community may take a bit of time, but I'm really pleased that so many of you have embarked on this journey. Let's turn to Ben Miller and the practices sharing their work on behavioral health integration in today's webinar. Ben?

Thank you so much Dr. Sessums. Great introduction. So welcome everyone to today's webinar. I think all of you on this call know today that behavioral health integration continues to be a very much discussed topic in health care and for good reason. We've talked about this before in other webinars, but as a quick reminder why this is such a high priority for primary care is because of the abundant prevalence of behavioral health in primary care [inaudible]. We know that somewhere north of 80% of individuals with a behavioral health disorder will visit primary care at least once in a calendar year. And 50% of all behavioral health disorders are treated solely in that primary care setting as you just heard so eloquently from Dr. Sessums. This is a practical reality that frontline providers deal with every day. Listen, we really do have an unprecedented opportunity in primary care to adjust a potential unmet need of patients with behavioral health.

So today, let me quickly go over Milestone 2, which I think all of you know by now, but just as a reminder for Milestone 2 and for behavioral health integration practices are aiming to address key issues in population health management using risk stratification methodology. And in 2013 you've focused on those at highest risk with poor health outcomes and preventable harm. And in 2014, you're looking to enhance support for patients who may be in lower risk strata but who are struggling to achieve health goals and at risk for negative outcomes. So in our previous webinars we've discussed how behavioral health integration can be used to better identify, measure and treat various aspects of behavior often primary care. But today, and I'm very excited about this, you're going to hear about our CPT practice [inaudible]. We're going to hear from some of the frontline innovators who are at the forefront of behavioral health innovation. So using a series of questions we're going to look at the three different ways that people have approached behavioral health integration and hopefully reserve some time at the end for questions. So without further ado Krystal, can you introduce our practices for today please?

Absolutely. So first I'd like to introduce Vanguard Medical Group out of New Jersey. Janet, would you tell us a little bit about your practice and where you're located?

Sure. We're -- good afternoon everyone. We're located in Verona, New Jersey. The Vanguard Verona location is one of five sites of our total practice, and we have nine physicians, three PAs and three nurse practitioners, one of whom is the behavioral health nurse practitioner.

Thank you. Our next site is Tilley Diagnostic Clinic out of Arkansas. If you could tell us a little bit about yourself.

My name is Absalom Tilley. I'm an internal medicine physician and with me today is Jessica Carpenter our practice care coordinator and she is an RN. And we also have a summer intern with us, Claire King. Our practice is myself, my wife Gina Tilley who is a family medicine physician, and we have Sara Williams who's a nurse practitioner. We're located in Malvern, Arkansas, which is 40 miles south of Little Rock and we do general primary care.

Thank you Dr. Tilley. Our third practice is Yampa Valley Medical Associates in Colorado. Will you tell us a little bit about your practice?

Hi. Good afternoon. My name is Leah Hemeyer and I am a care manager and behavioral health clinician with the Yampa Valley Medical Associates. We are located in Steamboat Springs, Colorado, a rural community about three and-a-half hours northwest of Denver. We have nine providers in our practice, seven doctors and two PAs and we are a family practice, general family practice.

10:08

Thank you Leah. All right. I'm going to turn things back over to Ben.

Thanks everybody. It's great to have such a diverse group of practices on today. So we're going to start in Colorado only because I'm a little bit biased and that's where I am with our first question here. Could you describe just a little bit how your practice came to a place where you decided to pursue behavioral

health integration, and what specifically -- describe to us kind of what led to this decision? And we'll start with you Yampa Valley.

All right. So that is an interesting question for our community. About two or three years ago, we have a Northwest Colorado Community Health Partnership that identified this need for additional behavioral health in this rural part of Colorado. We tend to have a high suicide rate in Routt County where Steamboat Springs is located and there were concerns about alcohol and substance abuse and just access to mental health care in general. So this partnership pursued grant funding and received grant funding two years ago to put a behavioral health clinician, which is myself into primary care practices throughout Steamboat Springs. So I was located in three different private doctor's offices here in Steamboat Springs for the last two years. With the expiration of that grant in March Yampa Valley Medical Associates brought me on to their staff as a care manager and also to head up the behavioral health work for CPI. So I think that's kind of where we came from, an opportunity through grant funding and then it just dovetailed nicely into the CPI work.

