National Webinar: Deep Dive into Behavioral Health

Presenter: Benjamin Miller, PsyD

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Hello, everyone. I'm Krystal Gomez from TMF's Health Quality Institute. Welcome to our national CPC webinar entitled Advanced Primary Care, The Role of Behavioral Health on the Primary Care Team.

I'd like to start things off today with a few announcements. The slides for today's presentation are available for download on the collaboration site. You can also download the slides directly from the WebEx environment today by using the top toolbar and selecting File, 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 presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products, or vendors are expressions of opinions of the person speaking and not an opinion of nor endorsement by the Center for Medicare and Medicaid Innovation nor TMF's 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 Q&A tab on the right-hand side of your screen.

I would like to begin by introducing someone who you are all familiar with, Dr. Laura Sessums. Laura Sessums is the division director of advanced primary care at CMMI.

Next, I'd like to introduce our subject matter expert for today's presentation, Dr. Benjamin Miller. Dr. Miller worked as a postdoctoral 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 initiatives involving integrating mental health into primary care.

So I'd now like to hand things over to Dr. Sessums to get us started today.

Thank you, Krystal. In January, as you recall, we had a national webinar about the three advanced primary care options for milestone two in this program year, behavioral health integration, medication

management, and self-management support. We've heard from across the region since then with many questions from practices about these advanced primary care options. And I know a number of practices are struggling with how to decide which of these options to choose and how to do the work. I certainly hope this webinar will provide very helpful information for you on the behavioral health integration option as you consider which of these options to choose when you do your first quarterly reporting by April 4.

As you'll hear today from Dr. Miller, an important question to consider in thinking about this are the needs of your population. In my practice, some years ago, we had a number of older patients with cognitive issues. There was also a separate group of patients who clearly had underlying behavioral health and or psychosocial issues that were complicating their engagement with the health care system and with meeting their health care goals. Substance use was yet another concern. And we wondered, what should we do to work on all these issues?

Our decision, initially, was to focus on depression and substance misuse. So with nursing staff, we developed a strategy for screening patients during the intake process. As patients were getting their vital signs checked, we screened for depression, and we used the PHQ-2, and then for alcohol and tobacco use. The results of that screening would show up in the EHR when the physicians or the nurse practitioners were seeing the patient and documenting the encounter.

Using a protocol, when the nursing staff identified a patient with concerning results on the depression or alcohol screening, they would verbally tell the provider, sort of like a warm handoff, so that those issues could be addressed right up front at the beginning of the visit. We actually were able to document that this screening process increased the number of patients whose tobacco use was addressed during office visits. And the screening really helped us identify patients with depression and alcohol misuse we likely would have missed. And so we could begin treating those folks.

A year or two after starting the process, we were then able to bring a psychologist into our practice on a part-time basis. And that improved our behavioral health treatment and consultation options even more.

Yet, none of these efforts addressed the cognitive disorders that were a significant concern among a different segment of patients. And the time providers would spend on treating problems in our large elderly population, who had a high prevalence of cognitive disorders, really was tremendous.

After realizing the enormity of the problem and the frustration that this engendered in our staff, not to mention the declining health of and risk of harm for these patients, we engaged one of our existing nurses who had a very strong geriatric bent. With some additional training, she became our geriatric care manager. And she was amazing. She could facilitate cognitive testing, engage community resources to support the elderly, and spend time with patients and their families and caregivers on the myriad social issues.

It was an incredible resource for patients and families. And I certainly felt a huge burden lifted off my shoulders. I was now able to focus on the medical problems the patient had and know that resources

were in place to make sure that they could get their medicine, get to specialty appointments, and the like.

I know you all want to hear a lot more about behavioral health integration. So let me turn the presentation over now to Dr. Benjamin Miller.

Thank you, Dr. Sessums. And what a wonderful way to start our talk today. I really appreciate you putting a face on what this looks like in practice. And we're going to do that again in just a minute here from actually one of our CPC practices in the field as to what they're doing for behavioral health.

Well, I want to welcome everyone. Today's webinar, as you know, is going to focus on behavioral health and ways that you all can better integrate behavioral health services into your practice. Our agenda will go as follows.

First, I'm going to highlight the milestone two requirements for behavioral health integration, paying specific attention to the definition of what we mean when we say behavioral health integration and the intent of the milestone. Next, I'm going to turn the mic over to my colleagues at Foresight Family Medicine in Grand Junction, Colorado to describe some of the work they are doing around behavioral health integration. And finally, we'll spend most of our time really describing strategies for primary care and how to better integrate behavioral health.

So let me start by turning it over to Dr. Reicks here. And we're going to hear from our practice in Grand Junction. It's going to be Dr. Greg Reicks, who's a family physician in Foresight Family Practice, and Lisa Barnes, his behavioral health provider. They're really two of Colorado leaders in this space. And we want to start with their story today.

So Dr. Reicks, can you and Lisa kick us off?

OK, thanks, Ben, for that introduction. And we're really excited to be part of this call and share some of the experiences that we've had so far with integrating behavioral health into our practice.

Just a little bit of background about Foresight Family Practice, we're a three physician practice with two mid-levels in Grand Junction. Grand Junction's a community of about 50,000 people but serves really a medical neighborhood of probably 150,000. We do have a local mental health center here that provides the mental health services, especially for our low-income or under-served population.

