

## TRANSCRIPT OF AUDIO/VIDEO FILE:

### **2012\_11\_08\_12.00\_INTEGRATED\_CARE\_WITHIN\_THE\_PATIENT\_ CENTERED\_MEDICAL\_HOME\_ THE\_HEALTH\_CENTER\_PERSPECTIVE**

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#### **BEGIN TRANSCRIPT:**

Slide – [www.integration.SAMHSA.gov](http://www.integration.SAMHSA.gov)

LAURA GALBRAITH: Hello and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webinar today titled "Integrating Behavioral Health and Primary Care in the Context of the Patient-Centered Medical Home. My name is Laura Galbraith, Director for the Center for Integrated Health Solutions here at the National Council for Community Behavioral Healthcare, and I'll be serving as your co-moderator for today's webinar. Before I introduce my other moderator who's joining me today I just want to give some housekeeping updates and let you know that today's webinar is being recorded and that all participants are kept in the listen-only mode. You can find the call-in number for the webinar on the right-hand side of your screen. Questions may be submitted throughout the webinar by typing your questions into the dialog box on the right and we'll get to those as soon as we have Q&A breaks throughout the webinar, and we'll try to get through as many questions as time allows. And lastly, at any point during the webinar if you experience technical difficulties please called Citrix tech support at 888-259-8414. [1:00] At this time I'd like to introduce Bill Reedy, Assistant Director for Behavioral Health Integration at the National Association of Community Health Centers. Bill will introduce our speakers and give you a little bit of a context for today's webinar. Bill.

Slide – Learning Objectives

BILL REEDY: Thank you, Laura. Welcome to all of you out there, we are delighted to be partnering with the Center for Integrated Health Solutions in the delivery of this webinar today. As you all know, integrated care is a hallmark of the patient-centered medical home, and behavioral health integration is a particularly important aspect of that integration. It's not only because of the concerns about the individual mental health and substance use problems that people experience every day, but also because of the complications that that raises in the

treatment of other medical conditions and care. [2:00] So this topic is of keen importance to all of us.

What I'd like to do is just kind of review briefly the objectives, the learning objectives for today's session, which are three. First of all we're going to focus on helping further your understanding of the role of behavioral health integration for effectively addressing not only NCQA PCMH recognition standards, but in the practical service that it provides in responding to the complex healthcare needs of people in patient-centered medical homes. The second objective is to identify for you the critical elements for providing effective integrative behavioral healthcare within the PCMH. [3:00] And then thirdly, we want to bring you some really practical insights from the frontlines. And we have two health centers that are going to share their experiences as they've integrated care using different models they've partnered and their experience with specialty community behavioral health providers, and discuss some of the changes that they are making related to PCMH, and just generally kind of share lessons learned and opportunities going forward that they see that may be beneficial to you.

### Slide – Agenda

I'm going to introduce, just give you a little background and tell you who our presenters are today, and then we will get on with our agenda. Our first presenter today is Judith Steinberg, a physician who serves as the Deputy Chief Medical Office for University of Massachusetts Medical School's Commonwealth Medicine Division. We're delighted that Dr. Steinberg can join us today. She leads the UMass Medical School team that is supporting the implementation of the state-wide multi-payer Patient-Centered Medical Home Initiative in Massachusetts. [4:00] She's also a clinical Associate Professor at the Medical School and she brings a broad range of experience, having served previously as Medical Director of several health centers in Boston. So we're delighted. So much is happening on a state level for all of us, it's important for all of us to kind of be aware. And (inaudible) going to kind of go through some of their experience and highlight the context implications of PCMH.

Our second speaker following up and talking about kind of in the trenches perspective will be Marty Lynch. Marty is the Executive Director and CEO of Lifelong Medical Care in California. He's been Director there for a number of years and has terrific experience kind of working with the concerns of the elderly and kind of providing integrated care. [5:00] He was the past Chair of the California Primary Care Association, served on a task force on integration and primary care for California and kind of helped them develop a plan to address Alzheimer's disease.

Our third panelist is Ann Lewis, who is the Chief Executive Officer of CareSouth Carolina, and she has extensive experience in federally qualified health centers, having shepherded the development of the program from its inception to expansion of many rural sites serving lots of people in South Carolina. She also has served as the President of the South Carolina Rural Health Association and has enormous experience on the subject of integration. She's a faculty member from the Institute for Healthcare Improvements, a breakthrough series of collaboratives, and a noted expert on the care model.

So we are fortunate to have such a distinguished group today. The agenda is straightforward, we're going to open with Dr. Steinberg who is going to give us the perspective from kind of talk about some of the states' efforts to transform healthcare, how that—

[audio gap 6:19–6:59]

#### Slide – Implementing Integrated Care in the Patient-Centered Medical Home: The MA Experience

JUDITH STEINBERG: —and also to ensure that behavioral healthcare is well integrated with primary care delivery. So this presentation will be focused more at the systems level as opposed to what's happening at an individual practice or health center.

#### Slide – Agenda

So what I'd like to discuss first is to make the case for why the patient-centered medical home and behavioral health integration go hand in hand, then I'll shift the focus to what's happening in Massachusetts, first about Massachusetts' efforts to transform primary care and then how we are promoting and supporting behavioral health integration in our patient-centered medical homes. Of course there are barriers to behavioral health integration, and we'll look at how the state is addressing these barriers. And then I'll finish up with some lessons learned.

