CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation

Practice Spotlight 7

March 7, 2014

In PY 2014, CPC practices will select one of three advanced primary care strategies — **behavioral health integration (BHI), comprehensive medication management (MM)** or **support for self-management (SMS)** — to build their practices' capability to provide comprehensive primary care. Each strategy may require refining your methodologies or enhancing your care team resources. In the coming weeks, the Practice Spotlight articles will highlight practices that have taken on these new strategies and share their "boots on the ground" approaches for this work.

More than one in three people in the Eugene metro area sees an Oregon Medical Group physician as their primary care provider. Employing more than 120 practitioners across 13 clinical sites, Oregon Medical Group is a physician-owned independent practice offering primary care in family practice as well as audiology, dermatology, gastroenterology, lab services, obstetrics, gynecology, otolaryngology, physical therapy, radiology and imaging services. Two practice sites are enrolled in CPC with about 21,000 empanelled patients.

Oregon Medical Group is well underway with integrating behavioral health specialists (BHS) in its two CPC practices and has started a pilot project of tracking improvement among patients with diabetes and depression. **Kathleen Howard, MS**, director of patient care and clinical support, is delighted with how far the group has come and how quickly they made it happen.

> *Although Oregon Medical Group is working with BHS as part of its team, it is not required to do the work of BHI for Milestone 2.*

"Of course CPC funding was a kick-start," she said. "But revenue is just one part of the picture until payer reform happens. When we started out, we looked at the whole picture. What would staffing patterns look like? How do we access other providers in the community? How will we know we're on the right path?"

The Eugene health care community is like every other health care community in this country: It has unique local characteristics that require institutional knowledge and working relationships with key providers.

To help Oregon Medical Group navigate the local health care environment as well as the payer expectations, **Terry Stimac, PhD**, a licensed clinical psychologist came on board in July 2013 as a subject matter expert and consulting psychologist. Terry's previous experience included serving as director of outpatient behavioral health at PeaceHealth, a large health care system in Oregon.

Terry Stimac, PhD, licensed clinical psychologist, and Kathleen Howard, MS, director of patient care and clinical support at Oregon Medical Group

"Terry's insight helped us steer through the community dynamics and helped us form a feasible model by coordinating with the local health plans," Kathleen said.

Terry and Kathleen started planning for the integration of BHSs by matching reimbursements with clinical

licensing standards. While complete payer reform will shift the model to population health and away from Fee-for-Service (FFS), the reality is that the start-up period must include a revenue stream to support staffing additions and expanded workloads.

Practices should consider engaging billing specialists or other persons knowledgeable about FFS reimbursement trends in the planning stages. Terry noted that not all payers in his area will reimburse for triage and care management, but they will pay for assessment and therapy in the practice setting.

Details like this are fundamental considerations in establishing the workflow and assigned tasks for staff. *(See table for tasks and assigned staff.)*

Task	Oregon Medical Group Staff Responsible
Screening/identification	MOA, BHS, Nurse or Care Mgr.
Evaluation/dx	Physician (hand off to BHS)
Referral Coordination	BHS
Tracking/measurement	Data analyst (data and risk mgmt.)
Family and caregiver support	Care Mgr.
Consultation	Consulting Psychologist

Note: This table can be adapted so the tasks Oregon Medical Group assigned to a BHS can be accomplished with other team members.

The next step was to engage physicians. Not only does physician buy-in influence how staff will embrace change, but it was also important to have a two-way conversation about expectations and needs during the integration of BHSs.

"Before planning the workflow, you need to ask your physicians what they want," Terry advised. "Our physicians specifically said they wanted access and real-time feedback when they referred patients to the BHS."

If you choose to hire BHS, what should you look for?

When adding a BHS to your team, Terry had three recommendations for practices:

1. Identify the professional who is familiar with your community resources and providers.
2. Make sure the BHS is a match for your clinic's culture and patients.
3. Ensure the BHS's credentialing allows for appropriate billing and reimbursement as well as clinical tasks.

For Oregon Medical Group, a licensed clinical social worker (LCSW) was a good fit for assessment and triage as well as working with the clinic's care management team. Oregon licensing requirements also allow them to use MOAs (medical office assistant) or MAs (medical assistant) for administering screenings.

"Our LCSWs quickly proved their value to our physicians," Terry said. "They are reliable and experienced, and their willingness in general helped smooth out operations."