Our experience with integrated behavioral health began about three or four months ago with the decision by the practice to integrate a behavioral health specialist in our office as part of milestone two. And we spent quite a bit of time looking for the right person, interviewing a few people. And finally, we were able to really hit the jackpot finding Lisa, I think, to come into our practice and begin offering integrated behavioral health services.

So I'm going to turn the microphone over to Lisa right now. And she's going to talk a little bit about the workflow.

So if you want to go to the next slide, that'd be great.

Thank you, Ben, for inviting us to speak. This is Lisa with Integrated Behavioral Health Services. And I've taken off my therapist hat. And we're looking at mind and body as one. So that's why my job title is integrated health specialist. And I hit the jackpot being able to do this with this job, too.

In this job, I come in early and look at the patients who are scheduled for the day and pick out those that providers are seeing who may have chronic health conditions, who are high on our risk scale, or maybe in the second tier of risk, but those whose conditions or kind of a perfect storm of events could jump them into a high risk category. Those are the people I'm seeing, those with chronic pain, sleep disorders, weight concerns, high A1Cs, depression, and various other mental health concerns also.

So I make a list for the providers. As I'm available, they call me in after their exam. We do the warm handoff. I take the patient to another room.

I think part of being an integrated provider in a practice is that collaboration with providers. We're working together. Sometimes I see patients who have high risk or adverse reactions to medication. So we consult with each other about concerns.

Meeting with patients, I can't be in exam rooms because of the need for the exam room space, I think this is a universal problem, exam room space for providers and patients. So I wander the halls and find an x-ray room or other places, just where we can meet in private. And it works. Being adaptable is part of this position.

I think that one of the areas that we have found is those patients on the high risk scale, we're doing intensive case management and helping those patients get their mental health and physical needs met to help them stay out of the ED and hospital and also move toward health or the high care that is needed. So I'm focusing more on patients in the second to third tiers of risk. We want to help those people move toward health in the community outside of moving into that higher tier.

I think one of the great advantages of this job is I'm able to use my behavioral health skills in identifying those patients with mental health and substance use disorders. And also embedded in that is looking at people's resiliency and resources, external and internal, and be a presence in their life.

I understand we'll be addressing questions later, Ben?

Yes, you will.

Thank you both very much for that. It's wonderful to start off with an example, both from Dr. Sessums as well as from you all at Foresight on what this looks like in practice.

Let's go a little bit deeper now into the definition that we've used for CPC for behavioral health integration. And as you just heard, behavioral health can address a range of mental and behavioral health issues. And we're going to touch on that range in just a second. But as a reminder, here's the definition on your screen.

"Behavioral health integration is an umbrella term for care that addresses any behavioral health problems bearing on health, including mental health and substance use conditions, stress-linked physical symptoms, patient activation, and health behaviors." And as you all know, in CPC, there is a focus on the integrated behavioral program and how it can include recognition, diagnosis, assessment, support, and treatment of persons with cognitive impairment, including Alzheimer's disease and other dementias. As you heard from Lisa just so eloquently right now, behavioral health has a vast array of resources that they can offer up at primary care that really does fall under this nice umbrella term we have here.

So the intent behind milestone two is to really look at how you can leverage your risk stratification methodology to address behavioral health issues in your population. And we also heard that just now from both Greg and Lisa.

We'll talk more about identification in a minute. But remember for 2014, it's not just about those at high risk. This is also about the rest of your population who may be facing challenges achieving their health goals.

So why BHI, behavioral health integration? Well, as a reminder for those of you not on our first webinar where we initially introduced the topic, behavioral health integration is a high priority for primary care because of the prevalence of behavioral health in primary care. Consider that approximately 80% with a behavioral health disorder will visit primary care at least one time in a calendar year. And 50% of all behavioral health disorders are treated solely in the primary care space.

And if we knew that referring these individuals out once we identified them was sufficient, we probably wouldn't be discussing integration at the level we are today. However, we know that the vast majority of referrals sent from primary care to outpatient behavioral health, patients simply don't make their first appointment. This means that we have an unprecedented opportunity in primary care to address the substantially unmet needs of patients with behavioral health.

So, as many of you on this call know, studies demonstrating the inseparability of mental health and physical health abound. There appears to be bi-directionality of diabetes and depression, supporting that both mental and physical health impact on one another. And when depression and diabetes are both addressed, positive diabetic and depression outcomes are generated.

Depression worsens chronic disease and is worse when co-occurring with chronic disease, more so than the impact of multiple chronic diseases without depression. Additionally, there's a persistent and significant relationship between depression and poor functioning with chronic disease. So it appears that clinical improvements in depression are associated with clinical improvements in aspects of chronic disease.

However, when patients present in primary care with multiple chronic conditions and chronic diseases that include depression, the depression is sometimes not treated. This overlap between chronic disease and mental health suggests that this inseparable relationship is crucial and important on focus for care delivery.

Steps further CPC practices to be involved with behavior health integration really begin by declaring, in the first quarter, whether or not you're focusing on behavioral health integration, med management, or self-management support. And obviously, telling us how you are changing your practice and what you are doing to address issues like behavioral health is very critical. And once you've chosen your topic, responding to the questions about how you are changing your practice for behavioral health or for medication management and then showing your progress each quarter is truly helpful and essential.

