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⇒ ROARA MICHAEL: Good afternoon, everyone, and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webcast titled "Role of Nurses in Health Home and Integrated Care Settings."

My name is Roara Michael, CIHS Senior Associate and I'm also joined here by Aaron Williams, who is the Senior Director of Training and Technical Assistance for Substance Use here at CIHS.

As you may know, the SAMHSA-HRSA CIHS promotes the development of integrated primary and behavioral health, including mental health and substance use services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.

In addition to national webinars designed to help providers integrate care, the Center is continually posting practical tools and resources to the CIHS website, providing direct phone consultation to providers and stakeholder groups, and directly working with SAMHSA Primary and Behavioral Health Care Integration grantees and HRSA funded safety-net providers and training/education program.

Before we get started, a couple of housekeeping items.

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And just a quick disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

Just before we move on to today's presenters, Aaron will discuss today's learning objectives and introduce today's speakers. Aaron?

AARON WILLIAMS: Thank you, Roara, and thank you for that introduction.

Hello, everybody, and thank you all for being on our webinar today. We have a very exciting webinar. We are going to provide a lot of information around the role of nurses in our integrated care. As you know, integrated care and innovation in behavioral health and primary care is still at the forefront of the models to provide holistic and comprehensive services. One thing that has come up as we begin thinking about integrated care Is what is the role of the nurses?

So we wanted to bring on a number of different presenters today that can talk about how nurses can be utilized within an integrated care setting. So today, in terms of the learning objectives, we want to explore some various roles and activities of nurses in the integrated care setting. We want to examine the advantage of using nursing integrated care as well as the skills necessary to work in an integrated care setting. And provide real-world examples in these integrated care settings. So before we move into our presentation, I want to make sure that we briefly gave some description of the folks I will be on today. I think we have a great purpose because here, starting off with Dr. Deborah Finnell. She is a professor at Johns Hopkins University and also the past president of International Society on Addiction.

After that, we have Dr. Teresa Jacobson, she is a licensed

professional clinical counselor. She is also the manager of Greater Cincinnati Integration Project which includes nurses, primary care providers, pharmacists, and peer wellness coaches.

After that, we will have Dean Visk, who is Director of Nursing, Greater Cincinnati Behavioral Health. He has a master of nursing from Xavier and is at Greater Cincinnati Behavioral Health.

Finally, before we going to questions at the end of the webinar, we have Yovan Gonzalez, who is working as a primary care provider that given her as part of the New York City hospital system.

So please keep in mind you can type in questions at any point during the webinar and we will spend some time at the end.

DEBORAH FINNELL: Thank you for the introduction. For those of you who are attending this webinar. I'm going to start talking a little bit about the nursing scope and standards. The American Nurses Association document of 2015, nurses scope and practice, describes what nursing is, what nurses do, responsibilities of what nurses are accountable for in the outcome of the practice.

Nurses are responsible for the direct care and delivery and the consequential outcomes specified in this ANA for national document.

What are listed here are six standards of care that align with the steps of the nursing process and the 10 Standards of Professional Practice.

In this presentation, I focus on substance use screening intervention, treatment, and referral to treatment. Which is defined by SAMHSA is a comprehensive integrated public health approach to intervention for people whose alcoholism or drug use puts them at risk. The desire is to prevent the progression of substance use to a diagnosable disorder as well as decrease morbidity and healthcare utilization.

Important, alcohol screening and brief intervention is level B by the United States prevent a task force with the recommendation that this service be offered or provided in practice.

As I present each component of the set of clinical strategies, I will provide examples of competencies that my colleagues and I are promoting for all nurses at the generalist level and for the generalist level RN and the advanced practice RN.

The current opioid epidemic highlights the critical need for all

nurses to have the knowledge, skills, and abilities to address the full continuum of substance use. That continuum spans any use that may potentially place an individual or others at risk. To those who are identified to be at actual risk, and to those at the highest risk who may have a substance use disorder diagnosis.

Documenting screening for risk is something that is done at nearly every contact in the healthcare system. Nursing and other healthcare providers take weight, temperatures, blood pressure, and pulse. These are basic activities that have become a normal part of healthcare and basic components of the nursing assessment. Screening is a strategy used in a population to identify the possible presence of an as yet undiagnosed disease in individuals without signs or symptoms.

Screening measures are designed to identify needs in a community early. A positive screen prompts the need for assessment and is importantly not used to diagnose.

Before administering a screen for a person who acknowledges alcohol use, it's important to ask which type of alcohol they typically consume and provide information about what constitutes a standard drink, shown in the graphic here.

The single screening question for alcohol and drug use are also shown here on the slight. A report issued by the Institute of Medicine titled Broadening the Base of Treatment for Alcohol and accumulating evidence is released and points to the effectiveness of screening in primary care for at risk alcohol use and counseling and treatment. Specifically, screening followed by a brief intervention has been shown to significantly reduce alcohol consumption, morbidity, and healthcare utilization in primary care patients. While the evidence related to drug use is mixed, this approach is recommended by SAMHSA and by the national Institute on drug abuse. Risk levels are determined by the score obtained by the Alcohol Use Disorder Identification Test, or the AUDIT and the Drug Abuse Screening Test, or the DAST. The lowest scores are associated with low or no risk levels in the highest scores are associated with the high risk levels. The middle zone, at risk, is associated with AUDIT scores of 4-13 and DAST scores of 1-2.

The associated standard for this is standard one assessment. The registered nurse collects comprehensive data pertinent to the healthcare consumer's health in the situation. So my colleagues, in -- specific to substance use for the generalist level suggests that the generalist level nurse collects data across

the lifespan on the amount, and pattern of the alcohol, tobacco, and other drug use using reliable and valid screening tools, some of which are noted here in this competency.

Graduate level prepared nurses and the advanced practice nurse will advocate and provide leadership and guidelines for the reliable and valid screening instruments.

