PARTICIPANT HANDOUTS

Exploring Behavioral Health Integration Models throughout Region VIII

MODERATED BY
Angela G. Green, PsyD, Director of Behavioral Health at Metro Community Provider Network

PRESENTED BY
Norma Randal, BSN, Clinical Operations Manager at HealthWorks
Sandi Larsen, M.Ed, LAC, LCPC, Program Manager for Behavioral Health at RiverStone Health
Jonathan Muther, PhD, Director of Behavioral Health and Psychology Training at Salud Family Health Centers

LIVE BROADCAST DATE/ TIME
Thursday, February 11, 2016
11:30am - 1:00 pm Mountain Time / 12:30 pm - 2:00 pm Central Time

PRESENTATION OVERVIEW
The purpose of this webinar is to introduce and expand on participants understanding and knowledge base of what it means to integrate behavioral health into the primary care practice. This presentation will address the levels of integration, present examples of three different Region VIII practices including their current levels of integration in the practice, behavioral health staffing models, and applications to specific populations. This presentation will also provide a description of exceedingly integrated primary care clinics and the critical aspects contributing to the high degree of behavioral health integration, including discussions related to physical space and workflows. Opportunities and challenges for creating a workflow that maximizes the behavioral health provider’s role as a primary healthcare provider, rather than ancillary staff will be presented. Collaborations with other members of the healthcare team in order to meet the need of addressing social determinants of health will also be briefly discussed.

TARGET AUDIENCE
This presentation is designed for participants who have a basic to moderate understanding of behavioral health integration into a medical primary care practice. Those who are interested in knowing more about how to get started or are beginning to build behavioral health into a primary care practice will benefit from this presentation. Discussion of the levels of integration, examples from 3 different Region VIII practices will be highlighted including their current levels of integration in the practice, behavioral health staffing models, and applications to specific populations. This presentation is suitable for administrators, clinicians, and program managers from medical, dental, and behavioral health disciplines.
LEARNING OBJECTIVES
At the end of this session, participants will be able:
1. To identify the “Six Levels of Integration”
2. To identify tools to evaluate current level of integration
3. To understand how to start the process of behavioral health integration
4. To understand how to design a workflow with highly integrated behavioral health/primary care collaboration, including roles of the behavioral health provider
5. To utilize 3 strategies to contribute to increasing behavioral health staff integration into the primary care workflow
6. To identify specific brief assessment and screening measures and strategies for use, including efficient documentation
7. To understand how to utilize a clinical pharmacist to expand access to evidence–based psychotropic medication management

CONTINUING MEDICAL EDUCATION CREDIT
This Live activity, Exploring Behavioral Health Integration Models throughout Region VIII, with a beginning date of 02/11/2016, has been reviewed and is acceptable for up to 1.50 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Application for 1.50 Prescribed credits for the archived version of the event will be filed immediately following the live event.

HRSA PERFORMANCE IMPROVEMENT & PROGRAM REQUIREMENTS AREAS
This event supports strong program management at Region VIII Community, Migrant, and Homeless Health Centers (CHCs) by addressing the following HRSA Health Center Performance Improvement and Program Requirements Areas:
- Program Requirements: Services – Required and Additional Services
- Program Requirements: Services – Staffing Requirement
- Program Requirements: Services – Quality Improvement/Assurance Plan
CHAMPS ARCHIVES
This event will be archived online and on CD-ROM. The online version will be available within two weeks of the live event, and the CD will be available within two months. CHAMPS will email all identified participants when these resources are ready for distribution. For information about all CHAMPS archives, please visit

DESCRIPTION OF CHAMPS
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-funded Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, please visit www.CHAMPSonline.org.

SPEAKER BIOGRAPHIES
Angela Green, PsyD
Dr. Green is a health psychologist and specializes in the area of health psychology and primary care. She has served as the President of the Colorado Psychological Association, the Behavioral Health representative for Colorado on the CHAMPS MPCN Steering Committee, and the Chair of her local PCA’s Behavioral Health Workgroup. Angela enjoys her work as a health psychologist and Director of Behavioral Health at the Metro Community Provider Network (MCPN), a federally qualified health center in Englewood, Colorado that provides integrated primary care. Her professional areas of interest include health psychology, integrated care, supervision, and professional development.