Thank you. Thank you very much. Let's go to Dr. Tilley. Tell us a little bit about your journey to behavioral health integration and why you all decided to pursue this for CPC.

Part of the reason that we decided that this was the way we were going to go is because we do also have a pretty significantly high percentage of our patients that carry the diagnosis of depression or anxiety, and we identified that pretty early on when we were looking at our patient dynamics. We also decided that we were going to pursue a little bit more aggressively the undiagnosed depressed patient and that's where we've kind of put our initial focus because depression is one of the main reasons that some people's underlying health just doesn't seem to get better and that's something that we're particularly interested in as we treat a wide variety of diseases in primary care. But we particularly liked depression because if often goes undiagnosed and untreated and is one of those things that can lead to other mortality morbidity that we're trying to identify and do something about.

Thank you Dr. Tilley, and thanks for reminding us the importance of addressing disease stage simultaneously to get the best outcome. It's always a helpful reminder. Let's go to New Jersey and Vanguard. Can you tell us a little bit about how you all decided to pursue behavioral health integration?

Sure. So we had also along with starting with our metrics when we brought metrics onboard and we started to actively pursue metrics in 2011 we also found that there was a large number of undiagnosed or diagnosed but not being treated depressed patients. And our ability to provide consistent access for patients in a timely manner was difficult and we initially started by having a collaborative agreement with a local provider who -- it worked out pretty well for a while, but over time that provider it stopped being -- the access stopped being quite as quick for patients, getting reports back to patients we're having a difficult time getting an appointment within a two to three week timeframe. So we did try to sort of work closely in the medical neighborhood, and the way the model came to Verona is that it had started about four years ago in our Cranford office and again it was due to a lack of in network behavioral health providers being available in the community, and those who were had a long wait time, so they started an on-site psychiatric nurse practitioner and they had very good success with that. So in

2012 we had a PNP come on-site here two days a week then three days a week, and we are now seeking a second provider to bring the Verona site up to a five-day a week coverage. And our psychiatric nurse practitioner has experience as a staff psyche nurse and outpatient treatment programs and really understands the importance of bridging from treatment and into community-based treatment and working with the PCP to collaborate on care. So that's how we brought the model in-house.

That's great Janet. Thank you. And thanks also for reminding us so many times that behavioral health integration becomes really shown at the forefront of what we need to do for practices because of the tremendous challenge of access. And that is I think if we were to poll everybody here today and ask how many practices have had a difficult time of that many would probably say that they have. But thank you for that.

Let's move onto question number two, and there's quite a bit here so let's walk through this a little bit. Let me read the questions and then Janet I'm going to come to you first with Vanguard. First of all, describe how your practice came to a place where you decided to pursue behavioral health integration. We've talked a little bit about what led to your decision. So now I'd like you to move beyond that and what does your patient population look like? And describe how you really can go through the identification and treatment process and what do you next? So talk a little bit about what this actually looks like in your practice. What does the day-to-day implementation of behavioral health actually look like for you? Janet, let's start with you again.

All right. So to just give you a little background about the practice, we have about 45,000 patients across all five sites and we saw 16,000 unique patients in 2013. So our behavioral health population is quite varied and actually not all the needs are met with our on-site provider. Some of the exceptions are that the patient needs to be over 18. Our provider doesn't work with suicidal patients or substance abuse patients or she does not do marriage counseling. So it's not that every need that we identify can be handled on site, but she typically does see patients with new onset depression, anxiety secondary to new diagnosis, people with chronic depression, complex comorbid patients, patients dealing with life changes like a loss of a job or caring for their parents. So that's kind of what our population looks like. And I didn't -- now do you want me to talk to you about how we deliver the care?

Yeah. I think that would be great. Walk us through -- we're going to talk about work flow in just a second, but maybe just describe a little bit on the surface how you deliver some it actually. What do the services look like?

Well, the psychiatric nurse practitioner has her own office. She does her own scheduling and her own case management, but we in the care coordination department have helped her to develop a spreadsheet tool so that she can create sort of a tickler list to be in touch with patients who she hasn't seen in her prescribed period of time. And referrals come from inside the practice as well as external referrals, and I know that's a question down the list a little bit.