Intervention can be as brief as a 5-10 minute conversation. This conversation is intended to motivate the individual to make a behavior change. By communicating screening results to other members of the healthcare team, providing and interpreting the screen results to the patient, and simply engaging in a conversation about the risk level and strategies for reducing risk. A systematic review by colleagues in 2016 examined outcomes of brief interventions for alcohol brief interventions delivered by various providers, including nurses, counselors, general practitioners, peers, psychologists, and social workers.

Alcohol brief interventions that were assisted by nurses in part had the largest reduction in the quantity of alcohol consumption at the first follow-up after the intervention.

This led to the conclusion that alcohol reduction outcomes are superior for nurses who deliver alcohol brief intervention when compared with the delivery of those in interventions by other healthcare providers.

Corresponding with this intervention, standard five is implementation. A registered nurse implements the identified plan. He there are a couple of examples for the generalist level within nurse influence the plan, underscores the neurobiological basis of targeted symptoms and assist in explanations.

Another example is that the nurse provides the healthcare officials with the intended and unintended effects of proposed therapies. Those might include medication treatments such as buprenorphine, methadone, acamprosate, naltrexone, disulfiram, naloxone, and nicotine replacement.

At the generalist level, or the graduate level, in the -- an advanced practice nurse coordinates with caregivers and systems to implement the SMART plan. And may also lead interprofessional teams to implement the plan.

Evidence that utilizing approaches such as motivational enhancement and cognitive behavioral therapy. FDA approved medications for alcohol use include acamprosate, disulfiram and naltrexone. And for opioid overdose, naloxone. For opioid use

disorders, buprenorphine is able to be prescribed by nurse practitioners and physicians assistants who have a waiver to do so. Additionally, methadone is a medication provided through clinics.

In providing these evidence-based treatments, these are the competencies we suggest for Standard 9. The registered nurse integrates findings into practice. At the generalist level, nurses learn and utilize knowledge to guide practice and prevention, dedication, and treatment of substance use disorders. Another example is they share evidence-based knowledge with colleagues, patients, families, and communities.

At the graduate level, the nurse critically analyzes data and evidence to improve practice in the prevention and treatment of substance disorders and develops new practice -- to enhance the consumer health -- health in the area of substance abuse disorders.

Referral to treatment aligns with the patient's need for substance abuse treatment based on the screening score and/or medical and behavioral factors. We suggest the use of specific community and other resources and arranges follow up.

In this report -- this referral to treatment aligns with Standard 15 utilization. The registered nurse uses the appropriate resources to plan or provide nurses services that are safe, effective, and financially responsible.

Examples of the competencies at the generalist level includes comprehends criteria for appropriate level of and resources for substance abuse treatment. And for the graduate level, provides leadership in identifying resource needs, reducing or eliminating barriers to accessing care, and promoting the creation of a variety of person centered resources for the care of substance use disorders across the lifespan.

It is advisable to consult with a specific pair to decide what -- check the website for the Department of Health and Human Services centers for Medicare and Medicaid services at the websites shown here. For current and updated information about what is available and reimbursable. Information in a publication related to expert services applies to the Medicare paper service plan also known as original Medicare and Medicaid.

Of course, money talks. More than a decade ago, Larry Gentilello and others produced a cost analysis of screening and intervention. The net cost saving of the innovation was $89 per patient screened or $330 for each patient offered an

intervention.

The benefit in reduced health expenditures resulted in a saving of $3.81 or about $4 for every dollar spent on screening and intervention. So it decreases mortality and saves money. Clearly, nurses at all levels have a role in providing a set of clinical strategies. Thank you.

TERESA JACOBSON: Thank you. As mentioned, I'm in Teresa Jacobson and I've been involved in helping leading integrated care in several ways over the last five years at Greater Cincinnati Behavioral Health Services. The last few years have been concentrating on those diagnosed with serious mental illness. This part of our presentation speaks to essential elements for nurses and considering meeting with patients in any integrated care setting as defined in the literature. First, though, allow me to set the stage.

As nurses and nurse practitioners, I am certain many of you have had prior experience working in the traditional medical model in primary care settings. Historically, when primary care providers identify mental health issues, they would be referred to specialists. For the specialists working in behavioral health, psychiatrists and other clinicians traditionally focused on the mental health only, perhaps referring patients to primary care.

But, unfortunately, the referrals were frequently not followed through on by the patients. Some of our behavioral health clients who have received care in the fragmented system have said there was a time they felt judged, ignored, or just too embarrassed to adjust to the emotional suffering.

Unfortunately, when there is a physical health or mental health crisis, expensive services such as emergency rooms are utilized and unmanaged health issues become very problematic. It wasn't long ago that our clients diagnosed with serious mental illness would have been institutionalized.

Some people still see mental illness is a character flaw, when truly, we know brain disorders should be treated as any other medical issue. In a fragmented system, those with serious mental illness had healthcare needs that went unmet. Our focus on SMI were -- dying 25 years sooner than the general population coming from modified risk factors like smoking, substance abuse, and access to medical care. We at Cincinnati Behavioral Health Services became an early adapter of transformative change is due to our commitment to region -- reverse the trajectory of this catastrophic force of persons dying 25 years early. As a result, we now have many doors which are client-centered. We have nurses

and integrated care at many of them.

We have partnered with some of the qualified health centers in Cincinnati. Over a decade ago, we developed the healthcare connection inside the medicine site, thanks to a healthcare integration grant, and we have created the another project due to a second grant.

Today clients with serious mental illness have access they didn't have before right on site at their comfortable behavioral home. Nurses who support clients in a psychiatric so site are providing care for their patients' physical health. It is a fully integrate model that is working and our Director of Nursing, Dean Visk, will be sharing you this model.

Our organization has also integrated physical and behavioral healthcare with -- by embedding behavioral health throughout Cincinnati, totaling 11 primary care sites where outreach touches thousands each year, impacting the mental health of those receiving primary care. Nurses play a vital role there as well, in assessment, collaboration, and patient education.