Norma Randall, BSN, RN, FCN
Ms. Randall is the Clinical Operations Manager at HealthWorks in Cheyenne Wyoming. She received her BSN from Regis University. Prior to becoming the Clinical Operations Manager at HealthWorks she worked as the inpatient and outpatient Behavioral Health Manager as well as Chief Trauma Nurse in the local emergency department. After ten years in nursing management at the local hospital she decided she needed a change. Norma had always desired to work with the underserved population and when the position became available at the Federally Qualified Health Care Center (HealthWorks) she decided to make the move.

Sandi Larsen, M.Ed., LAC, LCPC
Ms. Larsen is the Program Manager of Behavioral Health for Riverstone Health in Billings Montana, which integrates behavioral health in the primary care setting. Ms. Larsen started with Riverstone Health in 2010. Ms. Larsen has a distinctive understanding of treating mental health in primary care as well as educating primary care providers about mental health. She works as a Behavioral Health Provider in clinic and has a teaching role with the Montana Family Medicine Residency. She is a member of the American Balint Society. She currently leads a resident Balint Group and is dedicated to improving the therapeutic relationships between
doctor-patient. Prior to Riverstone Health, she was a clinician at Mental Health Center in Billings, Montana. Ms. Larsen is dually licensed making her focus on treating patients with co-occurring psychiatric and substance use disorders.

Jonathan Muther, Ph.D.
Dr. Muther is currently the Director of Behavioral Health and Psychology Training at Salud Family Health Centers in Ft. Lupton, Colorado, and a Senior Clinical Instructor at the University of Colorado School of Medicine, Department of Family Medicine. His primary area of interest is working with those traditionally underserved by existing systems and working with the Spanish-speaking population. His current specialty area is Integrated Primary Care Psychology and he is involved in direct patient care, training and supervision, as well as advocacy for healthcare policy change. He is committed to providing psychological treatment and assessment to remediate mental illness, behavioral interventions for medical illnesses, and evaluating health outcomes. Additional areas of research and clinical interest include integrated primary care and team-based approaches to care, provision of supervision and training to bilingual psychology trainees, child/adolescent therapy, and acculturation discrepancies within Latina/o families.

ADDITIONAL RESOURCES
CHAMPS Behavioral Health Resources webpage
http://champsonline.org/tools-products/clinical-resources/diseasecondition-specific-resources/behavioral-health-resources
Integrated Behavioral Health Project
www.ibhp.org
National Council for Behavioral Health
www.thenationalcouncil.org
Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Integrated Health Solutions
www.integration.samhsa.gov
University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center
http://aims.uw.edu
Exploring Behavioral Health Integration Models throughout Region VIII

Presented By:
Norma Randall, BSN, RN, FCN
Clinical Operations Manager
HealthWorks, Inc
Sandi M. Larsen, MEd., LCPC, LAC
Behavioral Health Program Manager
RiverStone Health
Jonathan Muther, Ph.D.
Director of Behavioral Health & Psychology Training
Salud Family Health Centers

Moderated By:
Angela Green, PsyD
Director of Behavioral Health
Metro Community Provider Network

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Interaction Question

Today, I am most looking forward to hearing about

• How other sites are integrated
• Tools to evaluate integration
• Designing an integrated workflow
• Integrated models and special populations
Interaction Question

How many total people, including yourself, are watching this event at this computer?

Why Care About Integrating Behavioral Health into Primary Care?