#### Slide – Behavioral Health Integration

So regarding the alignment of the patient-centered medical home and behavioral health integration, let's first look at what we're aiming to achieve through integrated care. [8:00] Here is one articulation of the goal: Optimize access and engagement in coordinated care to achieve improved health outcomes and reduce cost. So there are some foundational elements to behavioral health integration which we have included in our model, and these are first having a behavioral health focus in primary care such as including screening for behavioral health conditions and having the primary care providers and clinicians have the skill set to address patients with behavioral health conditions and to help patients with their behavior change. It also includes care coordination and information sharing, in particular in this case across the primary care and behavioral health sides. Also care management for the most complex patients; most of them have both physical and behavioral health comorbidities. And the integration and utilization of community resources to develop a more comprehensive customized treatment plan for patients. [9:00]

#### Slide – 2011 NCQA Standards

So this next slide, a slide that's probably familiar to many of you, shows the NCQA criteria, and here's an example of a definition of the patient-centered medical home. So as you know, there are six domains under which the criteria are categorized, and what we'll do is take a look and see how those foundational elements of care integration fit into these NCQA criteria. So as far as access and continuity, I would say that this requires a behavioral health focus in the primary care so that there will be increased access to behavioral services, care will be more patient-centered, it

fosters improved patient engagement. And having that behavioral health focus, in terms of screening and addressing the results of screening, will require team-based care, and again the optimizing the access. [10:00] In terms of identifying and managing patient populations, that too requires a behavioral health focus where patient-centered medical homes will be tracking and monitoring patients with behavioral health conditions and behavioral health components to their medical conditions, and this will allow for improved individual and population-based management.

Certainly there's a complete alignment with the planning and managing care and care management, and as I said this usually involves the patients who have behavioral health and physical comorbidities. Around self-management support, you certainly need behavioral health skills and a behavioral health focus to help support and empower patients in setting and achieving their self-management goals. And again, for tracking and coordinating care there is complete alignment there, care coordination and the integration of community resources. [11:00] So clearly the patient-centered medical home is well designed and is set up for the integration of behavioral health and primary care.

#### Slide – Primary Care Transformation in MA

So now let's turn our attention to the efforts in Massachusetts to transform primary care. And what you see in this slide in the light blue boxes are some demonstrations that we have put into place that are informing our understanding of how to transform primary care in Massachusetts. And in fact we're using these demonstrations to inform our newest model that's currently in design, and that's the Primary Care Payment Reform that you see at the bottom of the slide. So what I'd like to focus on is just one of these demonstrations, and that is the Mass Patient-Centered Medical Home Initiative. [12:00] So Massachusetts Patient-Centered Medical Home Initiative is a state-wide multi-payer initiative that's been sponsored by the Mass Office of Health and Human Services, and it's being conducted in partnership with UMass Medical School and Bailit Health Purchasing, which is a private healthcare consulting company. And much of the work that you see in ensuing slides represents the collaborative effort of these partners.

#### Slide – MA Patient-Centered Medical Home Initiative

So there are 46 participating practices in this initiative and they are very diverse. They're diverse geographically, standing across our state, there are different types of practices, different practice settings, different patient populations, and different sizes of practices. So 52 percent of the practices are community health centers, and that represents the fact that, although this is a multi-payer initiative, there is a public payer predominance to our initiative. It was hard to engage all the commercial insurers in our multi-payer initiative. [13:00] But other practices besides community health centers are our practices that are located in academic medical centers; many of them have residency practices. Some practices are practice sites of larger group practices, and then we have "onesy-choosy" private practices that are participating as well. This is a three-year demonstration; we are half-way through this demonstration, and this demonstration is really just a starting point for a grander vision set by our Secretary of Health and Human Services who is herself a primary care clinician. And the vision is that all Massachusetts primary care practices will be patient-centered medical homes by 2015, a very aggressive vision I would say.

### Slide – MA PCMHI: Incentive Alignment/Payment Reform

Now, we know that in the joint principles for the patient-centered medical home one of the important principles is that payment should support this type of model of care, so in our Mass Patient-Centered Medical Home Initiative we do have some payment reform elements. [14:00] So, in addition to the fee for service and also some start-up infrastructure payments that we provide to the participating practices, there are some new payment streams. There are two prospective payments that are paid to practices on a per-patient, per-month basis to cover medical home activities that just aren't captured in fee for service, like team meetings, enhanced access through e-mail, et cetera. And also a prospective payment for the services of a clinical care manager who will be managing that highest risk population of patients. And then the other type of payment stream that we are implementing is shared savings, so that practices who meet a quality benchmark are able to share in the savings if there are savings.

### Slide – Practice Redesign: Core Competencies

In this slide I show the core competencies that we're asking the practices to implement. [15:00] And what you can see here is that they're very much aligned with the NCQA and joint principles definitions of a patient-centered medical home. But we do highlight and call out the fact that we're looking to integrate behavioral health and primary care. Although it is included in probably each of these competencies of the patient-centered medical home, it was an important enough component of our model that we wanted to make sure it was highlighted.

### Slide – The Expanded Visit: Pro-Active, Team-Based Care

And then this slide basically is a diagram that shows how care would change in the patient-centered medical home, that it is proactive and that it is team based. And so that during the visit for example it's very clear about the roles and responsibilities of the different team members for the different parts of the visit. But in addition to the visit, there is care that's happening before the visit, after the visit, between visits. So care is pro-active. [16:00] And in addition, the team may be expanded to include other members such as, as you see here, a pharmacist, but also maybe a behavioralist, a community worker, peer partner, et cetera. So that's what we're looking to accomplish in the implementation of our patient-centered medical home model.