Another model we have used for integration involves assertive community treatment. It is an intensive and highly integrated approach for health delivery to those diagnosed with serious mental illness. But regardless of where integrated care is provided, nurses are helping to improve overall health and well-being.

No matter what door our clients come to, nurses are often the person first person a patient sees before he prescriber. They hold a very important role in this position, both in assessing patient needs and setting the tone for care. A whole person approach in integrated care helps break down judgments regardless of integrated care settings, using person centered language is very important. Instead of saying schizophrenic, we need to say a person diagnosed with schizophrenia. We don't want to use language that denotes personal feeling or regarding substance use, we don't want to use language like people choose an addiction or they lack the willpower or character to control their substance when we note the repeated use has some powerfully altered brain function and can create a neurological disorder.

Personal language is very essential. Nurses should refer to these patients as someone with a substance use disorder rather than substance use abuser or attic. Nurses can also help set the tone by treating mental health concerns as physical.

With 375 people in our program, they have experienced trauma in their lifetime. Providing patient-centered care and a culturally formed way, trust is formed, and a therapeutic connection can begin. Nurses can often provide advocacy for education to patients as well as modeling a perfect communication for other team members. If all team members used this informed approach, patients will feel welcomed, cared for, less judgment, and therefore less damaging self judgment and more help. Patients are very receptive to continue treatment because of this.

Activating prevention and management of chronic management often begins with the nurse. Interviewing is a guide to help missing practitioners have productive conversations with patients about behavioral change. Miller describes this to help patients with alcohol abuse. This is a highly researched evidence-based approach that enhances intrinsic motivation by resolving ambivalence.

This is accomplished by an answer in which the patient generates his or her own reason for change which is going to touch on some of the essential elements in motivational interviewing for healthcare.

This includes reflective listening skills and empathy. An example from one of our earliest clients with substance use disorder when she was trying to quit smoking. She said I have tried to quit smoking, but it's even harder than quitting heroin. The nurse did reflective listening and empathy, and said I've heard from a lot of patients that it is very hard to quit smoking. It sounds like you're putting a lot of effort into this. It must be important to you.

A nurse or nurse practitioner can convey to the patient that change is difficult and ambivalence about change is normal. By developing discrepancy, it sets the stage for organs for change from the patient. In this way, the patient use the current behavior is conflicting with their own personal goals or values and helps increase awareness and aid intrinsic motivation.

Resistances help patients often deal with discomfort created from ambivalence. Nurses practitioners who practice scare tactics might argue you realize you might develop lung cancer and die if you don't stop smoking. But that will only likely create an environment where patients become defensive and isolated.

If we roll with the resistance, we invite clients to argue for his or her own change by brainstorming to find solutions.

Let's take an example. Someone who is having difficulty finding motivation to walk. I hear you saying that you want to do some walking, but you're always exhausted. What things can you do to help with your tired feelings? This helps solicit the brainstorming for patient's own ideas and goals. Self-advocacy is an important area to patients. This is a confident belief that change can take place. Self-empowerment and self-control are obtained when patients believe what they are doing will make a difference. Just remember, the patient's own idea is essential.

Other techniques are cognitive behavioral strategies such as journaling, logging blood sugars, and blood pressures. All of these as you know, raise awareness. We can take it a step further and add a column for mood or feeling. All patients can become aware of how fluctuations in sugars or emotions may impact their mission. A few years ago I created a group in which we provided blood pressure monitors at the first group meeting.

I taught them how to do deep diaphragmatic breathing and monitor their symptoms. At home, I had patients take their blood pressure, write their mood, use several minutes of deep diaphragmatic breathing and recheck the blood pressure and pulse to see the difference it could make.

These are also helpful with asthma, anxiety, and other problems. Similar to biofeedback, patients can see the relationship between their emotions and their symptoms and can begin to take control.

Another area we see is health anxiety for the continuous worry about having a serious illness or disease characterizes in bodily sit sensations. Many humans have catastrophic thoughts. But when it comes to extreme, and even bodily sensation is analyzed, this is sometimes worsened by Googling healthcare symptoms, these symptoms can be impacted.

It's hard for even the best clinicians to decipher the overlap. Catastrophic feeling is distortion. When we do this, the worst possible outcome is assumed to be true. For nurses and nurse practitioners, cognitive restructuring is a way to help patients sort through their own thoughts and help bring the thoughts to awareness, focus, and examine them for irrational thinking.

Perhaps the situation is for a patient has noticed a slight elevation in liver enzymes on their chart. Someone who may have health anxiety may think the worst. What if this means I have cancer? The patient might struggle with this for days before returning to the nurse or nurse practitioner and they come in

with increased blood pressure, pulse, chest pain, and other symptoms. But sorting through this is key. It's common for us to think the worst of test results, but it's very possible the test is a false positive or something we should just watch. Education there is very helpful.

It has become more important to screen for a growing variety of symptoms. The assessment usually used in primary care visit -- settings identify depression and suicide. The primary care posttraumatic stress disorder screening and the general anxiety disorder screening. These can also show the value of treatment effectiveness when re-administered. Early identification leads to treatment to help those who are suffering.

In the behavioral health world, and death diagnostic assessment is important. We are asking clients of the holistic project to measure every six months overall quality of life and well-being. It's part of the SAMHSA grant.

As far as the behavioral health, he or she is about to see which informs the medical health assessment process. The feedback we get from the nurse practitioner and medical doctor is that our diagnosis here is mental illness and tends to have very complicated physical health conditions.

But keep in mind, some of these are receiving treatment for the first time in a number of years. The health outcomes we are seeing are incredible, as you will see from Dean's presentation, but we have seen a 50% improvement in function in everyday life.

You will soon learn about our unique approach to that. Our nurses are vital to triage of patients. Who call about their physical health and primary care providers. In the integrated fashion, they can sort through physical health concerns and from that patient with symptoms of pneumonia to someone who's glucose didn't register on the glucometer, nurses play a vital role in assessment, collaboration, care coordination, and the follow-through needed for enhanced health of the patient.