Angela Green, PsyD
Director of Behavioral Health
Metro Community Provider Network
Learning Objectives

At the end of this session, participants will be able:

1. To identify the “Six Levels of Integration”
2. To identify tools to evaluate current level of integration
3. To understand how to start the process of behavioral health integration
4. To understand how to design a workflow with highly integrated behavioral health/primary care collaboration, including roles of the behavioral health provider

Learning Objectives, Continued

At the end of this session, participants will be able:

5. To utilize 3 strategies to contribute to increasing behavioral health staff integration into the primary care workflow
6. To identify specific brief assessment and screening measures and strategies for use, including efficient documentation
7. To understand how to utilize a clinical pharmacist to expand access to evidence-based psychotropic medication management
Determinants of Health

Exploring Behavioral Health Integration Models 2/11/16

- 84% = the percentage of the 14 most common complaints that have no determined physical origin
- Behavioral health issues are likely to increase as physical health decreases
- More than 50% of primary care patients have undiagnosed depression
**Why are Patients Coming to Primary Care for Behavioral Health?**

- 80% of individuals with BH issues will see their PCP at least once per year
  - 67% of patients with a BH issue never receive treatment
- Up to 90% of patients with behavioral health needs rely on their PCPs for treatment of these needs
  - When referred to outside BH care (~40%), only about 10% make it to the first appt
  - 48% of visits for psych meds are with a PCP

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**Adverse Childhood Experiences Study (ACES)**

- Conducted by KP and CDC, 1995-97, n=17,337
- 10 types of childhood trauma = ACE score
- ACE score associated with high-risk health behaviors
  - ACE score of 4 strongly associated with:
    - 7x risk of ETOH
    - 2x risk of Cancer
    - 4x risk of Emphysema
  - ACE score of 6 or greater increased the risk of attempting suicide by 30 times!
Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
<th>LEVEL 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed, Merged, Integrated Practice</td>
</tr>
</tbody>
</table>

Behavioral health, primary care and other healthcare providers work:

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
</tr>
<tr>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Have separate systems</td>
</tr>
<tr>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate periodically about shared patients</td>
<td>Communicate regularly about shared patients</td>
</tr>
<tr>
<td>Communicate, driven by provider need</td>
<td>Communicate, driven by specific patient issues</td>
<td>Communicate, driven by need for each other’s services and more reliable referral</td>
</tr>
<tr>
<td>May never meet in person</td>
<td>May meet as part of larger community</td>
<td>Meet occasionally to discuss cases due to close proximity</td>
</tr>
<tr>
<td>Have limited understanding of each other’s roles as resources</td>
<td>Feel part of a larger yet non-formal team</td>
<td>Have regular face-to-face interactions about some patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have a basic understanding of roles and culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Actively seek system solutions together or develop work-arounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communicate frequently in person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaborate, driven by desire to be a member of the care team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have regular team meetings to discuss overall patient care and specific patient issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have an in-depth understanding of roles and culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communicate consistently at the system, team and individual levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaborate, driven by shared concept of team care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have formal and informal meetings to support integrated model of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have roles and cultures that blur or blend</td>
</tr>
</tbody>
</table>

Additional Resources

SAMHSA
http://www.integration.samhsa.gov

University of Washington AIMS Center
http://aims.uw.edu/

Integrated Behavioral Health Project
http://www.ibhp.org/

The National Council
http://www.thenationalcouncil.org/
Integrating Behavioral Health: The Beginning Basics

Norma Randall, BSN, RN, FCN
Clinical Operations Manager
HealthWorks
Cheyenne, WY
wyhealthworks.org

Interaction Question

How long have you been practicing behavioral health integration at your clinic?

• Just beginning to look into it / 0 years;
• Just starting/ less than 1 year;
• 1-2 years;
• 3-5 years;
• 6-10 years;
• 10+ years
HealthWorks: Cheyenne, Wyoming

- HealthWorks is a 501©3 not-for-profit Federally Qualified HealthCare center and an NCQA-Recognized Patient Centered Medical Home.
- Patient population is approximately 4,000; we provide 10,000 patient visits a year.
- 25% of our patients were identified in need of behavioral health intervention via 2014 UDS report.
- 45% of our patients are uninsured.