You know what? You all are just so comprehensive and thorough I actually guess I'm going skip ahead to next question because this is what we're going to be talking about, and Jan you just started talking about that, so thank you. Let's move down to Dr. Tilley. Can you talk to us a little bit about your work flow for

delivering integrated behavioral health within your practice? What does it look like? How do you identify the patients, how are they treated, what are the next steps subsequent to identification? Tell us your story.

We made the decision when we decided to do this particular project that we were going to look at depressed patients that we had not already identified as being depressed. Now eventually we plan on broadening out to get everybody covered because access for our particular patient population is an extremely difficult problem. And so what we were really trying to do when we were developing our method of how we're going to identify and treat these patients was to first look how we could keep as much as we possibly can in the practice. And then we also kept in mind the fact that we were not going to be able to get very much access outside so we were going to try to figure out a way to keep this sustainable once the initiative ends or when there is some sort of change to whatever the future holds. So we're looking for a way to make a difference now but also in doing this and keeping this as a part of our practice going forward. So having said that basically what we do is our patient care coordinator huddles with our nurses at the end of each day.

20:06

Interestingly enough it looks just like a smoke break, but be that as it may they get together and look at our patient list for the next day for the three providers and we normally see about 80 patients between the three of us in a day's time. So what they do is they identify two patients for each provider and they use basically their knowledge of our patients because they see them every day. We pick patients with multiple medical problems, someone who might have a recent major disease diagnosis, especially like a new diagnosis of cancer, we have people who have a significant change in their social status like a death of their spouse or somebody else in their family, and then of course we also include some of the elderly who are starting to have some cognitive decline that may be subtle at first and those are the main ones that we're focusing, the people that don't already have that diagnosis of depression. Those patients are marked in our chart.

We use electronic medical records, but I have a face sheet and they put a little blue dot, a sticker on the patients that have had the questionnaire and I guess they chose blue to remind me that they might be getting depressed or that way, so what we do is those patients while they're waiting on me will have filled out the questionnaire and we use a patient health questionnaire, PHQ-9 that has a simple questionnaire formula that has a numerical value and when they're sitting there talking to me I look at the value and determine if they're mild or moderate or severe, and then I start discussing more in depth during that particular encounter their depression. If they choose, and I think they need medical management then I'll start that myself and if they decline, which about half of them do and some more than half of the men seem to not really want to start medication, then they go back to our patient care coordinator Jesse who has had additional training and motivational interviewing techniques and is doing things currently to enhance her ability to help these patients and that's the path that they take.

And then in follow up usually a month later we give these people the same questionnaire and we're able to see if there's been improvement in a way that we can actually document numerically.

Very well said. Let me just kind of highlight a few of the issues that I could certainly bring up like [inaudible] technique is great. First of all, it looks like you're on a smoke break huddle. You described the need and the importance of communicating as a team, documentation, measurement, with clinical judgment included in there. I heard patient [inaudible] within the visit, I heard the importance of offering up non [inaudible] interventions like [inaudible] follow up and then documentation again. That sounds very thorough. Thank you for that.

Let's go back to Colorado, Yampa Valley. Can you tell us a little bit about your work flow for delivering behavioral health integration?

Sure. So we decided also to focus on depression and we use the PHQ-9 as well, but we start with a prescreen which is the PHQ-2. So we screen all adult patients with a PHQ-2 at every visit so it can be a sprained ankle, an infected finger, a physical, it doesn't really matter what visit type. If they're coming into the doctor we ask them those first two questions. If they, you know, if it's a patient that comes frequently, you know, every week or every other week we try to use good judgment so that the questions don't become annoying. So we try to catch every patient in the clinic at least one time per month with that screen.

If they screen positively to the PHQ-2 we follow up with a PHQ-9. The initial prescreen is asked by the nurse or the MA when the patient is roomed. If the patient screened positively to that PHQ-2 the nurse hands them the PHQ-9 to be completed. If the behavioral health clinician is in the clinic at that point the nurse would notify the behavioral health clinician of a positive screen and then I'm able to go in and visit with the patient, oftentimes while they're waiting to see the doctor to review the PHQ-9 and just talk to them about how they're doing. Yeah. Give them some extra support around depression, stress, sleep, anxiety; it can cover a lot of topics.