### Slide – Supporting Behavioral Health Integration in the PCMH

Now, how are we supporting behavioral health integration in the patient-centered medical home? Well, first we delineated what we feel are important elements of care integration that practices would want to implement in order to achieve behavioral health integration. We recognize that there are different approaches to care integration based on the setting that the practices are in and their patient population. And then, after delineating these elements of care integration, we developed a practice self-assessment that was based on them to get a sense for where the practices are at. At this point it's baseline, and we plan to use that and follow up to monitor their progress. [17:00] We've also included behavioral health integration quality measures in the measure set that we have put forth, again to monitor the progress of our practices as they

implement the patient-centered medical home. We set up a shared model through a learning collaborative, and we are in the process of developing a toolkit to help practices implement these elements of care integration. And the following slides will go into these in a little bit more detail.

#### Slide – Behavioral Health Integration: Approaches and Elements

So this is what we mean by distinguishing behavioral health integration elements and approaches. So there are different elements that are categorized under these five domains at the corners of this pentagon, and we'll look at the elements in a little bit more detail. But we recognize that practices may need to use different approaches to implementing these elements. [18:00] So, for example, some practices may need to have a non-located model where the primary care and behavioral health practice are not located in the same place, but they are coordinated, probably through a formal memorandum of understanding for example. Or they may be colocated and coordinated. That's like the practice where I practice, where behavioral health is upstairs and primary care is downstairs, but we have to work out our systems for coordinating our services. And then in the spectrum there's the fully colocated and fully integrated model, where primary care and behavioral health providers are working side by side each other in delivering care.

#### Slide – Integration Elements

This next slide shows some of the integration elements categorized under these five domains. And I won't go through all of them, but just to just highlight a few. The first domain is around the relationship in communication between behavioral health and primary care. [19:00] And one of the elements is about setting an expectation for patients receiving care, when they need it and where they need it, in terms of expectations for emergent, urgent, and routine care, both in primary and in behavioral health. And also in terms of having smooth handoffs between the primary care and behavioral health. In the next domain, patient care and population impact, that really gets at the having that behavioral health focus in primary care, including the screening and having the behavioral health skills used by the primary care team.

The next domain is around community integration, and again, using the community resources to enhance a treatment plan, but it also includes having a clear agreement with specialty mental health and substance abuse sites. [20:00] Under care management, one of the main elements is that the clinical care manager would be helping to develop and then implement in concert with the team and the patient an integrated treatment plan that includes both behavioral health and physical health treatment goals. And then lastly, under clinic system integration, this is really about the logistical relationship between primary care and behavioral health. That there's good health information exchanged, and that there's access to the schedules of primary care and behavioral health, and hopefully at some point same-day access for both behavioral health and primary care. So that gives you a feel for the integration elements that we feel are important for practices to be able to implement in order to truly have a behavioral health and primary care as an integrated delivery system.

#### Slide – MA PCMHI Practice Self-Assessment

As far as the practice self-assessment, we deliver this through Survey Monkey, and we had a wonderful response rate, although it did require some encouragement to get there. [21:00] And so what I have for you here is some examples of the responses from the practices, and again, this is their baseline state.

#### Slide – Patient Care and Population Impact Domain

So under the patient care and population impact domain, we looked at the screening for depression and alcohol, and what we found is that 70 percent of practices are screening for depression and alcohol, but most do not screen routinely; only about 35 percent are doing that on a routine basis.

#### Slide – Care Management Domain

Under the care management domain we found—and this one is definitely not a surprise—we found that most respondents do not have effectively coordinated integrated treatment plans. This implementation of clinical care management is a new service for primary care practices, and adding the fact that it's an integrated treatment plan between primary care and behavioral health makes it that much more complicated. So we have some work to do on helping to support our practices in this element. [22:00]

#### Slide – BHI Quality Measures

I mentioned to you that we also have a set of practice performance measures to monitor the progress of the practices, and the practices provide their data on these measures on a monthly basis. And here's one example of a measure that measures progress in terms of implementing integration of behavioral health and primary care. This is the depression screening of diabetic patients. So what percent of diabetic patients receive screening for depression. And I know there's a lot of trend lines here, but I'd like to turn your attention to the yellow trend line, which is the total population of diabetics in practices. And this is aggregated data across the entire 46 practices over about a year's worth, and you see on the Y axis the percentage. [23:00] So you can see very nicely that at the outset of the initiative about 20 percent of diabetics were being screened for depression, and now at about a year or so into this it's gone up to about 40 percent. So a nice response, but still room for improvement.

#### Slide – Learning Collaborative

I mentioned to you about the fact that we have set up a learning collaborative for our participating practices, and that learning collaborative includes different types of modalities of learning: learning sessions where practices get together and share best practices, as well as online courses, monthly conference calls, and specific webinars and calls with the clinical care managers. And what you see here are some of the topics that we have included in our learning sessions so far. And then I also mentioned that we are developing a toolkit for behavioral health integration that's accessed online through our Mass Patient-Centered Medical Home website.

#### Slide – [screenshot]

And that's in development right now, but what I have for you here is just a screenshot of what it will look like, and actually this community integration domain is live right now. [24:00] So practices can access this website, go on an online course, and then go domain by domain to look at how to implement these elements. And we really designed this to be very, very specific and concrete, with some resources for integration, and not keep it at the conceptual level, but something that's really of value to the practices.