Communication is key. Judgment free patient centered language and introduction to providers, timely, appropriate referrals and follow-up are all key components to integrated care. Collaboration and consultation should be very timely and consistent. Nurses can model this, always keeping the patient privacy a top concern. Nurses have opportunities to be leaders. Because of the roles nurse practitioners provide, they are paving a way to help with a change from episodic care to team-based centering across the lifespan. I hope that nurses truly embrace the integrated care environment and become key

collaborators for enhanced health and well-being.

As a full partner in this new health paradigm, nurses are pivotal in health – helping create health effectiveness, efficiency, and patient care.

Thank you for all that you do and the compassion you share. Thank you for your time today.

DEAN VISK: Good afternoon. I just want to thank everybody for being on the webinar well with us today. My name is Dean Visk, and I'm the Director of Nursing Services at Greater Cincinnati Behavioral Health. Today I'm going to talk a little more about the pre-integration -- what pre-integration looks like versus true integration when it comes to nursing practice. How to get to the point of true integration, and once you are there, and I'm going to use examples as Teresa had just mentioned, from our model. What are some of the benefits once you are there?

So first, I want to talk a little bit about what the role of the behavioral health nurse was pre-integration. This role looks a little bit different once we get to true integration. Our behavioral health nurses were doing a lot of screening. We were getting height, calculating BMIs, blood pressures, pulse, respiration, oxygen saturation, fingerstick blood sugars, and lipid levels. But as Teresa also mentioned, there was quite a bit of fragmented care. What do we do when we get a critical health indicator? Where does that patient go if they don't have a primary care provider or if they are not connecting in any way?

They were using their expensive resources in the community, going to emergency departments, and then not really knowing what the follow-up was after. Our behavioral health nurses were assisting in medication reconciliation and assisting patients with medication refills, but again, mostly on that behavioral health side to keep us patients that have maybe missed their behavioral health prescriber appointment, keeping them having access to their medications.

Our behavior health nurses were administering long-acting injections that were indicated for their behavioral health diagnoses. We were doing bonus education -- wellness education, but this wellness education was very behavioral health focused and it did pertain to physical impacts, it was more related to the impacts of the behavioral health medication.

We were working with patients on medication self-monitoring training, helping assist them filling premade medication packets

so they can adhere to the medications. But much of it was a behavioral health focus.

So some of the potential benefits of an integrated approach to nursing care include the patient is treated holistically. We are treating both the behavioral health and the primary care issues. There is better access to both behavioral health and primary care, and that nurse works as an advocate and resource for that patient. But when a patient comes into the behavioral health setting or the primary care setting and sees that familiar face, that nurse that has worked with them on both their health issues and primary care issues, there is a level of relaxation that a patient can experience, in knowing their provider.

Ultimately the research shows that this can decrease potentially. It can decrease patient hospitalizations. Increase patient satisfaction. Again, having that one stop shop with a familiar nurse that is working with that patient on both the behavioral health and the primary care side.

That nurse can also be a liaison with the primary care and behavioral healthcare teams, a liaison with the prescribers on those teams, and ultimately increase this patient's adherence to treatment.

Now, with all these great things that can happen, it doesn't come without its challenges. In developing integrated nurse care, coordinators, it's part of the culture where there is a belief in integration. A belief in what you are doing. Hiring and retention challenges, and lots and lots of training needs.

So first we are going to talk a little bit about believing in integration. How do you get staff to believe in the model and the culture of true integration? It starts with confidence and competence. If you have a behavioral health nurse that has been working in a behavioral health specialty for many years or a new nurse coming out of school, that may not necessarily have the confidence in their nursing skills or the competence or the training that they needed in order to be able to provide safe, effective evidence-based care on both the primary care and the behavioral health side.

When they are successful, you need to celebrate those successes. I always like to share the story of one of our behavioral health nurses, who for the first time in a long time since nursing school, actually was able to successfully use her phlebotomy skills again and successfully get her first blood return and do her first blood draw in many years. Those successes need to be celebrated.

As always, sharing the evidence. Sharing what we are learning and provide the literature and provide evidence-based practices to those nurses so that they can build confidence and competence in their practice.

Hiring and retention. It's really important that we look for nurses with primary and behavior healthcare experience during the selection process. But that's not always a luxury that we have. So it's important that we are supporting those nurses and developing integrated care practices within our culture and within our organization so that we can develop nurses into true primary and behavioral health integrated nurses.

Again, developing these integrated nurses through training and support, which I am going to talk a little bit more about.

So some of the training needs and resources to bring your nurse from pre-integration to true integration needs to happen in-house. There needs to be strong nurse leaders that have the ability to find the evidence, to model the evidence, and to train nurses.

Now, as we all know, nurses cannot possibly know every single thing. So in some instances, we need to reach out to other community resources, which I'm also going to talk about further in some of the next slides that we are going to see. And providing those nurses ongoing support and development.

This is an example of one of our in-house training tools that I personally love. It's a mannequin arm that helps nurses that either might be a little rusty in their phlebotomy skills or possibly may have never done phlebotomy in a patient care setting other than what they had done in their nursing school setting. So this was always available to our nurses at our location when we were training them on doing things from the phlebotomy to EKGs to suturing, to irrigation. Really teach teaching our behavior care nurses how to practice in a safe way and giving them opportunities to study where it is safe to make mistakes and to learn from those mistakes.

I also found it very helpful to have community resources that I could go to that I could utilize when there was something that maybe I could provide those nurses in house. I was fortunate enough to develop relationships with several of the nursing education programs in the Cincinnati area, and two of those nursing programs actually welcomed our nurses into their simulation labs, allowed them to be able to come in at any time, practice their skills on mannequins, the instructors there were just very, very helpful. They were wanting to give back to the

community and they believed in what we were doing, and they also made themselves available for our nurses if they needed to go to that site and practice their skills in a safe way.