So my role as a behavioral health clinician I think is to navigate that clinic workflow as best I can. So if I can get in and talk to patients while they're waiting for the doctor I find that to be really valuable, or if the doctor is right on schedule then I work with the doctor and the nurse to get in at the end to make sure that those screens are addressed.

We've also found, you know, and I can talk to patients about any topic, so you know, if the nurse or the doctor feels that the patient could use some support around stress or improving sleep or changing diet and exercise routines, managing anxiety, chronic pain, and then connecting to counseling. The doctor or the nurse can introduce me to the patient, so even if they haven't even screened positive I can still kind of have an introduction and offer support for the patient. So we find that warm hand off, that introduction to be really helpful in building trust between the behavioral health clinician, and you know, and the patient.

So, if I'm not in the clinic as the behavioral health clinician we have a referral process that doctors or nurses can leave referrals for me to follow up with patients on the phone or I can -- I keep track of the list and follow up with the patient in person the next time they're in the clinic. I think -- and then I guess the last thing that I'm available for is brief follow ups. So patients can make some appointments with me. I really try to keep those appointments limited and brief, so maybe a 30-minute appointment,

maybe three visits over a month to support them in whatever goals they might have around behavioral health or mental health, and then I do a lot of connecting to resources, so trying to connect them with ongoing therapy, psychiatry support, that kind of thing.

That's great. Thank you so much. And you bring up an important issue too that I think is kind of critical to remind us at this stage and that is that the screening tools that have been proposed such as like the PHQ-9 can also be used repeatedly over time to monitor symptoms, and I think we all heard that just a little bit from each of the -- I don't want to leave this topic because I heard a couple of things come up. It might have been implicit within your answers, but I want to go back to this last question here, or number three, around delays and services. So what happens if there are high demands from the behavioral health team that day or for the behavioral health services, and there does need to be some type of waiting how do you all track or make sure that patients don't fall through the cracks? What are some of the strategies that you've found that once you've identified so you can follow up with those patients over time. Let me go back up and I think because you mentioned this just a minute ago [inaudible] let's go back to you and just ask what is your process to make sure that patients don't fall through those cracks?

Sure. So within our EMR nurses, doctors, providers can send me messages about patients and so I can keep kind of a track of those messages. All of my documentation happens within the EMR so doctors, nurses can see what I'm working on with patients, and I also have the ability to set kind of a tickler system, so if I want to follow up with a patient next week or in two weeks I'll get a reminder in my EMR system to call that patient.

Thank you. And Dr. Tilley, I want to go back to you on this one as well. What happens when they're [inaudible], how do you all make sure that you can follow up with those patients that you might be able to do something with that day?

We use a similar documentation and every time that I treat one of these patients in this category I document that and I'll also send the referral or the notice or a message to the patient care coordinator. That same message goes to the nurse group. I use just as a blanket because if the patient care coordinator isn't there or she's doing something else at that moment she's not able to take care of that then they take note of that and also use a similar thing to make sure that that is followed up on. And that's -- I neglected to mention earlier, a part of what they talk about in their huddle meetings when they're discussing who's coming up and have they been seen before. We haven't been doing this long enough to see a lot of follow up yet, but they already are using that process to make sure that as few people fall through the cracks as possible.

Thank you. And I just realized that we had a question that came through that I wanted to make sure that we covered and [inaudible] it's going to come back to you. And the question is what is your numerical cut off for a positive PHQ-2 and what score on a PHQ-9 do you consider for a patient to be diagnosed as depressed?

30:13

So with the PHQ-2 we say it's one of two questions if answered positively, and those questions are in the last two weeks have you lost interest in things that you used to enjoy and in the last two weeks have you felt down, depressed or hopeless. And if the patient answers yes to either of those questions we consider that a positive prescreen, and then they complete the PHQ-9 and I don't have my specific cut off for the PHQ-9 at my fingertips, but we use that as a screen and not as a diagnostic tool. I think it just gives us an insight as to how the patient is doing and for further evaluation and conversation around their depression, so it doesn't necessarily mean a diagnosis of depression. Although it definitely outlines the symptoms of depression.

Great. Thank you. Let's go back Janet to you, I want to before we do this last question I just want to check in with you and see if there's anything you want to add on what happens when there are patients that are identified, did not have a delay in receiving services.