#### Slide – Addressing Barriers

I mentioned that there are—and as we all know—that there are a lot of barriers to behavioral health and primary care integration, and we know that they are payment regulatory, but they also are real and perceived. And one of the first things we need to do is to clear up and clarify barriers that are real and dispel those that are perceived, but in addition there are some real barriers, as I mentioned. And what's happened to date in Massachusetts is that the primary care association, the Mass League of Community Health Centers, the Department of Public Health, and the (inaudible 25:03) Health Association in Massachusetts collaborated to review the regulatory barriers to behavioral health integration and then actually disseminated that in a summit, and an approach to relieving those barriers was announced. And basically practices can come to the Department of Public Health with their proposal for behavioral health integration and identify the regulatory barriers that are standing in the practices' way, and on a case-by-case basis, practice-by-practice, the Department of Public Health will consider waiving these regulations. And clearly, over time what will happen is that there will be a theme; as practices present their barriers, I'm sure it will be very similar barriers and there will be more systemic change. [26:00]

#### Slide – Lessons Learned

So in summing up, we've had a lot of lessons learned, even in our year and a half of this demonstration, and here are some of them. First, engaged leadership is definitely required for successful transformation. We see this at the policy and political level, where it's through the engaged and active leadership of our Secretary of Health and Human Services who has a vision and is pushing that forward that's making this happen in Massachusetts. And also at the practice level, practices that have leaders that are engaged in this initiative who have set their vision for change and who are providing the resources for change in terms of staff time, in terms of the IT infrastructure and quality improvement infrastructure. Those are the practices that are making significant strides.

Secondly, care management and care coordination are key elements of the patient-centered medical home and integrated care. [27:00] They are, especially the clinical care management, very new services to primary care practices, and so they are a challenge, but we feel they're very important and we're putting a lot of our efforts around supporting the implementation of these elements. Third, payment reform definitely drives delivery system change, and so we have focused on making sure that payment reform is part of our initiative, and in our new scaled up model that's in design currently we are advancing the payment reform model as well. There are other factors for delivery system change, but payment reform is one important one. And lastly,



we've learned, as many around the nation have learned as they are implementing the patient-centered medical home, that change is hard. Thank you.

[silence 27:50-28:25]

?: Bill, I think you might be muted.

BILL REEDY: Can you hear me now?

?: Now we can hear you.

BILL REEDY: Okay, sorry. Thank you, Dr. Steinberg, it was a great presentation. Before we move on to the next presentation, I would like to just remind everyone, if you have questions for our presenters please use the place on the screen there to type in a question and we will make sure we reserve time to address questions later on in the webinar. [29:00] Now I'd like to turn the program over to Marty Lynch, who is going to share his experience on the behavioral health integration and involvement with the PCMH at Lifelong Medical in Berkeley, California. Marty.

MARTY LYNCH: Thanks Bill, and thanks everybody. It's exciting to have so many folks on the call or on the webinar interested in this whole issue of integrated primary care and behavioral health. Bill, let me know if there's any problem with my slides. I see them up and I assume they'll be good, but you interrupt me if there's any problem.

BILL REEDY: Sure, I will.

#### Slide – Lifelong Medical Care

MARTY LYNCH: Okay, good, thank you. I'm going to try and give you just a little bit of background about our organization so you know how to place us, I'm going to talk a little bit about the kind of approach we use to integrating care, and finally I'm going to come back around to what we see some of the policy issues being that either are barriers or opportunities to looking at integrated care approaches. [30:00]

So let me start with a little bit about Lifelong Medical Care. I think we're a little bit different as a health center in that we were founded by the Gray Panthers, who are a senior advocacy organization. So, where most health centers come out of moms and kids services in their communities, we started with elder services and over the years have added lots of moms and kids and the typical array of service. But I think what it does in our case is leads us to perhaps a little bit more emphasis on adults with chronic problems, including behavioral health problems, and certainly the elderly still that we see as well. So again, plenty of moms and kids, but a little bit maybe heavier interest in the complex care population. [31:00] You can see from the slide that we're providing care in a number of primary care clinics. We also offer a program in California, it's called the [Delta A?] Healthcare, which is a specialized program for disabled adults and elders, but it's being squeezed back by the state, as the state like many states in the U.S. is in austerity mode. We offer dental, we have school-based sites, and maybe particularly of interest for this discussion, we also partner with the Corporation for Support of Housing to offer support

of housing services for the chronically homeless. We're not the housing provider here, but we're putting primary care and mental health services into housing sites that you might call single-room occupancy hotels, or similar types of sites, working to keep chronically homeless folks housed and off the streets. [32:00]

We also run a specialized program for frequent users of the local emergency department, that in our case, which is—you know, we're in the San Francisco/East Bay area, Oakland, Berkeley, Richmond. In our case many of the frequent users of the emergency departments are also homeless, so in that case we're working to get people housed and settled and then get them engaged in primary care and mental health services in order to get them care at a much more appropriate level than the emergency department. You can see our size there, about 40,000 patients. A good Medi-Cal mix, but also a significant uninsured population, and of course a little bit of private in Medicare as well.

#### Slide – Lifelong: A Model Rooted in Integrated Care

I think I mentioned the top two points here, but I want to say that I think that like many health centers around the country we've been pushed, and been willingly pushed over the last decade I'd say, to think about best practice chronic care. [33:00] And for many of us that started with diabetes and moved to cardiovascular, or an asthma, certain other conditions. But certainly it's brought us around to thinking of depression care and some behavioral health issues in more of a chronic care model, which certainly we're trying to get our consumers or patients involved in their own care. We're managing populations using disease registries, we're trying to make sure that we're very systematic and that our providers are using best practices.