So let's just take a minute and consider the pathways to integration. First, many practices may only be coordinated with an external behavioral health entity. Some may not be at all.

In the coordinated pathway, which you see here on the screen on the left-hand side, behavioral health and primary care physicians are working in their respective systems. Communication may be limited to a referral. And collaboration may be nonexistent, if it's there at all.

If a practice is to enhance this approach, there's a few things to consider. First, what is the relationship like with the external behavioral health provider and or system? Is there a way to assess whether or not patients show up for their referral, if they're sent? And if so, how do the patients do? Can outcomes be tracked and shared? How can information about the patient be shared between practices in a way that's meaningful to the individual providers?

Evidence has shown that patients often don't choose to follow up on referrals for this route. So that needs to be considered too.

Our second pathway is around co-location, which is similar to coordination in that the behavioral health provider is still responsible for receiving referrals and treating mental health in a more specialty way. The difference here is that the behavioral health is quote, unquote "co-located" or on site. And within this model, there is more of a likelihood that the providers interact. But collaboration may still be limited since the behavioral health provider is busy with traditional mental health visits during the clinic day and may be unable to be flexible for other patients' needs.

And then finally, being integrated, our final pathway here, allows for a more seamless access to behavioral health. And as I think Lisa demonstrated beautifully, she's available when the patients or the providers might need her. Pulling out patients and going in exam rooms or x-ray rooms, excuse me, to talk about what may be going on with the patient is really a hallmark of this integrated model, seamless.

So referrals that are made to specialty mental health are often made by the behavioral health provider who see more patients for a range of mental health and chronic disease issues. In this pathway, warm handoffs are very common. And the behavioral health provider is often doing brief interventions and problem solving therapies rather than traditional mental health visits.

So whatever your approach, it's important that you're able to assess if that approach is the right one for you. And if so, how can you improve it.

So let's get back to the bone of behavioral health integration. First, you have to be able to identify patients who you want to receive some type of behavioral health intervention. Using your risk stratification process, as we mentioned before, is definitely one avenue.

It's important to consider the question, how are you identifying patients with co-morbid or underlining behavioral health conditions? So let me walk through a few examples of how.

Well, if we consider that the lifetime prevalence of depression is about 17% and depression in primary care ranges anywhere from 10% to 30%, you can really start to assess your population and see those that may not necessarily have been identified. Further, we know from studies that depression is not recognized in 67% of primary care patients. So based on some of these national prevalence data, you can begin to assess where your practice is with prevalence of behavioral health diagnoses, like depression.

Well, I know this is not new for many of you around risk stratification and has already been discussed just briefly. It is the backbone of CPC. But how can your risk stratification process help identify patients who may have a behavioral health diagnosis that may have gone undetected? For example, what happens if you look at some of your patients who do not have a behavioral health diagnosis and who are not showing improvement on some of their chronic disease? Is it possible that there's an underlying undiagnosed behavioral health condition? You can look at your cohort and begin to ask these questions.

Are there ways to integrate behavioral health into your risk stratification process you're already working on now and refine it to make it more effective at identifying behavioral health? In some cases, offering a formal screening and using standardized measures may both find new cases and allow you to monitor those cases that you've already discovered. So let's consider the role of formal screening, just for a second.

First, it's important to note that there are many ways to begin to identify behavioral health in your population beyond that risk stratification we talked about. Some of these you may already be familiar with. Examples may include the front desk administering a screener, the patient self-identifying with symptoms and then a screener is administered to confirm and assist that diagnosis. Or, quite common, providers may introduce a screener to help assess possible underlying behavioral health conditions.

However, we know that screening in and of itself is not sufficient. Screening in and of itself does not improve outcomes.

The United States Preventative Service Task Force has recommended not screening for depression in adults unless there are staff-assisted supports in place to take care of patients who screen positively. This means that following up with the patient after they have screened positive is one of the most critical components for improving behavioral health conditions.

So consider, who is responsible for following up with the patients after the screen? Who stores the data? And where are those data stored? How often is the tool used in practice? And can the tool be used to monitor symptoms beyond the initial diagnosis?

Let me offer up an example for this in just a second. Before I do, let me show you all some measures that are very common in primary care.

The measures that you see here, PHQ-9, AUDIT, you've heard some of these mentioned already on the call today. These are all available online. And you can find in your own leisure.

But what you can see here is that many of these measures have very few items and don't take much time for the patient to complete. But more importantly, they don't take much time for you to score, which is really critical in the hustle and bustle and busyness of primary care, to be able to look very quickly at these screening tools, at these measures, and assess whether or not the clinical diagnosis that you were thinking is indeed accurate.

Here's an example of an algorithm for depression treatment in primary care. And this is just one example. You'll see that the entire framework is built around the PHQ-9, which is the tool that I just showed you for depression. Since the nine item scale can give a total score and assess for things that are very important, like suicidality, decisions can be made instantly as to what may need to occur with the patient.

For example, if the patient scores in the mild to moderate range, we know from evidence that it's not always a medication that needs to be prescribed first. In fact, if behavioral health providers are on site, it's possible that they are capable of delivering very brief problem solving interventions.