Care Teams

- We have three care teams that consist of a Provider, a Registered Nurse (RN), and a Medical Assistant (MA).
- We currently have one Clinical Social Worker (CSW).
Assessment of Need

• Providers performed a daily tally of patients who would benefit from brief in-house intervention.
• It was determined that on average, four patients per provider each day would benefit from on-site brief intervention for behavioral health needs, including substance abuse, depression, and other mental health conditions.

Steps to Take

• We formed a group several months ago to weigh our options: CEO, CSW, clinic manager, and medical director.
• We discussed our options with the quality committee.
• We put in place an MOU with the local community mental health center to assure that our patients were taken care of as we addressed the total integration in our clinic.
Integration Framework: Weighing it all Out

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Staff already in place</td>
<td>• Patients already here</td>
</tr>
<tr>
<td>• Long wait time</td>
<td>• Payer source</td>
</tr>
<tr>
<td>• Incomplete communication</td>
<td>• Less barrier to care</td>
</tr>
<tr>
<td>• Travel</td>
<td>• Communication by EHR, meetings, soft handoffs</td>
</tr>
<tr>
<td>• Cost</td>
<td>• Limited resources</td>
</tr>
</tbody>
</table>

Facilities

• We are in the process of expanding our facilities so we can have on-site collaborative behavior health services.

• Currently we refer patients to the local community mental health center; however, there is a three-month wait.
Challenges

- Making sure our patients receive the services they need and that communication between the two facilities remains open.
- Physical space is limited at this time.
- Referral sources for our patients is limited with extensive wait times.

Staffing Needs

- Currently we have a CSW in-house who assists with the referrals to the local community mental health center.
- We are in the process of hiring a master-prepared therapist who would be able to meet all of our mental health needs to include substance abuse.
Staff Training

• All clinical staff will be trained
  – SBIRT
  – Motivational interviewing
  – Substance abuse
  – PHQ2 is completed on all patients, if needed a PHQ 9 is completed.
  – Suicide training
  – Opioid prescription awareness training
• Key front staff will be trained on suicide and motivational interviewing

Operational Considerations

Currently
• We do not share an EHR
• Transportation
• Cost to the patient
• Wait Time
• Meet occasionally

Goal
• Fully integrated behavioral health services in-house.
• Soft handoff
• Joint EHR
• Patients would follow our existing sliding scale fee schedule.
• Meet routinely to collaborate care.
# Quality Improvement

**Currently**
- Minimal collaboration
- No statistics or QA measures in place
- Communication is sporadic and driven by specific patient issues

**Goal**
- Regular meetings
- Measure our outcomes
- Collaboration driven by care teams
- Formal multidisciplinary huddles daily
- Ability to determine the number of soft touches

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# Wrap Up

- Begin with a needs assessment.
- Determine if you have the space; if not; how will you find the space?
- Train staff well in advance.
- Seek work-arounds until you are able to fully integrate behavioral health.
Integrated Behavioral Health in Primary Care

Sandi Larsen, M.Ed., LAC, LCPC, Behavioral Health Program Manager

RiverStone Health
Billings, MT
(406) 247-3350
www.riverstonehealth.org

Introduction to RiverStone Health

RiverStone Health is a provider of primary care and public health services. We offer homecare and hospice, medical and dental, education and public health services. We are also a teaching health center, training residents in primary care in the Montana Family Medicine Residency.

History of Behavioral Health Program

Our Integrated Behavioral Health got started with a Service Expansion Grant from HRSA in 2008.
Community Health Center

- Main Clinic
- Dental Clinic
- Rural Clinics in Bridger, Joliet and Worden
- Healthcare for the Homeless Program – clinics at Hub, MRM and St Vincent DePaul
- Youth Services Center
- Orchard School Clinic
- Yellowstone County Detention Facility (YCDF)
- Pharmacy

Providers

PCPs 17 FTE and 24 Residents
BHPs 7 FTE
Psych Pharm 0.5 FTE

Total Clinic Visits 75,679
Total BH/SA Visits 2,909
Our Integrated Behavioral Health Mission

To provide access to behavioral health services to improve the physical and emotional well-being of our patients.