At this time, BHSs are embedded in the two CPC clinics one day a week. The medical group has plans to add a second day as the schedules fill. At that point, behavioral health integration will then expand to other clinic sites, which they expect to happen in 2015.

Who to screen? How do you screen? What tool?

Currently, Oregon Medical Group screens patients as physicians refer them. The MOA or MA provides the patient with a Patient Health Questionnaire, or PHQ-9. Patients can easily complete the one-page tool in a few minutes, and the MOA can score it equally quickly. It also can be administered repeatedly over time, which is useful for tracking a patient's progress. *(See insert on the next page for Oregon Medical Group's scoring, diagnosis and treatment considerations for adults.)*

CPC practices are encouraged to refer to the Program Year 2014 Implementation and Milestone Reporting Summary Guide, pages 10–13, for an implementation framework for behavioral health integration. This section of the Implementation Guide also includes key questions practices should work through as they plan this work.

BHSs also may use other screening instruments according to patient needs. Terry pointed to the SBIRT (Screening, Brief Intervention and Referral to Treatment) tool as appropriate for early identification of chemical dependency and referral for treatment. The practice's physicians selected patients with diabetes who also have a diagnosis of depression as a patient subgroup to track over time. Later this month, Oregon Medical Group will mail a PHQ-9 to about 700 patients eligible for this subgroup. As responses are returned, scores will be

recorded in the EHR. Over time the practice will track scores on the screening tool as well as look for improvement in the patients' HbA1c results.

"We're following a model called the DIAMOND study that had exceptional results," Terry said. "Based on the patient's score, we'll modify care management and intervention."

Later in 2014, the practice will expand screening by asking all patients to complete a PHQ-9 during their office visits. One important consideration in operationalizing this workflow was to ensure payers would reimburse for administering the PHQ-9 separately from the E/M code.

At Oregon Medical Group the BHSs record the PHQ-9 scores in the practice's EHR, allowing physicians the quick feedback and input they wanted. If a referral is needed, the BHS coordinates that as well as any care coordination services with the care management team. The follow up and follow through assures the physician that patient needs are met appropriately and in a timely manner.

If the patient is referred to a specialist, the referring specialists agree to communicate patient status back to Oregon Medical Group, so the BHSs can track if patients are adhering to treatment. If patients drop out or are a "no show" at appointments, the BHS contacts the patient.

PHQ-9 Scores, Diagnosis and Treatment Consideration for Adults

1. If PHQ-9 is less than five, no intervention is necessary. Re-test in 9-12 months. If second score remains less than five, consider changing diagnosis from depression to history of depression.
2. If PHQ-9 is between five and nine, ongoing follow up with PCP is suggested with a PHQ-9 in three to four months or when seen in follow up at least once per year.
3. If PHQ-9 is between 10 and 14, consider diagnosis of Dysthymia and antidepressant medication and possible referral for mental health evaluation. Re-administer PHQ-9 in three to four months.
4. If PHQ-9 is between 15 and 19, consider diagnosis of Major Depression, moderate to severe and antidepressant medication and referral to mental health provider for assessment and treatment.
5. If PHQ-9 is 20 or greater, and/or current suicidal ideation, immediate referral to a mental health provider for assessment or warm hand-off to the mental health specialist in the medical home is recommended.

Author: Terry Stimac, PhD

Putting it all together

At first, integrating behavioral health was an intimidating task for Kathleen.

"It's big and it can be hard to do," she said. "Our physicians knew they needed this in our practice, but it takes time to make it work."

However, when it works, it immediately makes a difference for patients who need the services.

"One Friday afternoon at the end of the patient visit, we identified a patient who was clearly in crisis with suicidal ideation," Terry recounted. "The physician connected the patient to our BHS with a warm handoff through a phone call. The BHS evaluated the patient over the phone and set up an appointment for him on Saturday morning."

Terry continued, "She also set up a crisis plan if he worsened overnight. They talked about who he should call and where he should go if he felt he needed help. He understood that help was waiting for him the next day, but just in case, he had a plan."

The patient was seen the following day and started treatment.

"Our physicians are thrilled," Kathleen said. "They are relieved that we can help people like this and it's amazing to get the right services at the right time. That's what it means to be a patient's medical home."

In the next Spotlight: An In-Depth Look at Medication Management

TMF Health Quality Institute

This material was prepared by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Any statements expressed by the individual and resources cited in this publication are not an opinion of, nor endorsement by, TMF or CMS.