However, the point of the slide is to show how one measure, the PHQ-9 in this case, can be used to serve two functions, assessment and then monitoring. Using this repeated measure over time allows for you and your practice to better understand how patients are doing with depression and other behavioral health diagnoses. Is it indeed working?

Identifying behavioral health is not just about referring new cases that are identified. It's about treating the target. Treating the target gives you tools that you may not realize you had. It increases your comfort level with looking at how to treat certain mental conditions, like depression. Just as you use A1C as a measure for diabetes to assess how well your patients with diabetes are doing with their blood glucose, the PHQ-9 can be used repeatedly to assess the effectiveness of your interventions.

It's also important to note that, since you will be collecting very important data, storing these data in structured or discrete fields is critical. If the behavioral health provider simply documents the score in a free text field, those data are much more difficult to extract and sometimes even more difficult to find. Many practices have taken to integrating the PHQ-9 into their vital sign list as a way that they can routinely access those data.

So once you've identified patients who have behavioral health diagnoses, who treats them? Well, if behavioral health is not on site, there may need to be some type of relationship building with outpatient behavioral health providers in your community.

First, do you know the behavioral health providers in your community? If not, what are some strategies that you can employ to meet them? If you want to rely on an enhanced referral system and coordination

of care to address behavioral health, are there ways you can track the referrals that you send to these outpatient providers? Are there ways that you can communicate to the behavioral health providers on the outside and find how your patient is doing?

One of the benefits of having behavioral health on site is that oftentimes communicating about the progress of patients happens as you both see the patient. The referral and communication components are quite difficult in a standard set up and less problematic when behavioral health is on site.

So what are the range of behavioral health services that are offered? Well, as seen on this slide, there are a range of behavioral health interventions that can be offered by behavioral health providers in primary care. Behavioral health providers may be well suited to address a range of behavioral health needs in primary care patients and potential functions of integrated behavioral health providers as depicted in this slide that you see in front of me.

Let me start on the left-hand side with psychosocial barriers to care. Addressing psychosocial barriers to care, a significant portion of your population that comes to primary care have a psychosocial component associated with them, which directly and indirectly affect health outcomes. Barriers include social, cognitive, and behavioral factors that influence patient engagement and health status. Therefore, addressing these barriers, which may include social determinants of health, are very critical.

Moving on to number two, addressing evidence-based interventions for lifestyle changes to improve physical health. Medical problems requiring behavioral or psychological interventions often result from challenging behavioral changes patients are asked to make to improve their health such as, diet, exercise, stress reduction, and medication adherence. Robust literature for redesigning primary care to better adjust health behavior change and balance as people die prematurely secondary to lifestyle choices more than anything else. So we need to consider roles that our behavioral health providers can play around these underlying health behavior interventions.

The third step down here, addressing mental health and substance use problems. As I just described, our review and synthesis suggest that mental health and substance use concerns from the literature is really more about from identification to active treatment. And it represents a principle domain of need addressed by integrated behavioral health providers.

Primary care providers, as we know from research, often under recognize or misdiagnose some of the underlying behavioral health conditions. And so with our behavioral health providers on site, we can now offer front line interventions for depression, anxiety, substance use, and others. So one improvement strategy for this particular category is clinical decision support tools with symptom-based protocols for referring to behavioral health specialists who can diagnose, treat, and track patient outcomes.

Fourth, addressing the needs of patients with multiple chronic conditions. And this is really mental health and physical health concerns, which is the vast majority of patients presenting to primary care. When we consider the role that multi-morbidities have and multiple chronic conditions and how common they are and how they contribute to poor health behaviors, multi-dimensional treatment plans

often require interventions involving multiple health behavior change and or behavioral health interventions with pharmacotherapy. This is all about working in concert as a team and what role or what function does the team bring to play here to address the whole person concerns, the whole person needs.

And I know we have a couple of questions coming in on this slide. So I'm going to wait on those in just a second. Let me work through this. And then we'll circle back around to those.

Finally, the fifth piece here on severe mental health, addressing the needs of persons with severe mental illness is very important. And patients with severe mental illness have higher rates of mortality and greater prevalence of chronic disease when compared to the general population. And so addressing the needs in this population is critical.

However, we know that these patients may have more severe behavioral health needs that need to be managed in specialty behavioral settings. Care managers and the like may help bridge the gap between primary care and specialty behavioral health settings for these individuals. It's still critical though, as has been pointed out, that you have the relationship with where you might send these patients to.

So how do we build practice capacity? Well, we can start by offering up trainings on site. There are a multitude of programs online that allow for providers to learn more about behavioral health integration. And as I've mentioned, practices can start by getting to know those behavioral health providers in their community. You may be surprised at some of the behavioral health providers in your community and their interest in primary care.

And then, finally, considering how you can have a shared workflow, as demonstrated really quite nicely by Lisa in one of the previous slides, and how the practice can help foster more of a team-based care mindset with the behavioral health provider included. So without a workflow, oftentimes providers are simply left to their own discretion as to how they want to involve behavioral health. And really, creating a more mature process to involve your team is essential in improving the outcomes of your patients.