Guideline for Psychiatric Care at RiverStone

• Developed due to scarce psychiatric resources in the community

• Many patients presented to establish care upon discharge from the local psychiatric center.

• We started the process of looking at our policies and procedures. Out of that came the Mental Health Guideline.

• As part of implementing the guideline we created an Integrated Care Clinic.
Guideline for Psychiatric Care at RiverStone

Within the guideline
- Depression without psychotic features
- Anxiety disorders
- Bipolar Disorder
- ADHD

Not within the guideline
- Unstable psychosis
- Patients who have required long-term or recurrent psychiatric admissions
- Severe personality disorders

Interaction Question
When would you refer a patient to the behavioral health team?

- Emergent concerns
- Diagnostic clarification
- Brief therapy
- Lifestyle modification
- All of the above
Reasons to Refer to Behavioral Health Team

- Resource questions
- Emergent concerns
- Diagnostic clarification
- Brief therapy - 6 to 8 sessions
- Lifestyle modification (smoking cessation, weight management, sleep hygiene, stress management)
- Chronic pain care planning
- Chronic illness management (diabetes, hypertension, IBS, heart disease, asthma, COPD)
- Substance use issues

How to request consultation with Behavioral Health Provider

- Warm hand offs (clinic, precepting table)
- Lync instant messaging
- Provider sends message through electronic medical record
Workflow

- Behavioral Health Provider is requested by PCP
- Medical Provider introduces BHP to patient in the clinic exam room
- Brief behavioral health intervention occurs in the exam room if clinic flow allows. If medical provider needs room freed up, BHP moves patient to behavioral health clinic room

How we design our BH templates

- Behavioral Health Provider schedules are designed to allow follow-ups for patients met in warm handoffs
- Templates are built to have four 30 minute follow-up sessions in each 4 hour clinic, along with 30 minutes in-between to allow for warm handoffs
**What is a Clinical Psychiatric Pharmacist**

- Pharmacists graduate with a Doctor of Pharmacy degree. Pharmacists can become board certified in areas such as pharmacotherapy, psychiatry, oncology, and pediatrics.

- Some pharmacists in Montana are Clinical Pharmacist Practitioners (CPPs), recognized by the Montana Board of Pharmacy and Montana Board of Medical Examiners. CPPs are experienced, board certified patient care providers.

**What Do They Do**

- Functions as a clinical pharmacist on our care team and practices under a Collaborative Practice Agreement with our physicians.

- Reviews medications and makes recommendations for treatment on patients referred by physicians.

- Expands the level of psychiatric care that our primary providers can manage.
Our Integrated Care Clinic

- Co-visits with our Behavioral Health Provider and Board Certified Psychiatric Pharmacist (BCPP)
- 1 hour appointment slots
- Patients referred to this clinic are often previously in psychiatry but can no longer access care, are discharged from our psychiatric center, or other treatment facilities.

The Behavioral Health Provider and Board Certified Psychiatric Pharmacist (BCPP) meet together with the patient.

Behavioral Health Provider

- Review of available mental health records
- Request for additional records for review
- Full biopsychosocial history obtained
- Diagnostic clarification will be initiated
- Review status of funding source
- Consider referral to care coordinator
Psychiatric Pharmacist (BCPP)

- Review of all the patient's medications (not just their psych meds) to ensure that their co-occurring medical conditions are also being adequately treated.

- The BCPP completes psychiatric medication histories and assess for adverse effects, looking for options that may be more effective or better tolerated.

If patients are determined to be out of our Mental Health Guideline, they are referred back to specialty providers

Primary Care Physician

- Review plan from Behavioral Health Provider and Psychiatric Pharmacist (BCPP)
- Develop plan
Their Value

- Studies have shown that pharmacist-provided CMM improves outcomes, reduces overall healthcare costs, and shows a positive return on investment (ROI), although medication costs may increase.