Sure. So just part of what -- part of the follow up if there needs to be a bridging mechanism between when we've identified the patient having depression and when we're able to see them again is based on our sort of collaborative work flow because the -- we also use NEHR so that the providers and the nurse practitioner are all able to work together in terms of the diagnostic direction what's happening with the patient, and once the provider has referred the patient and patients are referred from providers, care coordination, payer data, we also do the PHQ-2 of the screening for every patient every visit as part of a document we call my agenda where a patient is able to write why they're there for the visit. And the PHQ is embedded in that and that also triggers the PHQ-9 if either one of the two questions are positive. So we have kind of a broad base of referral to the providers and if the patient is identified but can't be seen that day or is already being seen but can't be seen more frequently we have a couple of strategies. One is that the provider will see the patient as a bridging technique until the behavioral health provider is available. Another is that we do have a behavioral health provider at another site that we can set up an appointment to be seen at the other site which is maybe 20 minutes' drive from here. And a third thing that we've been doing is care coordination is working pretty closely with behavioral health both on a population management of depressive diabetics and also in general trying to help with the work flow for behavioral health because it has caught on. We do have repeat visits. The initial is one hour and the repeat is 30 minutes, but that's why we're looking for a second behavioral health provider so that we can cover five days a week and when there isn't an availability to get someone in in the timeframe the behavioral health provider would ideally like then care coordination will make outreach calls to just sort of keep in touch with the patient, make sure that there is -- if there is medication on board that there is adherence, maybe help them to find a support group in the community setting, and we also use an internal email called the [inaudible] to keep in touch about patients and the behavioral health provider will always find the provider who has referred the patient and either write a note or do a huddle with them or have some sort of feedback within usually two to three days after seeing that patient initially so that they can create a plan of care together about where they're moving forward with the patient.

Excellent. Thank you. We're getting some amazing questions here and I don't want to lose our stream of consciousness here with the topics. So let me just stay on the charting for a second. And then let me ask and I will actually start with Dr. Tilley, you on this one. One of the questions that came in from the

community is do you have any privacy issues with charting in the electronic medical records for behavioral health, and if so how do you overcome this?

No, I think we haven't really noticed that much because everything we do is internal and what we publish to the patient portal is it is what we choose to do and frankly that hasn't really come up to be an issue yet. I know that there are patients who are reluctant with the whole electronic medical record system about privacy, but I mean we basically apply the same HIPAA idea across the board regardless of what we're talking about, whether it's a sore throat or somebody's depression or suicidal ideation, so that really hasn't been a big issue for us.

Okay. And let me just open this up for Yampa Valley or for Vanguard. Either one of you had any issues with this around privacy and confidentiality in the electronic medical record or anything you'd like to add to what's been said?

This is Janet in Verona. I haven't had any issues here with privacy or confidentiality problems. As a matter of fact I think it's actually been extremely useful for the primary care doctor and for care coordination to be able to read the behavioral health notes because we are then able to really surround that patient with the type of support that they ideally could use. But what I did find, and this was one of the questions that was a little bit later and that we may be covering, is between outside agencies of our practice it can be really difficult to help patients engage transitioning from say one IOP to another IOP or one inpatient facility to another inpatient facility. Between facilities sharing records seems to be very disjointed. Some facilities will fax the records to the new place. Others will only have them sent to a service they use printed and mailed and that can take so long that if a patient really needs that intensive help within an inpatient stay it can be very difficult to help them to bridge and sometimes we'll use our in-house behavioral health person to sort of stay the course during the five or seven working days that it takes for external facilities to work together, but I find that there's not one uniform way that records are shared or kept and that has been an issue on several occasions helping patients to negotiate the medical neighborhood of behavioral health services, but not really at the practice.

Thank you for that. This is a really critical area and I think many times when you start talking about behavioral health integration one of the first things that individuals bring up is around privacy, confidentiality and HIPAA, and I will tell you there's quite a few resources that are out there that can help educate us all on what's allowed and what's not allowed. One of the key takeaways though that I think I can say here, and we actually kind of ingest in our [inaudible] call it HIPAA-annoia unfortunately sometimes people get a little bit too activated over what HIPAA does and doesn't do in this space and so our rule of thumb is that when you're working on the team and it's staying under the same roof together collaboratively with the patient this is what health care is about. This is what we should be doing. And so you're actually protected as an entity in that context. As Janet was just saying, sometimes when you leave the safety of your practice and you collaborate with external providers that may have different types of ID status and the like it becomes a little bit more challenging and that's where we need to get releases of information and the like. But I would encourage all of you to look into this issue because there's quite a few dispelling of myths that we could do as a community around this topic that I think would go a long way in helping us promote better integration.