Always, looking at the literature. I am constantly looking at the literature for what the evidence is saying. What are the best practices? What are the differences that are being made? What are the changes? Coming from an educational background in nursing, I always have good old textbooks, Lippincott, always available to our nurses, to be able to look at the steps. If there is something they haven't done in a while, and they don't feel confident in that skill, it's available. We can sit down. We can look at what the evidence and the literature says, what the textbooks say, and we can walk our nurses through those skills so that they feel supported.

So this is a really important slide. Once you have done this training and provided this support, what does the role of the integrated care nurse look like? It's different than the behavioral health nurse in that it encompasses more that holistic approach that we spoke about earlier. It's that nurse assisting in the primary care provider in providing true integrated nursing care. Or vice versa.

It's the integrated nurse providing that support for that behavior health provider that may be struggling with a patient that may have ongoing medical issues and being that liaison between the two so that collaboration can happen. Providing both primary and behavioral healthcare. Integrated wellness education, which we will talk about more in some of the next slides. Integrated team huddles and what those look like. We will talk about that in some of the next slides, as far as what our treatment teams now look like. Triage in between appointments, something that Teresa mentioned, has been vital to the success in the continuity of care and how the integrated care nurse works.

For example, we don't have a primary care provider at our site every day, but we do have an integrated care nurse there every day during business hours. If our patients need assistance with anything from behavioral health to primary care, that integrated care nurse can triage that phone call, they can determine whether that person needs a higher level of care or whether that person needs to make an appointment with our primary care provider or if it's a behavioral health issue or related to the behavioral health medications, again, triaging it to our behavioral health providers.

That integrated care nurse has a very holistic view of everything that can happen with that patient, rather than having a fragmented care of sending them to emergency rooms if they don't need that level of care.

They are a collaboration medium between providers, as we have already mentioned, and just empowering healthcare change in this population. Many of these patients, we all know, have either not had good experiences with primary care, but they feel comfortable coming to their behavioral health setting and to have an integrated behavioral health nurse that is truly working in an integrated fashion to meet them at the door and be able to triage their issues is very, very valuable.

Here is an example of some of the integrated nursing and education that we may provide. Some of the models that we may work through with our patients. You can see closest to you, there is a model of vessels that are different stages of occlusion with athero- and arteriosclerosis. When we are doing our lipid screenings, we can pull this tool out and begin to explain to the patient what does this mean. Why are we taking your blood? Why are we doing these tests?

Here's why, and here's a model that we can show you as to why we are doing this. The effects of diabetes on different body systems. To the far right, you have what is one occluded vessel and one very un-occluded, free of any type of plaque vessel that we can show a patient what it looks like for those blood cells to go through the clean vessel versus the occluded vessel.

That kind of show and tell type of integrated nurse education has an impact on patients.

Integrated care team huddle. Here, prior to starting the day at our primary care suite, we have our pharmacist, our integrated nurse care coordinator, we have our primary care providers, and we have an administrative MA all huddling together that same day to talk about the patients that are coming in for the day.

Then you have the integrated care multidisciplinary training team. This team includes representatives from the behavioral health provider to the primary care provider to the pharmacist to social workers, care management supervisors, at times care managers. We have our integrated nurse care coordinator and at times, when necessary, we also can bring the patient in to that integrated multidisciplinary treatment team to discuss what is happening with the case and all the players that are involved in that nation's care can get input and be able to speak with the patient.

All of this leads us to this role of the integrated care nurse care coordinator. We are doing community nursing visits. Patients can't come to us, that we are going to them. We are collaborating with specialists. We are making referrals to specialists. Coordination of care and continuity of care is a vital thing that really helps these patients holistically get what they need from their treatment team.

Our nurse care coordinators are advocating for wellness. Again, we are working both in behavioral health and the primary care setting.

Here are some critical data that we have collected with our patients, and I'm just going to briefly for the sake of time just draw your attention to body mass index. When we started this, 82.1% of the patients were at risk. We are now seeing data in using these integrated nurse care coordinators, every one of these patients that we collected data on, has in some way, shape, or form, then touched by an integrated nurse care coordinator. 41.5% had improved outcomes. 1.9% no longer at risk.

That's huge. A 41.5% improved outcome is definitely clinically significant and definitely very, very proud that having this model, we are showing changes in the critical improvements in our patients. Thank you.

AARON WILLIAMS: All right. Before we move into the next presentation, I want to quickly remind you that if you have any questions, feel free to type them into the box and we will try to get through as many of them as we can at the end of the presentations. Thank you. Yovan?

YOVAN GONZALEZ: Hello. My name is Yovan Gonzalez, and I am a nurse practitioner that practices in New York City. The reason I am here today is because I have always been interested in integration of primary care and behavioral health. But it was not until about a year ago when I started my program that I realized we could not provide our patients with competence of care if we did not also integrate substance use screening and management.

So today I'm going to be talking about integrating at two facilities where I work as a family nurse practitioner. And first we will talk about primary care and the second brief example will be integration of primary care in the behavioral health at the Roberto Clemente center.

So Gouverneur is the largest -- over 60,000 patients per year.

It is also a federally qualified health center. It is the largest -- system in the country. Gouverneur is situated in the lower east side of Manhattan. Approximate one-third of our patients speak Spanish and another group speak Chinese. Many were born and raised on the lower east side, and many of them come from all over New York City.

About 40% of our patients are uninsured and the majority of the rest have public insurance, meaning Medicaid and Medicare.

The -- we conduct approximately 50,000 -- annually. We have 32 primary care providers which includes nurse practitioners and about 20 nurses. At Gouverneur nurses are involved in all levels. I'm going to be discussing them one by one.

At the department level nurses are involved in three different programs of integration. We have the collaborative care program, and the integrated care committee. First we have the collaborative care model which is based on the impact models from the University of Washington. This is an evidence-based model that looks at patient -- that is patient focused. The leader is the primary care provider which could be a nurse practitioner or medical doctor. Our team also involves psychiatrists and a nursing care coordinator. Patients in our primary care practice are screened using the PHQ-9 tool and persons with a score of 10 or above referred to the program.