- Pharmacists can add to the healthcare workforce by assuming some medication management tasks, increasing physicians’ capacity to complete tasks that only a physician can perform.

For programs that don't have a Board Certified Psychiatric Pharmacist (BCPP), other pharmacists can get additional training in psychiatric medications through the College of Psychiatric and Neurologic Pharmacists at www.cpnp.org which has a number of educational opportunities including a BCPP exam preparation course, discussion cases, webinars, and an annual conference.
Critical Elements of our Integrated Team

- Co-location
- Shared EMR
- Warm handoffs and visits at POC
- Part of the Pre-visit planning and huddle time
- BH providers are on the medical staff and attend provider and team meetings
Behavioral Health Overview

- Integrated Model of Care
  - ≠ Co-located, consultative model
  - = Behavioral Health Provider; shared responsibility; team-based care
- Patient-centered, community-oriented, need-driven
- Triple Aim Oriented
- Scientist – Practitioner
  - Provision of clinical care: empirically-supported interventions, generalist clinicians treating broad spectrum
  - Organizational: measuring outcomes [new], team-based model of care
- Cultural Competence & Awareness of Health Disparities
  - Bilingual BHP’s, awareness of barriers to treatment, reducing stigma

Catchment Area and Clinics

Map showing various cities and clinics.
Who Are Our Patients (2015, All sites)

~70,000 Unique Patients, ~300,000 Visits/Year

<table>
<thead>
<tr>
<th>Patients by Age Group</th>
<th>0 to 5</th>
<th>5 to 17</th>
<th>18 to 64</th>
<th>65 and over</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>14.9%</td>
<td>22.2%</td>
<td>57.6%</td>
<td>5.3%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Below Poverty line</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Private</th>
<th>CHP+</th>
<th>Uninsured</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>61%</td>
<td>52.5%</td>
<td>5.7%</td>
<td>13.0%</td>
<td>2.8%</td>
<td>26.0%</td>
<td></td>
</tr>
</tbody>
</table>

Who Are Our Patients (2015, All sites)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Hispanic</th>
<th>NH/White</th>
<th>NH African American</th>
<th>NH Other</th>
<th>Unreported</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>57.61%</td>
<td>34.74%</td>
<td>2.24%</td>
<td>2.20%</td>
<td>3.22%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th>English</th>
<th>Spanish</th>
<th>Other</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>59.11%</td>
<td>37.4%</td>
<td>3.49%</td>
<td></td>
</tr>
</tbody>
</table>
Cultural Considerations for Improving Access

- Acculturation: highly acculturated patients are more likely to access care
  - Acculturative stress: sense of being marginalized by dominant culture
- Latinos tend to express somatic complaints in response to psychological distress more likely to present for medical care
- Heterogeneity of the Population: Significant variability exists
  - Language, documentation status, immigration history, education, health practices, extended family

Interaction Question

How could a highly integrated behavioral health model help address culture-related barriers to care?

- Improving access to care
- Decreasing stigma related to mental health concerns
- Sensitivity related to language competence
- Ensuring a patient/family-centered approach to care
- All of the above
Addressing Disparities & Reducing Barriers

- Integrated Primary Care is more accessible and less stigmatizing than referral to specialty MH care
- Primary care settings are typically the first point of contact for all health conditions
  - Especially for minority and limited English proficiency populations
- Integrated health approaches focus on whole-person care:
  - Treat patients across the life span
  - Involve prevention and early intervention
  - Patient-centered, strength based, solution/recovery-focused

Behavioral Health at Salud

- Represented in 11 of 12 clinics & mobile unit
- Goal of 25-30 clinical FTE; 3:1 PCP:BHP ratio
- Various disciplines: Psychology, Social Work, Counseling, (Psychiatry)
- Employed by Salud and by partnering community mental health center agencies
- Psychology Training Program
Behavioral Health Training Program

- Postdoctoral Psychology Fellowship (APPIC member)
- Pre-doctoral Psychology Internship, University of Colorado, Dept. of Family Medicine
- Psychology Externs
- Social Work & Professional Counselor Externs