I think it's worth saying, because this webinar is related to patient-centered medical home or health home, that I think our philosophy, like many health centers, is very good for integrated care, it very much fits the philosophy of patient-centered medical home and the things that MCQA and other accrediting bodies will be looking for. [34:00] But I think what our challenge is, is to move from a philosophy in providing these services on the ground to being much more systematic and collecting data that proves that we meet the characteristics of a medical home, and that's a challenge. As a health center we're about half-way through electronic health record rollouts, so we don't have important data and such that would help that process, but I think it's worth just commenting that we all—or almost all of us I think—come from a philosophical background that fits the patient-centered medical home. We use a range of visits and interventions and groups and such. I'm not going to say a whole lot more about that in this particular slide. [35:00]

#### Slide – Beyond the Medical Model

But what we are interested in is an approach that does look at our patients from a little bit more holistic approach. And that not only includes mental health/behavioral health, but it also includes things like dental services and other long-term services needs. We want to make sure that we're taking care of whatever it is that gives our patient, our user, the best chance of being healthy and in the community, and we think integrating primary care and behavioral health is one of the keys to that, especially in our population.

### Slide – Integrated Medical Homes: A Good Place to Start

I think for us—Judy talked a little bit about the different levels of integration and coordination and collocation or not. For us, we firmly believe in collocation as a key aspect of having our care integrated. [36:00] We went through a study at our over 60 health center sites, or our geriatric site, a number of years ago that was supported by SAMHSA that looked of the affect of integrated onsite mental health and primary care versus referring people out to external mental health agencies for care. And probably not to anybody's surprise on this webinar, we found out that there was a much greater uptake of the behavioral healthcare services when we could walk the patient down the hall, have the doctor or nurse practitioner walk them down the hall, meet the behavioral health provider and start the relationship that way. Much better uptake than if they had to go across town and use a referral, even though we had an agreement with that referring organization. We use standard assessment tools as part of our intake process in our work with our patients. Of course our providers can also refer people easily into our behavioral health services as well. [37:00] And what we see is folks, despite stigma issues, if we can accomplish the stigma issues related to behavioral health services, that if we can accomplish that relationship, that warm handoff, that service that really is integrated, we get patients who really appreciate having these services.

### Slide – Lifelong's Primary Care Model

Now, in our clinics we would have the typical medical staff, including nurse practitioners and docs and PAs and such, but we also have psychiatry time in every one of our primary care clinics, in addition to LCSWs, who in the federally qualified health center world I think are the backbone of behavioral health integration. We have some clinical psychologists on staff, but LCSWs are much more heavily represented. [38:00] Because our patient population includes people who certainly are severely mentally ill, as well as folks who just have behavioral problems that might be related to their chronic medical disease, we want to have a fairly heavy team onboard and we want the psychiatry time. We also, in our local public system, we don't have enough capacity to see all the people that have severe mental health problems, so there's some pressure on the health centers to pick that up beyond just the level that would come with normal primary medical care. Of course we do provide psych medications, and of course the psychiatrists are able to provide some of the consults with our primary care providers on those kinds of issues. We also are working on a what we call case management—you might call it care coordination—beyond simply professional mental health services. [39:00] We're worried about what's going on in the patient's life. I mentioned the homeless population earlier, but it certainly goes for other populations, where if other key needs are not met it's very hard to have a successful outcome on the medical and the mental health side. We do a lot of partnering, and I'll talk about that in just a second.

### Slide – A Spectrum of Care

But let's touch base for a minute, where even though we see a population that has a range of behavioral health and mental health problems, we are concentrating on short interventions, we're concentrating on interventions that could be made in the work with our basic primary care team.

We're trying to pay lots of attention to people whose chronic medical problems are affected by mental health issues. [40:00] And we now have our own internal data, and I know this is consistent data, that suggests that things like hemoglobin, A1C control or sugar control for diabetics, we do much better on that if we're successfully able to get those diabetics into behavioral health support as well.

Now, many of you have probably seen data that says people with severe mental illnesses die about 25 years earlier than the population in general, and that most of that mortality disparity is due to medical conditions that they have rather than directly a mental health condition, although certainly mental health effects work with the medical condition. One of our reasons for approach with this in trying to close that mortality disparity is knowing that our job is to make sure they get worked with on the medical conditions, but to do that we have to integrate. [41:00]

Now, when we talk about motivation focus, that just goes back to what I said about the chronic care model before. We're trying to work with our patients to get them to pick the goals that they want to work with. Certainly we all have that experience that our doctors and our professionals work with people, prescribe medicines or prescribe activities and the patient never—might be able to repeat back to us, but doesn't necessarily go use it. And our feeling is we really have to transition to this role where we work with folks around what they want to do.

#### Slide – Community Collaborations

Now, I mentioned a minute ago our community collaborations, and this goes with our belief that integrating primary care and behavioral health services is key to improving health for folks who have significant mental health problems. [42:00] And we know that not everybody sees one of our clinics as their primary care location. Many of the folks who have the severe problems have been in mental health systems for some time, and we're not expecting that they're automatically or easily going to show up at our doors. So one of the things we've done is we tried to partner with both the public and the nonprofit agencies. Down at the bottom of the slide that's up you'll see that one of our most recent efforts is actually to place a satellite medical clinic within the county's largest mental health clinic. We've got it going just in the last few months, but so far successful and letting us get medical care to people who would not normally get it. [43:00]

Same principle but fewer numbers are collaborations we have with local nonprofits that are dealing with some of the most severely mentally ill and homeless adults, some of whom are elderly as well. Where we're in essence imbedding our medical staff into their mental health teams and our medical staff are becoming a part of their teams. So we think integration can go both ways. Integration can mean a mental health organization partnering with a federally-qualified health center to bring in medical care, it can also mean a federally-qualified health center really enhancing its mental health capacity so the patients that come to our doors can in fact get the kind of mental health care they need as well as the mental health services.