Then there is also -- for patients who are referred to the program. They are provided evidence-based treatments that can include motivational interview that Teresa talked about and also cognitive behavior therapy. There is a weekly consultation with a psychiatrist, and outcomes are measured using a psychometric tool like the PHQ-9. This is been important in managing our patients with depression, but we have also noticed that patients that were being referred also exhibited anxiety disorder. As a result, we are in the process of integrating management and screening of management of patients that have generalized anxiety disorder as part of our collaborative care model.

Second, we have the bupenorphine clinic. As was discussed before, beep and orphan is used in the treatment of patients with opioid use disorders. We have a waiver to prescribe buprenorphine. For nurse practitioners, it's 24 hours.

Our clinic is modeled on the treatment program based at the Boston Medical Center. The program's director is a nurse. Her name is Colleen LaBelle. If any of you have met Colleen or heard her speak at a conference, you will probably already know what a force she is for the expansion of this model and as an advocate

for patients with opioid use disorders.

In this case, a physician has been wavered to prove prescribe buprenorphine. A nurse coordinator is working in concert with the physician. The nurse care manager plays an essential role in evaluating and monitoring patients that are part of this clinic.

If needed, the manager will also assist in connecting the patient with referrals to treatment, major health groups, and recovery programs as well.

So we have the integrated care committee. This is a professional team that is composed of a psychiatrist, psychologist, social worker, and a nurse practitioner. So each team member brings their own expertise to the table. As the nurse practitioner on the team, I provide the primary care perspective. The patients are referred to the team by the primary care providers. Patients are referred for different reasons that can include mood and anxiety, personality, psychotic disorders, and substance abuse disorders. The team decides how best to manage the patient's, which includes psychopharmacology advice to the primary care provider, referrals, et cetera.

As a result of this program we have many success stories including that of a patient was referred to us by -- abuse of family members from her own country, and she could not go back there. We were able to connect her with services that help to start the process of seeking asylum. We also connected her with a therapist that spoke Spanish and specialized trauma management.

At the organizational level, we have the primary care behavioral care committee. In this -- groups across Gouverneur discuss our place in the organization. We have -- several departments. In terms of nursing involvement in this committee, we have the chief nursing officer, Sherilyn Wright, along with a family nurse practitioner. This committee provides a great platform to discuss integration programs that are seen and implemented in different departments across our organization. And we are able to share and discuss some of the challenges with integration in different population groups that we serve.

For example, due to the success of our care program in our adult medicine program, our colleagues in pediatrics and OB/GYN are starting similar programs. We also know that our pediatrics department is implementing a program called Strong Moms, where they monitor moms with postpartum depression at two, four, and six months after delivery. This program also includes nurses.

I know I'm here to talk mainly about the adult primary care department, but these sort of programs are also crucial because they also help close the integration gap and address behavioral health at every stage of the life cycle.

At the systems level, we have the buprenorphine, project ECHO. That connects teams with experts. This model is now being in implemented at New York City hospitals to provide support to primary care teams from across the system that are starting their own buprenorphine clinics. We currently have 17 facilities involved in this program. Each week has a different focus. Nurses and nurse practitioners that are buprenorphine champions also participate in this video conference. And the nurses within the system provide a unique perspective of the challenges of buprenorphine nursing managers.

For example, one of the managers at last week's session talked about the challenges that she faced in her day-to-day practice. She mentioned that it was dealing with things like disappointment and toxicology. One of the experts was able to provide immediate feedback that explained the toxicology only brought up the conversation about other substance use. So this -- it's this kind of exchange that makes this weekly session extremely valuable.

There are many challenges and threats when you're dealing with integration, but also creates a lot of opportunity to build on your organization strength. I consider myself fortunate to be working in a place where our mission is to provide conference of healthcare to all New Yorkers without risk of their ability to pay or immigration status.

And like many clinics around the country, we also have some challenges. These challenges include things like electronic medical records that do not integrate a psychometric tool and lack of a substance abuse department. But this challenge also creates an opportunity to use innovative models like our integrated care committee, our collaborative care model, our buprenorphine clinic, and other items.

Finally, I'm going to talk about primary care at the Roberto Clemente center. This is a picture of the center here. This is a health facility located in the East Village neighborhood in New York City. It is part of Google Health as well, and was founded in 1982. It serves mainly immigrant and poor families and they are purely Spanish, bilingual, and bicultural. I was brought into the clinic in 2012. Coming to the Roberto Clemente is in the was the place where I began to understand how important it

was to integrate part primary care and behavioral health.

The primary care at the Roberto Clement the center is small, and it is made up of a nurse practitioner, myself, a nurse, and an assistant. We have daily huddles much like with Dean's team, and we have patients we refer to primary care. Last year when I was waivered to prescribe buprenorphine, we opened our own buprenorphine clinic, and as of January of the current year, we have integrated universal practices and referral to treatments in clot desperate primary care treatments. And we are also working on an on-site educational program that will allow all members at the center to have access to the expert online program on demand.

We have routine integrated care meetings with staff from both behavioral health and primary care and the primary care department to manage conflict. One of the most important roles of this clinic I think is developing a nurse care coordinator. She works both for the primary care and the health department and facilitates communication among all team members. One day Laura can go from talking to a patient about managing their diabetes to providing a brief intervention with a patient who is taking too much alcohol and administering an antipsychotic injectable.

Finally I want to say that nurses around the country are really transforming patient care. We get active involvement in integration practices at the department, organizational, and assistive level. They are also doing this while advancing their own education and working with interdisciplinary teams. Thank you.

AARON WILLIAMS: All right. Thank you. I want to say thank you to Deb, Teresa, Dean, and Yovan. This was a very robust presentation to the gay really good examples of the types of things nursing can do, because -- quality integrated care, standards of practice, as well as different models for the services guys provide.

So now we have a bit of time here. What we want to do is we have a number of audience questions. Again, if folks have questions, feel free to take them directly in. Let me try to go through as many of these as we can, and I will sort of read out some of the questions to our speakers here.