So finally, how can you, as a practice, better know where you are and where you need to go for integration? Well, there are a variety of tools available that allow practices to assess their integration status. Two, in particular, are listed here on the slide in front of you, the AIMS Center Patient-Centered Integrated Behavioral Health Care Principles and Tasks and the Integration Academy Self-assessment Checklist. This allows you to show how you've evolved your model, how you've improved it, and consider a baseline assessment of where you are now and then maybe even re-administering this tool over a time period of 6 and 12 months and see how you've changed.

As a greater number of primary care practices and health systems begin to design and implement integrated behavioral health services, there's a growing need for quality measures that are rigorous and are appropriate to the specific characteristics of different approaches to integration. So more practices are faced with the challenge of finding measures that help assess the degree to which they're providing integrated health care.

So one tool I want to describe here, and you can see the URL there, is what we call the IBHC Measures Atlas. And this is accessible through the AHRQ Academy for Integrating Behavioral Health and Primary Care's main website. And really this atlas aims to accomplish three things. Number one, to present a framework for understanding measurement of integrated care. Number two, it provides a list of existing measures relevant to integrated behavioral health care. And finally, number three, it organizes the measures, by this framework, to help the user identify the most appropriate measure for your goals.

So let me talk about the atlas really quickly. Why do we want to measure what care looks like? Well, these measures can help you understand the changes in your practice. And why would you be interested in that? Well, your practice will naturally evolve and improve as it relates to behavioral health.

So currently on this website there are nine core measures and eight additional measures of integrated care available through the atlas. New measures are added frequently as people like you report measures that you found to be helpful in primary care.

So there's three ways to search for a measure on the website. You can look by core measure, functional domain, or you can actually be guided to a measure. Each search option will lead you to a list of measures from which you can select from your area of interest.

So we've gone through this pretty quickly. And I know I've seen the questions come up here. But in closing today's webinar and starting to move towards our question and answer section, this was really meant to provide a few starting places for practices around behavioral health integration.

Let me turn back to our Foresight practice, who started off today's call.

Greg and Lisa, I just said a whole lot of information. And I made it sound very simple. What did I leave out? What are some just thoughts that you might have based on the information that I just offered up?

Well, I think that was a really good deep dive, as we call it, into the ultimate goal of integrated behavioral health. I think that what we've discovered, it really is important to change the mindset of the providers. I think that when we first started integrated behavioral health and having Lisa here, we were zeroed in on mental health issues. And many of our initial handoffs were regarding abnormal screening tests for depression or anxiety or substance use. And we kind of forgot about everything else.

And now, as we've kind of matured in our process and as we talked about looking at a different risk strata of patients, we're now getting Lisa involved in a whole host of things including, weight management, goal setting, smoking cessation, managing a whole host of lifestyle things that we know patients know they need to do it. They've been educated on the importance of lifestyle changes. It's just a matter of getting them motivated to do it. And that's where Lisa's skill set comes in particularly handy is doing the motivational interviewing and identifying barriers and setting some short-term goals and getting patients at least started into making these changes that are so important for their long-term health.

Great point.

Lisa, any closing thoughts from you?

Yes, I think that a big focus of what I'm able to do here, and I'm thrilled to be able to do it, is working with people, my mission, my personal mission, to help promote people's engagement in their own health in a health care environment. And I'm able to do that here by teaching skills and strategies and also taking the focus we are more than our illness, so helping people recognize that.

Well, excellent. Well, as anticipated, we already have a couple of questions just for our Foresight practice.

So Krystal, let me ask you, if you don't mind. What are the questions that we have for both Greg and Lisa?

Sure. The first question is for Lisa. What are your credentials?

I'm a LCSW, licensed clinical social worker. And I practiced in private practice for over 25 years and volunteered in communities that I lived in with people who were homeless and had high needs.

Great, thank you.

Our second question is, what type of reimbursement for Lisa's services can be billed through in the primary care setting?

This is Dr. Reicks. That's a good question. We really haven't explored that much in our practice. We're basically funding Lisa through the payments that we're getting from the payers as part of CPCI. And so we're not billing for any of her services right now.

Going forward, as time evolves, we hope that the payers recognize the value of this and will continue to provide some global payments to practices who provide this service. So when we're negotiating new contracts with payers now, we let them know that we have this service. And our expectation is that we're unique and we're different. And we expect to be paid in a different manner than practices that don't have this service.

Thank you. And there were several questions around that. So I think that you covered most of the questions around how you're billing in your practice.

I don't see any other questions-- oh, I have one more. How often should practices be giving the PHQ-9, Audit, GAD-7, Mood Disorder Questionnaire, et cetera? Each visit? Or is there a particular frequency?

Let me start with that one. And then I want to know, Foresight, what you all do.

So for those of you in practice, as I mentioned, the importance of these measures is that you have a baseline assessment of the patient's status on that particular condition. The importance of repeated use of these measures is to see how well the patient is improving over time. There's nothing that prevents you from doing these measures every time the patient comes in the door. We know, for example, with

the PHQ-9, it asks about the last two weeks of the patient's life. It says things like, in the last two weeks, have you been experiencing, fill in the blank. And it goes through the questions.