#### Slide – Non-Licensed Staff: Essential Team Members

I would just call out here that key members of our team are the nonprofessional folks, and I'll call out a couple of them. I've mentioned the case managers already, but I want to call out these what

we call clinical care assistants, and some folk might use medical assistants to do this job or nurses to do this job. [44:00] It's essentially folks who are our panel managers for chronic disease management panels looking for folks who need a certain kind of care and making sure that they get it, that the professional providers are providing what's needed, also doing some education and support on the phone for folks with chronic problems including mental health problems. Also we're lucky enough to be in a geographic area where there are some training programs, so we are able to beef up our behavioral health teams with some of the graduate students in programs nearby in the Bay Area here. So that's lucky, and if you're in an area where you can do that that's great.

#### Slide – Reimbursement Policy Barriers

I want to spend a few of my minutes talking about policy issues. [45:00] I'm not a medical director, I am not a behavioral health provider, although I did long time ago have a counseling psych degree, but that's not what I do. I'm a CEO and I do advocacy and try to keep the organization going. So I see some issues out there, and some of this also comes from the work I've done with our state primary care association, but also with the National Association of Community Health Centers. There's a couple of issues that come into play here. Number one, a number of the folks who need integrated services aren't duly eligible for Medicare and Medicaid. Some of them are Medicare eligible. And remember, you can be Medicare eligible both by reason of age, but also by reason of long-term disability. So Medicare of course has reimbursement for mental health services. As I found it in the health center world, we're not so familiar with how that works. [46:00]

Now, admittedly Medicare is still working on the equity issue to have its mental health payments come up to par with its medical payments. And admittedly, if you're in an area that used Medicare managed care or Medicare Advantage programs, it may be more complicated because those entities sometimes subcap or carve out the mental health services. But in general, if we're serving either the dual population, Medicare/Medical, or Medicare-only populations, part of this crowd, we need to understand these issues and these need to be made easy. And our providers need to be credentialed in these managed care organizations or the subcapped organizations. Also I think certainly the question of integrating Medicaid behavioral health services with Medicare is a challenge as well. [47:00]

In many states it works differently, but in our state the local counties have a carved our Medicaid behavioral health program that's pretty much totally separate from the medical delivery side. So it is a challenge. These days under health reform I think there's a lot more interest in integrating, but historically a very siloed system. So accomplishing integration with that is a challenge. Again, some states have this issue of whether the state Medicaid program will pay you for a medical and a mental health visit on the same day. Of course that's a real disincentive to doing that warm handoff or the nurse practitioner or doctor walking the patient down the hall and having them get a visit right then and there with the LCSW, which we know increases uptake of services and really improves the chance for success. So there are some just basic barriers. I'm sure there are others, if we got phones open we'd find a number of others, but those certainly are on my mind. [48:00]

### Slide – Opportunities for Integration

But I think there's also a number of opportunities right now for integration, and I think the election the other night says that we're going to be moving forward with health reform. Beyond the coverage initiatives, I think there certainly is an interest in different parts of the health system, mental health system, hospital system working together in a much more organized way. I mentioned the duals earlier. Fifteen states are working with CMS right now on demonstrations that would integrate medical care, mental health care and long-term care for the dual eligibles. I think that's an opportunity. You have programs like PACE, Program of All-inclusive Care for the Elderly, which historically has integrated these services, and some health centers sponsor or partner with PACE programs around the country. [49:00] I think certainly as we move our patients into managed care or accountable care organizations, so called ACOs, again, there's a reward for integration, there can be shared savings in arrangements that really help us do this integration job. And then finally, a number of the states have access and are looking at medical home demonstrations that get them a 90/10 match on their Medicaid dollars and offer I think some opportunity for providers within those states. So health reform I think in general creates a really sweet opportunity for integration.

### Slide – Resources

Finally, I put up a link here, and I'm sure this will be available, for a guide that I did for the National Association and HRSA related to elder care that talks a little bit about a variety of integration issues that I thought you might be interested in.

[http://www.nachc.org/client/documents/publications-resources/GD\\_ELD\\_07.pdf](http://www.nachc.org/client/documents/publications-resources/GD_ELD_07.pdf)

So thank you very much. Bill, I'm going to turn it back over to you.

BILL REEDY: Thank you, Marty, that was terrific. Again, I'm going to remind everyone, if you have questions for Marty or any of our other panelists please type them in and we will reserve some time to talk about those. [50:00] Now I'd like to turn the program over to Ann Lewis, CEO of CareSouth Carolina in Hartsville, South Carolina, who's going to describe her health center's experience with behavioral health integration in the patient-centered medical home. Ann.

ANN LEWIS: All rightee. Let's see if we can get this thing going here. Can you all see my screen?

LAURA GALBRAITH: Yes, we can. If you'll just make sure to speak as clearly and as loudly as possible that would be great. Your voice is kind of—you're a little low.

ANN LEWIS: Okay. It's the Southern accent too. Marty's on the west side of the coast, and I'm way over here on the east side where all of these soft-spoken Southern women are, so I'll speak up. [51:00] You've got a lot of consistency between the model that Marty talked about and the one that I'm going to describe. Our integration model at CareSouth is very, very similar. And I'm following the same outline that he followed.