Our Mission

To deliver stratified, integrated, patient-centered, population-based services

- utilizing a diversified team of behavioral health professionals who function as primary care providers, not ancillary staff,
- and work shoulder-to-shoulder with the rest of the medical team in the same place at the same time with the same patients.
## Clinical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>06/2014 – 05/2015</th>
</tr>
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<tbody>
<tr>
<td><strong>Screening</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>• child [devt, bx], adult [sx distress, substance abuse, DV]</td>
<td></td>
</tr>
<tr>
<td>• yearly</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>[n = 3, 273]</td>
</tr>
<tr>
<td><strong>Consultation</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• dx/recommendations, brief intervention, crisis intervention</td>
<td>46%</td>
</tr>
<tr>
<td>• “real-time referral”, direct contact, “curbside”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[n = 6, 787]</td>
</tr>
<tr>
<td><strong>Psychotherapy</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>• individual, family, group</td>
<td>27%</td>
</tr>
<tr>
<td>• in-person, teletherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[n = 3, 947]</td>
</tr>
</tbody>
</table>

### Clinical Services [continued]

<table>
<thead>
<tr>
<th>Service</th>
<th>06/2014 – 05/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Management</strong></td>
<td></td>
</tr>
<tr>
<td>• connection to resources, advocacy, coordination of care, etc.</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>[n = 511]</td>
</tr>
<tr>
<td><strong>Shared Medical Appointments (SMAs)</strong></td>
<td></td>
</tr>
<tr>
<td>• interdisciplinary team appt</td>
<td>Unavailable</td>
</tr>
<tr>
<td>• OB, DM, chronic pain</td>
<td></td>
</tr>
<tr>
<td><strong>Psych Testing/Assessment</strong></td>
<td></td>
</tr>
<tr>
<td>• cognitive, academic, adaptive funx, personality/bx</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td></td>
<td>[n = 111]</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BH Screening

Screen for Life Stressors & Outcome Rating Scale (ORS)  
Follow up Measures

Outcome Rating Scale (ORS)  
Baseline functioning/distress

- Depressed mood
- Anhedonia
- Nervous/tense
- Worry
- Marijuana
- Illicit drugs & Rx misuse
- etoh abuse per episode
- etoh abuse per week
- Trauma (4part)
- Domestic violence

 Dep  PHQ-9  GAD-7  DAST  AUDIT  PCL
Anx
SA
etoh

Program Development & Evaluation

- Reducing ER overutilization: Targeted screening & intervention to identify risk factors, e.g., complex medical, co-morbidities, chronic pain
- DM Shared Medical Appointments: Predictors of barriers and engagement, BH and physical outcomes
- BH Outcomes: Validating PCOMS measures in primary care; comparing outcomes to other treatment settings
- Team-based care: Improving BH and biomedical outcomes; casting a broader net; demonstrating our model works
Current Challenges

- Ever-evolving changes in the healthcare policy and financing landscape
  - i.e., Accountable Care and Behavioral Health sustainability
- Systematic Triage – Ensuring patient need is appropriately assessed and treatment takes place in the location best suited to meet that need
- 42 CFR, Ensuring the agency is protected as related to documentation and health information exchange

References


Auxier, A., Farley, T., & Seifert, K. (2011) Establishing an Integrated Primary Care Practice In a Community Health Center. Professional Psychology: Research and Practice, Advance online publication. doi: 10.1037/a0024982


Questions?

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Thank You for Joining Us!

Your opinions about this webcast are very important to us.

Please complete the event Evaluation for this webcast.
If you are applying for CME credit, you must complete the credit questions found at the end of the Evaluation by Thursday, February 18, 2016.

Each person should fill out their own Evaluation/Credit Survey.

Please refer to the SurveyMonkey link provided under the “Handouts” tab of the online event. The same link was provided in the reminder email sent out in advance of the event, and will be included in a follow-up email to those logging onto the live event. Please pass the link along to others viewing the event around a shared computer.