This is really one of those decisions that practices need to make themselves, if they're being administered at the annual physical, every time the patient comes in the door. I worked in one practice where every patient that was given a diagnosis of diabetes simultaneously received a PHQ-9 screener. So there's multiple ways that you can use this.

But the critical piece here is you have to be able to answer the question, are patients improving in their care? And if you're not using measures to really assess how a patient is or is not improving, then it begs the question, well, what are you doing to assess that?

So Dr. Reicks and Lisa, how do you all administer? And how often do you administer?

Well, what we decided to do here is we're administering the PHQ-9 to every patient over the age of 13 on an annual basis. So that's our baseline. And so we're doing that now. We're collecting that data now and recording the results in our EHR in a structured data format. And then, depending on the score, that sort of determines follow-up screening.

So for patients who have a score greater than 15, which would indicate more severe depression, there's an intervention. Something happens. And then those patients come back in four to six weeks and are re-screened with the same tool.

For patients with a score between 10 and 15, what we're really doing right now is most of those patients are having a warm handoff or getting together with Lisa at some point. And then we're sort of leaving it up to Lisa, based on what her intervention is, on when those patients are re-screened. But we're telling Lisa, we want those patients re-screened within six months or so.

For patients under 10, we're really not re-screening them other than at an annual revisit, if they come back in.

Now we're also using the GAD-7 and the AUDIT-C as part of our screening process. So everyone's getting a GAD-7 and an AUDIT-C, which is for alcohol use, on an annual basis.

Same process for the GAD-7 if it's a positive screen above a score of-- I can't remember right now what score. But if it's above a certain score, those patients are also getting re-screened at four to six weeks for that.

We haven't quite figured out about re-screening using the AUDIT-C whether it's really useful to re-screen people with AUDIT-C or not. We're still debating on what's a positive AUDIT-C, what's not a positive AUDIT-C. But it at least alerts the providers and Lisa if we think there's an issue with alcohol use. And there's a brief intervention around that.

So before we leave this topic, let me just point to the screen again. And maybe now that we're talking about this, I can show you all the algorithm. This is exactly what was just described. And as you see here, this is from a particular practice that we worked with in Texas.

The re-administering of the tool was done in four to six weeks. And this is based on, obviously, it takes time for patients who are being given an intervention, whether it's a pharmacological intervention or it's a behavioral intervention, it's going to take time for that to work. So looking four to six weeks out subsequent to the intervention or routinely given intervention, you can start to assess, is there a score change? And then re-administering that over time until you reach your target range.

Many practices that we've worked with in the past, unfortunately, have had patients with the same diagnosis of depression for months and months and years and years. And I'm sure some of you have seen the cases of patients who are on the same dose of SSRI for years. There's really reasons to start to look at the effectiveness of those models for treating things like depression and using tools like this, or algorithms like this, to inform us.

Thank you, Ben. We have another question. This one's also about Lisa and her workflow.

Lisa, how do you work with your care manager in your practice? And also, is there any overlap or different referral patterns from the providers? And also, how do you use risk stratification in deciding which patients to see?

I was fortunate, when I came to this practice, that there's a part-time care manager for each of the physician providers. And they are all highly, highly skilled, so a tremendous gift to be able to work together. They each follow up with all of the patients in the high risk categories. We also have meetings every other week to look at the risk stratification and patients' needs.

Our work is very collaborative. We sit next to each other, visit about the patients and their needs and what each of us are doing. We also visit and are able to ponder, how are we effective? And we question ourselves and what we're doing. And that's very helpful.

Thank you. The next question is, how do you protect your behavioral health notes in your integrated chart or your EHR?

This is Dr. Reicks. That's an excellent question. Because we had a lot of discussion around this topic when we first started this project. Because we have a health information exchange here in Grand Junction. And right now, all of our progress notes that we create as providers within our office are automatically uploaded to the health information exchange and part of the patient's virtual health record it's called. And those notes can then be accessed by providers who are credentialed properly throughout the community. And so we had a lot of concerns about the regulations around behavioral health and counseling and actually sought some legal input into that.

And the way we're doing that now is Lisa is documenting within our clinical record. She documents in a progress note, just like the providers do. She's very general in what she's talking about. She doesn't talk or document issues that might be more sensitive to that particular patient.

And we feel like what she's documenting does not meet the standard for a psychotherapy note, which is what the attorneys have told us should be protected within a chart. And so that's the way she's documenting. And those notes are being uploaded. At this point, we feel comfortable that we're not violating any regulation in that regard.

And this is Ben. I just want to chime in on that. This is a really important distinction. For those of you that are new to this space, what Dr. Reicks just pointed out and the difference between a progress note, or a process note, and psychotherapy note, it's important. But it also goes back to what we've described in this webinar today, which is the function of behavioral health in primary care.

Providing population-based interventions on the team in primary care is not specialty mental health. And so how these are documented and how these are stored within the EMR is really almost like a different way of practicing behavioral health. So it's important for those of you that are conceptualizing your model to really think through that role, the function of behavioral health, and then, therefore, look at the documentation according to that.

And Dr. Miller, as a follow-up to that, what kinds of credential are common for behavioral health practices in primary care?

It's a great question. Really, when we start to look at who the behavioral health providers are in practice, we start to ask the questions around the functions. What are the functions necessary for the primary care practice to have on site integrated behavioral health?