## Slide – Who Are We

So just kind of a quick touch on who we are to describe how we might be similar and even different from Marty's organization. We are an FQHC, a community health center. We're located in actually five counties. That's a little typo there. I think sometimes I get, you know, a little moment of memory lapse. We have ten service locations. All of our locations are in very rural and very medically underserved areas. We've been around since 1980. We started in a real small community with only four staff persons and myself. I've been the CEO of the organization since 1980. [52:00] Mercy. But who's counting? Services, very similar to how Marty described the services at Lifelong, with family practice, pediatrics, of course internal medicine, women's health integrated (inaudible). The 3040D pharmacy services that we've really been able to offer our patients have been extraordinarily important for our behavioral health patients. So that's been a very unique aspect of being an FQHC. And then there's social services, outreach, care management. Our dental program is sort of unique a little bit. It's a transportable dentistry program to children that are predominantly school-based. And we also have a Ryan White program for targeted care to victims and families with HIV AIDS. [53:00] Sort of unique though, because I believe we are the only community health center in the nation. And it's very interesting that Marty describes their sort of focus over there at Lifelong to the elderly, as do we.

We are an area agency on aging. Many of you all may have heard that terminology, or also they're beginning to use terminology called aging and disability resource center. We've been that designee with the state since 1992, so that's really given us a really interesting perspective on meeting the needs of the elderly. And if you look, if you go on even the Administration on Aging, the federal entity's website, you will see that even in this capacity they are very, very much aware of the significant need that our elderly have for behavioral health, and preferably integrated. [54:00] We are also serving about 36,000 patients, 29 providers. We use both physicians and mid-levels, over 300 staff. And then of course, as you know, around community health centers we have the community-based board of directors.

## Slide – Integration Plan and Manage Care: PCMH Standard 3

I kind of set up my slides to really relate to some of the key patient-centered medical home standards and how they really relate back to integration. So this is just really kind of the Ann Lewis perspective of integrative behavioral health in the patient-centered medical home. But Standard 3, if you go back and you at Judith's slide that kind of gives an overview of the NCQA standards, Standard 3 is around planning and managing care. [55:00] And the Element A actually says that there will be evidence-based guidelines implemented, and goes on further to say at least one identified condition must actually be related to unhealthy behaviors, and they go on to describe that, or a mental health issue.

So we've been engaged with integrated behavioral health for over 20 years; we've got a long history in doing this. And I think one of the aspects that's pretty important is that we provide this in the context of recognizing that it plays such a large role within our organization. It's at the top management level in our organizational structure, behavioral health services, and the plans are integrated everywhere—strategic plan, healthcare plan, business plan, performance improvement plan—it's just embedded. Our senior leadership is very much in tune and engaged with this,

providing the will, ideas and the execution necessary to ensure behavioral health. [56:00] We have specific system-level performance, both process and outcome measures, that are related to behavioral health, and I'll share a few of those a little bit later on.

### Slide – Integration Plan and Manage Care: PCMH Standard 3

Then going on to look a little bit deeper in the Standard 3 of the NCQA standards around planning and managing care, and when it talks about the evidence-based guidelines, we're not doing anything too extraordinary. We're using the ARHQ guidelines for depression management, the PHQ 9 symptom checklist for depression assessment, a wonderful tool that's been evidence-based. It's been translated into many different languages, and it's very easy to implement. [57:00] One of the things that we recognized pretty early on is that we need to assure that all of our providers, both physicians and mid-level, our counselors, our nurses, our social workers, everyone, had a good exposure and training to the psychopharmacology that our behavioral health integration really gave a heightened attention to. So we really invest pretty heavily in that to assure that everyone is up to date and very exposed. And of course the DSM-4 training for all the behavioral health staff, and using evidence-based problem solving therapies. These have been the backbones around the evidence-based guidelines that we use and that we use to implement the integration. [58:00]

### Slide – Integration – Identify and Manage Patient Populations: PCMH Standard 2

Moving along on our integration, the patient-centered medical home Standard 2 talks about identifying and managing patient populations, and specifically Element C talks about a comprehensive health assessment. And they're very specific. They say in addition to a physical assessment, a comprehensive assessment of the patient includes social and behavioral influences. So this really is beginning to talk about—you heard Marty speak of the care model, this is really beginning to talk about the delivery system design within your model of care. Ours has been that we chose to have LMSWs, Licensed Master's Level Social Workers, and LISWs, Licensed Independent Social Workers. These are configurations that are in our state that we chose frankly because of the reimbursement issues. Without having these types of credentials we would have run into pretty significant reimbursement issues. [59:00] We've got 14 of these individuals, they're employed throughout CareSouth Carolina.

One of the things that we have found very effective is to not try to really bite off the whole enchilada, but to use a stepped clinical counseling type of process. And by stepped level of care I mean doing an assessment so that at the highest level of need there will be a care plan that is really much more engaging, much more frequency and so forth, for the individual patient. This really allows us to give a structure to determine not only the frequency of the visits but who all on the team is going to be using the services and what services are they going to be directing towards the high-need individual. Our stepped-level now is three steps, literally. [60:00]

Part of our delivery system design has been around designing an appointment system that assures that we can support the needs of our patient. Currently we're managing about 3000 patients with depression, and of course we've got even more that have other diagnoses that are related to behavioral health. The thing that we found most beneficial was to make sure that we had the



ability to have follow up activities achieved and that there would be multiple appointments on the same day. We are very fortunate in South Carolina. By multiple appointments I mean for both the primary care provider and the behavioral health. We kind of call that "max packing."