I'm cognizant that we're getting close on our time here and I want to make sure that we get to all our questions, so let me go to our next question. We've had a few come in from our community around reimbursement attainment and I know that's a big topic and I want to get to there, but let me go on to our question number four because I do think this is critical for those of us that have seen transformed practices to describe what differences have we seen, whether it's in our providers, whether it's in our patients since we've integrated behavioral health. And we can start with you in Colorado at Yampa Valley. What differences have you seen in your practice?

I have seen some really positive differences. I think there is an openness and willingness to talk about mental health concerns and, you know, in a competence in that we're better able to address them either through my work as a behavioral health clinician. And just to mention I am an LPC, so I am trained as a therapist, which I think is kind of helpful in thinking about how we address our mental health concerns.

39:55

I also hope that we're reducing stigma around mental health and giving patients an avenue to talk about, you know, how they're feeling in a setting that they're comfortable, you know, with a doctor that they trust and hopefully opening up additional conversation around mental health, depression, anxiety. Also, let's see, I think the providers specifically who have really learned to work with me have found -- I hope they find that there's more time in their days. So if they have a particular patient that takes up, you know, who might be a very long -- likes to tell lots of stories and talk about their stressful weekend or the stress, you know, maybe trouble with sleep or things that, you know, behavioral health things that the provider might be able to hand off to me and sort of I can take the reins on certain topics with the patient and really help the patient feel heard. So I hope the providers feel like they have my support and also hopefully have a little more time in their days. And then I think also there is a better connection with our mental health community I think that the doctors I work with have a better understanding of psychiatric services available, counseling available, how the mental health center works and other private counseling providers in town.

Thank you so much. Let's go back to Tilley Diagnostic in Arkansas. Dr. Tilley, what differences have you seen in your practice, your providers and your patients since you started doing the behavioral health integration?

Well more specifically within the practice I think the nurses have definitely felt more engaged in the total care of the patient rather than just being more focused on patient flow, taking vitals and taking care of things after the visit. I think they've gotten more interested and certainly have seemed to be very pleased with identifying those patients that need and I've noticed that within the practice. The patients themselves have most of them have been somewhat surprised to have this brought up, especially as I mentioned before the guys who seem to be a little bit more reluctant to talk about certain issues and even though they may seem surprised at first they also have [inaudible] that we have taken the time to ask something more than just how their diabetes is doing or about their blood pressure, are they exercising as much as I asked them to do last time, so I think that's made a difference. And in the same way with the providers. I think it's brought us a little bit more comprehensive level of care that we can

take pride in and feel good about and I think it's helped overall. We haven't done it long enough to see much more than that, but I have noticed that initially.

Great. Thank you very much Dr. Tilley. And Janet let's go to you. All right. Tell us a little bit about the differences that you've seen since you've started behavioral health integration.

Sure. Well, we've seen a lot of difference and I'm in the process of working with our nurse practitioner to try and figure out -- try and quantify this a little bit. She has an active case load of about 133 patients. She had 110 appointments in April over 13 scheduled days with a 9% vacancy rate, so that would be 10 slots out of her entire April schedule were either not scheduled or were no shows. So I think that that shows that there is a very concentrated need and utilization of her services. We're able to offer this to patients who couldn't afford a private pay option because of, you know, because of whatever insurance plan they're in. The fact that providers are more likely to refer to behavioral health because they have some control about the access and they have a knowledge of what type of therapy is going on if there's going to be medication started they can make sure that it's going to be collaboratively developed along with what the other comorbid conditions may be. The patients are very comfortable accessing services in a familiar location. Like just episodically I've noted that patients who tended to have more sporadic use of outside behavioral health and many missed appointments frequently have better adherence to their onsite behavioral health appointments. We're able to track when a patient has not been into see the nurse practitioner, and that's almost impossible to do when they're using outside resources. And there's a much more fluid flow into outside services. I think that all of us on staff are much more aware of psychiatric emergency screenings, what every county in New Jersey has a mobile unit, we're more aware of what hospitals have an ER that has a mobile unit or what hospital has an inpatient unit, what the IOPs are, which IOPs will service adolescents, and whether there are counseling options within our community and slightly outside of our community and neighboring counties. So just the sort of cascading information that has come out of having behavioral health onsite has been very useful to the team and I think that the patients really are much more likely to try it even if they are initially hesitant. I often find when I speak with patients that with a new diagnosis for example that they're a little hesitant to take on another appointment, but when you explain that behavioral health might be a way to help them cope with a new diagnosis, or with their spouses or their parent's new diagnosis it's something that they don't always think of on their own and I have many, many patients who come for short-term sort of a bridging technique to get through the crisis period of having such a change in their life where they are mostly responsible for managing that change and I have found that to be sort of an unintended benefit of having behavioral health onsite that it's not really treating a current depressive issue or really an issue that the patient had prior to being the caregiver for someone else who has a problem. But it's been a wonderful resource.