The first question is sort of more at the beginning, so more for Deb or Teresa, are there any special requirements for RNs, nurses, to be able to provide intervention?

DEBORAH FINNELL: It's Deb.

AARON WILLIAMS: You are fading out a little bit.

DEBORAH FINNELL: Better?

AARON WILLIAMS: That's better.

DEBORAH FINNELL: Okay. As I talk in my presentation about the competency, we really talk about brief interventions in terms of a conversation with the patient. And so that kind of brief intervention is something that nurses have been doing for a long time, having those conversations, providing information about for example, blood pressure, we give the person information about their blood pressure and compare that with whether that is in the normal range or the hypertensive or hypotension. So it's well within accepted practice for the registered nurse and clearly for the advanced practice nurse.

AARON WILLIAMS: Okay. Thank you. I have another question here, actually a couple of questions, I will put them together. Thinking through funding for these positions, how do you formulate your models? I think the question is open to Dean or Teresa as well as Yovan. How do you get funding for your various positions?

DEAN VISK: Depending on the state and with the changes to Medicare and Medicaid, it really just depends on what that nurse is doing. We are lucky in Ohio that with our behavioral health design, we are able to do more holistic care based on our sources, which we can now look at issues with a patient's medical issues without having to just focus on the behavior health issues. You want to look and see what your sources are and kind of see what you're doing, if it's sustainable. There are additionally some things to think about it comes to that.

AARON WILLIAMS: Okay. That makes sense. If you're thinking about going through and doing services and activities and checking to see if those are obtainable within that state. This is correct.

We have another question. I have an MSN with a -- can this be used in the role of advanced practicing nurse?

DEAN VISK: No. They actually have two -- I guess I need clarification on the question. Are they asking if a Master’s prepared nurse who has an MSN in education, can have prescriptive privileges? Is that what they are asking?

AARON WILLIAMS: Well, they don't mention that. I would assume that -- will they be able to work in some of these settings, I

guess.

DEAN VISK: Absolutely. They can work in some of the settings and typically the APN credential is generally considered a nurse prescriber. So the answer to that question is no, unless they have their MSN and are advanced nurse or nurse practitioner and passed the appropriate boards and be able to prescribe, they would be able to prescribe. But absolutely. A Master's prepared nurse can practicing and advanced way because of their scope of practice, having that specialty. So I would use an MSN in education to train staff, train nurses, develop education programs and training programs and things of that nature.

AARON WILLIAMS: That makes sense.

DEBORAH FINNELL: Can I just add to this? Just to build on that, the difference is that the advanced practice nurse is typically defined according to the roles as Dean mentioned in terms of life insurance certification, nurse practitioners, clinical light specialists, certified nurse, midwives, and certified registered nurse, anesthetists, all within those four roles or advanced practice nurses. And I would just underscore what Dean mentioned in terms of the MSN in terms of a focus on education putting a person in a role with education to staff. The others are really direct care licensed providers.

AARON WILLIAMS: Thank you.

We have another question. In my experience, I come from the school of thought where medication is the sole solution to mental health concerns. So talk a little bit more about how nurses are trained to really engage into this health solution. Teresa, I thought you were discussing some MRI as part of your presentation earlier as well. So is this something you want to take a shot at?

TERESA JACOBSON: Actually, I'm going to defer to Dean on that one.

DEAN VISK: It all boils down to what Deb just said. Scope of practice. So a registered nurse that doesn't have that credential proved to prescribe medication, still within the scope of practice, has a myriad out of the list of nursing interventions that they can perform. So somebody that may be experiencing auditory hallucinations, yes, an antipsychotic medication may be helpful for that. But also, some are in intervention in providing reality orientation for that patient, helping the patient identify coping skills. So there are things called nursing care plans and concept maps that are well within

an RN’s scope of practice to provide intervention that are not medication in nature.

AARON WILLIAMS: . Thank you. Another question that came in, I guess it's a couple that came, really directed at Yovan. In the clinic sexy mention, how many RNs are supporting the PCPs and what is the case load for each nurse or nurse provider?

YOVAN GONZALEZ: About, like I said before, about 32 providers and about 20 nurses. Not all are working full-time or at the same time. A lot of times it's about one nurse to every 4-5 providers at a time and they are there to pursue support the provider whenever they needed with motivational viewing, education, education around disease management or medication management and all of those things.

So there is definitely support there for every single provider.

AARON WILLIAMS: Got you. Thank you for that.

We have another question here that has come in and I guess they are asking questions about -- are you using a particular resource to establish, the seat or have you created a set of nursing competencies that are open source? Can you talk a little bit more about some of the nursing competencies and where people can have access to those things?

DEBORAH FINNELL: I can start by fielding this. The American Nursing Association has scope and standards for all of nursing. So that is our primary go to for our manual for those standards of care and standards of practice that I mentioned at the beginning of my presentation. The work that our group has been doing with support from SAMHSA has been to develop competencies that are focusing on substance use that are –

AARON WILLIAMS: Deb, you've faded out a little bit at the end when you are talking about resources for SAMHSA.

DEBORAH FINNELL: Okay. Is this better? We have drafted the competencies and they currently are in the process of going through a review process and vetting with response from other experts. So what I showed today it was just kind of a sampling of some of those competencies.

AARON WILLIAMS: Okay. So they are still kind of in the development stage, but at some point they will move forward.

DEBORAH FINNELL: That's our goal, yes.

AARON WILLIAMS: Thanks for the clarification.

Here we have a question that is kind of open to folks here. If you all have seen or there has been resistance to it in permitting integration in the way you guys talk about on the webinar, where does this resistance typically come from? Does it come from the primary care providers, the nurses themselves, or from other people who are part of the team? So if resistance is there, where does it come from and how are you working through that?