And sometimes you may have functions that are more consistent with a discipline like social work, so social worker. Sometimes you may have functions that are more consistent with a discipline like a psychologist. It really begs the question for the practice to assess their population that they're serving and then start to decide which behavioral health provider might be the best for us.

But the most credentials that we see are psychologists, social workers, licensed professional counselors, marriage and family therapists. Sometimes certified addiction counselors are very common in primary care and to look at psychiatry as well. But as we all know, there's not a lot of psychiatrists that are available out there in our population that we could use at the level of intervention that we've described today.

I think that's really helpful to hear all the different varieties of professionals you could have working in your clinic to achieve this integrated behavioral health.

Can you describe-- I don't know if this is better for Foresight or for you, Dr. Miller. But one of the questions is to briefly describe those first steps that you took when you began doing this implementation process. And for Foresight in particular, were you previously using any behavioral health screening tools? Or was this newly implemented when Lisa came on board?

Why don't you all take that one, Dr. Reicks?

OK, well I guess maybe the second question first. We had been doing some screening with the PHQ-9 tool for reporting for meaningful use and some other reporting. But the big difference has been the intention now of getting Lisa involved in those people who have a positive screen and having appropriate follow-up screening. We really weren't doing any of that really to determine if what we were doing was effective or not. So we now have much more intention on getting follow-up measures of how patients are doing with the screenings.

The first part, I guess, was more, I think, just making the decision on how we were going to use Lisa within our practice and really focusing on not strictly mental health type of issues but expanding that to really a whole host of things that can have negative outcomes on patients' health.

I see one of the questions is, how many providers per BHP? So we have three providers here, two mid-levels. The use of Lisa varies significantly by provider.

We have one provider here who still practices in a very paternalistic style and really feels like he can manage most of his patients' health care needs and uses Lisa very little. And then we have myself who I use her a lot. So it's going to vary. Your providers are going to really vary in how they're going to use the behavioral health provider.

So we have typically only two physicians in the practice each day. But Lisa's patient volume has averaged anywhere from probably 5 to 15 warm handoffs a day. And we expect that's going to get even busier as we get more comfortable with her skill set and what she's able to do.

So I think certainly one behavioral health provider for two physicians works well. I think that if you're a really busy practice, one physician per behavioral health provider could even work.

Great point, Greg. And I'm glad you said it that way. I will just give a couple of heuristics here for those of you interested in this topic of workforce.

The Department of Defense, a few years ago, proposed one of our first ratios of behavioral health to primary care that we had ever seen, which was one behavioral health provider to four primary care physicians. But I think, as what Dr. Reicks just described, what we're seeing now is that the demand, especially from a population-based approach has been discussed today, it is a little bit higher than that. We want more behavioral health presence.

So one paper that came out recently looked at one behavioral health provider for every 2,500 patients. And that includes other various components, such as the care manager, that have been mentioned today. So it's a great topic that no one's figured out the right number yet. But it definitely depends on the population that you're serving and how often you think you're going to utilize the behavioral health services, as was discussed.

OK, so the next question. Does Foresight do a periodic review of patients under active treatment? How does the practice track patients in treatment to assess their goal?

Well, this is Dr. Reicks again. What we've done is we've taken these screening tools and the scoring behind the screening tools and we've developed, basically-- I don't want to say a flow chart. But we're entering all of this data into a structured format. And then we've got-- I've lost the word, [INAUDIBLE] flow sheet, where, just like we're tracking pro time INRs on a regular basis, we put the scores for these screening tests into a flow sheet. So the behavioral health person can click on that flow sheet and see what the scores have been over the course of time in one simple view. So that's kind of the way we're tracking response to treatment is through repeated screenings and scoring of these and mapping those into a flow sheet.

And we're working [INAUDIBLE].

And what was the next question?

OK, so the next question I see is, does Foresight track improvement of depression using a diagnosis code? Or is there another way that you're tracking it in your practice?

No, as I said before, if a patient scores greater than 10 on their screen, they're re-screened at some point. For those more severe, re-screening sooner takes place. And that's really the way that we're tracking response to treatment is with using the PHQ-9 and seeing what their scores are over time.

OK, great. Thank you. And let's see the next question. So it's another question for Lisa.

Do all of your patients come to you via warm handoffs? Or are some patients actually scheduled to spend time with you?

People are invited to schedule, if they would like a follow-up to the warm handoff meeting. And some people do. I explain that this isn't a therapy session and that I meet from 15 minutes to 30 minutes. And I need to be available for the providers to call me out of the room.

And the follow-up meetings are often about coming back to skills or strategies. If someone's having a grief response, checking back in with them. I do make follow-up phone calls also. But I'm really trying to avoid having my schedule busy with appointments so that I am available for the immediate needs.

So if you do have a patient come back and you feel that they need ongoing therapy, do you have a certain clinic that you refer to?

Yes, depending on their insurance. And I'm new to this community. So I'm getting to know providers who take different insurance and sliding scale. So it really depends on the patients' needs, the provider's expertise, and the payment avenue. And that takes some time getting to know the community in that way.