Thank you Janet. We have several questions coming in on financing, and I'm going to jump to that in just a second. First of all, let me address another question that came up and is around summarizing the screening tools for follow up and the scores. And the PHQ I think has been most predominantly mentioned today, and let me just give a quick one-on-one on that very briefly. Most practices who use the PHQ-2 just so you know where that comes from is the first question on the PHQ-9. And while each PHQ-9 question gives a patient a chance to rate it on a scale of one to three, they really the PHQ-2 is

used as almost like a pre-screen for the PHQ-9 as you heard Leah describe. The symptom and the severity based on the scores is very simple. If you're using a PHQ-9 [inaudible] you have 27 total score, one to four would be considered minimal depression or none. Five to nine might be in the mild depression range. Ten to 14 would be in the moderate depression range, whereas 15 to 27 -- 15 to 19 actually is what we would call moderately severe, and then 20 to 27 is the more severe depression range. And so just using cutoff scores like that oftentimes practices do make different decisions depending on the scoring criteria. That was a great question.

Let's go down to financing here, which is a little bit of a curve ball for our practices, but I think that many of the folks out there asking about this are getting at some of the heart of the issue here around how we support financially the behavioral health integration. So one question that came in asked are you billing separate for the behavioral specialist visit, and if so how are you handling multiple copays? So let me just open that up to all three of you, and if any one you'd like to discuss that please let me know. Maybe I should have asked a question. Are any of you billing separate for your behavioral specialist visit?

This is Dr. Tilley. We aren't because we're utilizing this within the clinic, so we basically use the patient care coordinator and her skills as another way of not having to try to refer out to any of the referral resources that we have because they are so limited. So we pretty much incorporate that into the current visit and we are not billing separately for that at this point.

Great. Janet or Leah, anything to add to that question?

Well, this is Janet. So we're working on a model that is based on the Federally Qualified Health Center Model which the Cranford office first saw in an Institute for Healthcare Improvement conference, and we follow those guidelines. So our -- we're billing as the bills -- the psychiatric nurse practitioner bills by time spent face-to-face time, not the complexity of the diagnosis. And behavioral health diagnoses are used, but regular CPT codes are billed.

Great. I think that answered one of our other questions, which -- what codes are you using for billing.

50:00

Leah, let me turn to you. Are there any other additional items that you'd like to add here on either what codes you're billing or how you're taking care of the behavioral health service in terms from a financial perspective?

Yeah. I don't have much to add because we do not bill for my services. A lot of my work for the last five years has either been grant funded or through CPI funds.

Great. Thank you. Well, Leah, let me stay with you just for another second because we had another question to come in that I think is aimed a little bit at you. And the question is just curious how many warm handoffs do you see for follow-up counseling at another time. So how many times do you see a patient there in the moment from the warm handoff versus maybe in the later point in time another day for a counseling appointment?