DEAN VISK: This is Dean. Anecdotally, from my experience, it always for me comes from that confidence and competence. If I have a behavior health nurse who doesn't feel confidence in their skills in performing a certain procedure, then obviously they are not going to be really happy that they have to do it. I find once you get them to the point where they are confident and competent in doing the skill, they love doing the skill and become champion at that skill. So I think a lot of it stems from developing that in the nurses.

As far as other members of the team, it's a culture. It's developing a culture in your organization that really supports and sees value in integration.

DEBORAH FINNELL: I can add to that, Dean. When we had Dr. Lucas, a medical doctor that was overseeing the project with us. And she had so much involvement with teaching us and grooming us for this integrated care model. And she give up her off days to join us in launching services because she believes in the model so much.

YOVAN GONZALEZ: I agree with you, Dean. There is a lot in every single discipline. And it's due to lack of confidence and competence. I was one of those people that was resistant to it. And I think going to the doctoral program, meeting Deborah Finnell changed me. And I feel now that is something that is necessary. And I'm doing my best to educate other people to build their confidence, to build their competence. And you find a lot of allies when you do that.

DEAN VISK: Absolutely.

AARON WILLIAMS: Thank you for those perspectives on that. I agree with you all about building the confidence in the providers and moving from there.

As a segue, we have another question here that talks a lot about a lot of time practices are attempting to engage integration in the collaborative care model. For many people who have tried this, it's burdensome on a number of different levels.

Financially, culturally, administratively, operationally. So how have you all worked with the integration projects and integrated care and collaborative care, how have you moved past those challenges in terms of the overall burden in the process?

TERESA JACOBSON: We have to keep reminding ourselves that it's a marathon. And you learn along the way. We didn't always know what we didn't know. So it's kind of like trusting in the process and trusting in what we were learning to build that culture. And having the right people on the team was a big plus.

AARON WILLIAMS: Got you. Okay. Anyone else want to chime in on that one?

YOVAN GONZALEZ: I want to agree with Teresa. I feel that all the time, it is necessary and that's why I feel that we need to go and do everything we can to integrate behavioral health and primary care.

AARON WILLIAMS: Okay.

We have another question here. How do you all share patient health information across the interdisciplinary care team?

TERESA JACOBSON: I can answer that for the holistic healthcare program. What we are doing, we have two systems currently. We are creating team huddle notes using our system and that is shared among the treatment team members. So we are still working through some of the processes of the system integration. But at this time, that's what we are using.

YOVAN GONZALEZ: At Google Health, we have the same system. Both behavioral health and primary care share the same.

AARON WILLIAMS: . That makes sense. So we have a limited time here and a couple more questions to see if we can get through. Thank you all for sending in these questions. If you have questions, you can again, type those in and we will try to get them in, in the remaining time.

One question here is what is being done at least from your perspective to continue to promote, educate, and prepare primary care providers or even nurses as a part of this, for integrated care? Do you have a sense of what is happening at an educational level, graduate level, for training and integration?

DEBORAH FINNELL: This is Deb. I can speak to this about what we are doing at Johns Hopkins. We are looking to be connected close by to the medical school on public health, and we have another university that has a competency program. Multiple times through

the year, the students come together to do interprofessional education activities. And they last for several hours, usually during the evening.

What is great about that is that we are teaching and showing students the value of understanding each other's discipline and needing to articulate what each discipline brings to the table. So I think integrating this content early on in the education will be helpful in terms of the next generation of providers that are going to be providing that kind of care and perhaps not seeing the same type of resistance that we currently see.

AARON WILLIAMS: Got it. Thank you. Does anyone else want to chime in about that one? Are they seeing of the things that are happening?

Okay. We have time for a couple more questions. We have one, I think this is for Dean, when you're looking at some of the outcomes, can you share just a little bit more about what the timeframe was from baseline until you saw some of those successes at the end?

DEAN VISK: Absolutely. I believe the first interview was on the baseline, and the second one is at six months. So we have actually seen differences in six months. We are three years, almost, into our integrated care project, the grant we have been given. So the actual data that I presented and Teresa, correct me if I'm wrong, this is data from about 2.5 years?

TERESA JACOBSON: It was actually run to the most recent assessment. So it is at all different levels of the assessment. Some at 6 months, 12 months, 18, 24.

DEAN VISK: We assess at six months intervals. So some of these data are patient that are very new, some are patients that have been there from the beginning.

AARON WILLIAMS: Got you. One more question here. This might be a good way to kind of segue into wrapping up. I am the only RN that works with social workers in our setting at my facility. Any advice you could offer on how to incorporate integrated care into my facility? So thinking more broadly about that question, any advice you all would give in terms of getting the ball rolling at facilities?

TERESA JACOBSON: We recently met with some folks at an orphanage locally that are exploring integrated care. They have done some things that were kind of interesting to consider, such as bringing in a primary care provider occasionally to check in

with the kids.

There are certain ways to get started, but also at the same time, you want to start building that culture of integrated care as soon as possible. Even if it's having flyers and brochures available and teaching the kids some things they can do for activity. Nutrition, there is so much that can be done. What do you think, Dean?

DEAN VISK: I think, just to piggyback on that, nurses can definitely be champions of that. Nurses, by their education, they are taught to see the patient holistically. So if you have a nurse that is in your agency that can really drive home the importance of wellness and proper nutrition and screenings and being able to have an impact on some of your other staff and getting them to buy into that culture, I think that nurses, there is a great opportunity for nurses to be champions of that.

AARON WILLIAMS: Okay. Thank you. So thank all of you for your presentations today. We are just about that time. On the screen now we have some other resources for folks on the call. CIHS has a webpage and also some other resources on the page that might be of interest to you.

We want to thank Deborah, Teresa, Dean, and Yovan for their wonderful presentations today. And for all of you who joined us today on the webinar. If you guys want to learn more about integration, you can visit our website or you can e-mail us. So once again, I want to say thank you to everyone. You will be directed to a survey at the end of this webinar, so thank you all for participating and think our presenters for a wonderful job today. Thank you all. Have a wonderful afternoon.

[End of webinar]