I'm going back to something that Dr. Miller talked about is that when I do meet with providers in the community, I'm emphasizing the importance of shared information, not the details of patients' lives, but that they get back with the providers. And also, I'm helping with the diagnostic information going to the

people that I refer to. So we're trying to silo less and have more coordination, with patients' consent. The patients are a part of that decision.

So about how many patients would you say you see in an average week?

I don't know. [LAUGHING] I haven't even gone back and looked at that.

Some days, as Dr. Reicks said, the low would be five or six. And some days it's as high as 15. It really varies. And there's other meetings throughout the week also. But I look at the providers' schedules. And when they're booked, I keep my schedule as open as I can.

Great. Well, I think one last question that I see. Do you know about how long the warm handoff takes when you receive a patient?

We're getting that down. So whether it be the nurse practitioner, the physician's assistant, or one of the physician providers, they're asking me to come in, introducing me with the patient in the room, and explaining what the patient concerns are. So there's that.

I don't know. What would you say? It's a three minute, two to three minute engaged handoff.

And that helps so much. Because the patients are really connected with their providers. And I'm silent during that time, taking notes and looking at the patient, looking at the provider. And there's a joining that happens in that silence.

And then they come to wherever I'm meeting that day. So it's not very long.

It's a warm handoff with the patient in the room with you?

The patient is present and hearing what I hear. So they know what I know.

That's a really important point. I want to highlight that just for a second.

There's many models on how to do this. But I think it's always very nice for the patient, if you think about the patient experience, to have the person they have the relationship with, their primary care provider, introduce the other member of the team. It normalizes behavioral health. It allows for the seamless transition of that care to a new provider that's going to be working side by side with the person they have that relationship with over time.

It's a beautiful way to do this. And we've actually seen many times, the primary care providers, it allows for further rapport building with their patient. For example, if the primary care provider is seeing a patient and the behavioral health provider comes in, they may start with a very simple overview of that patient, highlighting some of the amazing clinical changes that that patient has made over the last five years.

You know, Ms. Smith, I want to introduce you to Lisa. She's our behavioral health provider here.

Lisa, Ms. Smith has done some amazing things to manage her diabetes the last year. Let me tell you about a couple of these.

And then, however, we're finding that, of recently, she's having some difficulty in managing some of the emotions that come up with her diabetes. I was hoping that today we could spend some time talking about what we could do to help her here.

And so there's many ways that you can work this. But really, you think about it from the patient's perspective and how that team is now surrounding the patient and how you, as the primary care practice, can introduce them to someone that's really there to help.

And may I jump in, Ben, with that?

Yeah, please.

We're laughing right now. We spent some time figuring out kind of that elevator speech of walking in the room. And it's evolved. It's not rote now. It's really evolved.

But the topic is, I'm here as the integrated health provider. And I'm not medical. And that's all I need to say for people to take off.

Go ahead.

Yeah, I think that's a good point. We kind of went through a whole host of ways to introduce Lisa. We weren't really sure we wanted to even have the word behavioral in there. Because there was so many, I think, red flags that would sometimes go up in patients' minds when they heard that.

And so I think the providers are all doing it a little bit differently. But we're introducing Lisa as our health coach, our health educator, our instructor to good health, whatever just happens to pop into my head at the moment, depending on the patient's needs. But I'm trying to kind of stay away from too much complicated language that might raise some red flags for the patient.

And let me remind everybody that's listening today, as I highlighted at the beginning, there are multiple ways to address behavioral health in your practice. We've been spending a lot of time the last 20 minutes talking about the integrated model and what that looks like when the behavioral health providers are on site. But it's very critical for you to understand those other avenues and pathways to achieve behavioral health integration within your practice.

So I just want to remind everybody that today. It's not one size fits all, as they say.

Krystal?

OK, so I have time, I think, for one quick question and then a follow-up question. The first question's for Lisa.

What do you wear when you're seeing the patients? Are you wearing scrubs? Are you wearing a white coat? Are you wearing professional clothes? I know sometimes that can affect your relationship with your patient.

[LAUGHING]

I am in this office where people are really good dressers. So I'm probably the low on the totem pole of professional dress. I wear office attire.

OK.

Go ahead.

OK, so the next question really is, as you've adapted this behavioral health integration into your practice, what are some of the challenges that you faced? And then, what are some of those next steps that you'll be taking to help your practice continue to grow?

Yeah, this is Dr. Reicks. I think the challenges that we faced at the onset was truly finding the right person. People who have training in traditional counseling, this is really a complete shift of the way they've been trained necessarily and the way they handle patients.

So at the onset, if you're going to be talking to people in the community or bringing someone into your practice to do this work, they need to kind of understand that this is not traditional counseling work where patients will be scheduled to see them every 40 to 50 minutes. This is different. It's what we call high impact brief intervention type of counseling. And that's really the key, I think, is finding the right person, having them understand really what we're interested in and what our goals are within the practice.

Thank you. So I just want to close today and just explain what we have coming up next as far as learning opportunities. On Thursday, March 20 we have our CPC attributions refresher. The next open mic is also Thursday. And then we have our next really intense look into self-management support scheduled for March the 25th.

And now I just want to thank you all for attending. We hope that you found this presentation informative. And thank you all for your wonderful questions.

We 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. Thank you and have a wonderful day.