Sure. So my ideal day I shoot for 10 warm handoffs, so that could be the provider introducing me or that could be me just going in and having a meaningful conversation with a patient about behavioral health, meaning that I've talked to them about intervention, their strategies they can use to better manage their mood or their stress or their sleep, whatever the issue we're talking about. And then with my work at Yampa Valley which is just the last two months that's really given me the ability to schedule with patients and I think that will be kind of a work in progress, something I need to monitor and let go because I think there's a great value of me being available for the clinic and the providers knowing I'm there and being able to pull me in in that moment when the patient, you know, is struggling with mental health or whatever the issue might be and being able to introduce me at that time versus trying to follow up with a patient at another time. So I guess in my ideal day if I could have 10 warm handoffs that are just very brief in nature maybe 10 minutes with a patient, and then maybe five or six follow-ups with the patient, which might be 30 minutes in length.

Thank you very much. We're going to move onto question five, but Janet I'm going to come back to you because there was a clarification on your answer. And they specifically wanted to know about which code in particular are you using for the nurse practitioner that you described.

Okay. So we're using primary care visit codes. I think you should email me. I think you should --

Okay.

They should email me so I don't give the wrong code number, but we're using primary care codes.

Yeah. There's a couple of those codes out there, so I understand how that might be confusing enough. An email follow up would be more appropriate. Thank you for that. Okay. We've got two more questions here, and we're running out of time, so let's just quickly go through these and then finish up for today. So question number five, what would you say remains the biggest challenges for behavioral health integration? Janet, let's just stick with you on this one.

Okay. So well, I think I've mentioned what I think is one of the two issues, access like consistent follow-up access I think is a real challenge. As I said we're trying to add a second person to our behavioral health team and she currently does do a lot of follow up with patients, but you know, you don't want to become the same problem that you've complained about in the community where there's an in network provider who doesn't have any appointments or no appointments within let's say three to four days when the patient really needs to be in to see someone. So I think access is always a big issue. Behavioral health patients who have long-term diagnosis, more difficult diagnoses aren't always adherent patients, so trying to find a way to do follow up with them in between visits which is sometimes what care coordination does. We step in and work with the behavioral health provider to make those intermediate phone calls and do some care coordination work to help that patient understand that this is a very valuable appointment that needs be maintained just as any specialist appointment or primary care doc appointment would be. So trying to ensure that patients are adherent to their behavioral health schedule. And then trying to work with other providers in the medical neighborhood in a more collaborative way. I think that those are all challenges that the actual subspecialty of behavioral health I think is, you know, it's a very complex area and the people who work within it, you know, it takes a

while to kind of get to know what's normal and what's expected in this area. It's not so protocol driven as the rest of medicine seems to be. So you have to be a little more flexible. You have to utilize community resources more and, you know, kind of wear that hat a lot when working with the behavioral health patient.

Great. Thank you. Dr. Tilley any quick challenges that you all continue to see from behavioral health integration?

The integration within the client has not been that difficult and actually is going pretty well, and we're making the biggest effort on trying to keep things in the clinic as much as we can because clearly our biggest challenge is outside of the clinic. We have both federally funded and privately funded counseling services available locally, but very little by way of actual psychiatric intervention is available because our psychiatrists in the area are spread thin and just aren't very well assessable to us. So we're trying to do everything we can to keep things in and that clearly is our biggest challenge is what do we do with the problem patient that we've identified and tried to treat? Where do they go and how do we get them there is still something that we haven't yet quite solved.

Thank you. And let's go to our last question, and Leah I'm going to turn to you on this. What tools, resources or training have you and your behavioral health integration team found to be the most useful?

So a lot of the training and experience I've gotten is kind of just in the moment like trying to figure it out as we go and learning to be flexible and adjusting to the practice, you know, as needed, adjusting to providers as needed. The SAMHSA integration website I have found to be really valuable, and I can make sure we have that link available to everyone. I also -- I seek out webinars. I think there is some good websites and just I think just reading as much as I can on the internet and then reaching out to experts like you to verify what I'm doing make sense.

Thank you very much. Krystal I'll turn this back over to you just because of our time.

Great. Thank you, and thanks for all of our wonderful questions today. I know that there are a few that have been left unaddressed and what I'd like to say to everyone who is still waiting on an answer that we will develop a follow-up question and answer document that will be posted to the collaboration site and it can include things like the resources that were mentioned by our panelists. So with that I want to thank everyone for attending. We hope that you found this presentation informative. You can exit this session by clicking on the file menu option at the top left of your screen and select the option to leave the session. You will be taken to a post-webinar survey that needs to be completed in order to receive credit for attending this presentation. And once again, thank you for everyone's time and participation in today's webinar.

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