The other thing that we found to be very beneficial in our scheduling is a 15/45 minute rule in our schedule. [61:00] And what we mean by this is, our visits with our behavioral health counselors are usually in increments of 15 minutes, going up to the 45 minute max. The top of the hour, the top 15 minutes of the hour, however we want to slice and dice it is open, and at that time the behavioral health counselor is literally out in the hall, very available to the primary care providers, available to outreach workers, available to nurses, et cetera. So in their typical daily schedule, where they would have 45 minutes available for hands-on clinical counseling, but keeping 15 minutes of every hour open to be able to be accessible and available and do the important things that Marty was talking about, these warm handoffs. [62:00]

Our nurses triage all of our patients—all of our patients—for the depression assessment. They use the red flag depression statements off of the PHQ 9, they implement the PHQ 9, and our standard throughout our organization is that all patients have to have this depression screening at least once annually. And of course, according to the guidelines those with clinically severe depression have it much more frequently. We've embedded into our delivery system design telephone visits for follow up in care management and self management goal follow up and tracking. Oh boy, it would be great if we could manage to get some of these things reimbursed, but in this particular category telephone visits are not currently reimbursable. [63:00]

Predominantly we do a type of primary care mental health assessment in treatment. We do, like Marty described also, a little bit of specialty mental health care too. We've had such decimation in South Carolina of the community mental health centers' budgets that this is really become more and more failures of access for so many, many patients. So we've found ourselves having to be much more engaged in providing these higher levels of specialty mental health care.

I've already talked about the collocation. They are very collocated, literally in the same building, down the hall, very accessible. One of the tools that we have found to be extremely beneficial is the tool of a huddle. Our care teams huddle together. [64:00] And some of them do it at different times. They may do it in the morning before their session starts, they may do in the afternoon, they may do it at the end of the day prior to kind of getting a grip on what's going to be coming in and happening the next day. These huddles are quick, they're very fast, they're ten minutes. You know, everybody stands up, nobody sits down and gets all settled in. But they're very effective for being able to have a collaboration or a heads up around the patient that may be coming in that the primary care provider is pretty sure may need a clinical counselor consult or a warm handoff. So we've found that to be one of the most valuable tools in achieving the warm handoff.

#### Slide – Integration – Enhance Access & Continuity: PCMH Standard 1

Moving along, around the Standard 1 in the patient-centered medical home standards is around enhancing accessing continuity. [65:00] Specifically, Element E talks about the medical home responsibilities, where the practice is concerned about the range of the patient's health (inaudible). These standards could not get any more specific around the expectation for

integration, because they specifically talk about whole person orientation, they specifically say including behavioral health, and the coordination across many settings. Just like Marty described earlier, of significant value is being able to have a registry that allows us to track, report, trigger follow up dates, look at opportunities for improvement. Currently we're using the PEX data management system. [66:00] It integrates with our electronic health record, but really gives us a pretty robust tool for being able to do all of this track and manage and give us some decision support. Our mental health notes are integrated into the primary care medical record. Our mental health providers, as I described earlier, are part of the care team doing the huddles. Data is reported monthly on a score card. We have an employee portal by which this information is available. It's also very transparent, it's all unblinded. It's not used for finger pointing or anything like that, as discussed, it's site meetings, staff meetings, provider meetings, monthly PI meetings. It is truly tools that are used for improvement.

#### Slide – Integration – Provide Self Care Support: PCMH Standard 4

Moving along, around the patient-centered medical Standard 4 that describes and talks about the self care support and the community resources. [67:00] I think it's very interesting that Element A is a must-pass element around this. Factor 6 in Element A actually talks about the practice providing evidence-based counseling. It could not be more specific. Giving specific examples of their expectations around coaching, motivational interviewing, the whole nine yards. I think these patient-centered medical home standards are significant in their expectations for integration. We've actually developed for our self management support a little depression management handbook. It includes a few key education pieces, an action plan with the goals identified. All of our clinical staff have been trained on self management goal setting. One of the very simple tools that we've found that have been most effective you can find here at this website, [www.howsyourhealth.org](http://www.howsyourhealth.org), developed by a group out of Dartmouth. [68:00] And then of course, near and dear to everyone is the motivational interviewing that the National Council has developed, which is an extraordinarily competent tool that can be used to really lead forth an individual into achieving a degree of confidence that they can manage their healthcare. We actually measure this, this is one of our standardized measurements, along with the measures for individual self management goal setting. Medication monitoring, all of this is embedded within our standards.

#### Slide – Community Resources

Our community resources. Every community is going to be different, but the thing to really stress is, we can't ever use and relate enough to our community resources, this can really make or break us. [69:00] Of course you've heard Marty describe the community mental health center relationships. In our state they've been devastated by budget cuts, so that collaboration and relationship is extremely important. This may be somewhat unique to some folks: DJJ stands for in our state Department of Juvenile Justice, and we've found them very receptive to our integrated model. Of course, our Department of Social Services, mental health for our geriatric patients in long-term care, the folks that provide domestic violence assistance, and as I mentioned earlier, HIV Ryan White patients also.

#### Slide – Quick Take aways...

We've found that having our onsite behavioral health counselors is just the whole key to it. [70:00] And of course, as I spoke earlier, having our Master's Levels that are licensed and that meet our state requirements for reimbursement. Our program has been in place for over 20 years, so hang in there. It takes a little bit of time before this reaches a comfortable level with everybody engaged. Providing comprehensive assessment and diagnosis has been essential. That description that I gave around scheduling around this same-day access. The 45/15 minute rule has been enormously helpful, especially when you can lead them to these hallway consultations, as Marty described the warm handoff. The care monitoring and the condition management is absolutely one of the most essential tools. Providing this patient self management support, measuring patient confidence, which we do on a routine basis. [71:00] How confident are you that you can manage your healthcare? Integration of behavioral health has been significantly successful in improving that confidence. Follow up in tracking is essential, having the brief behavioral change strategies, along with the individual psychotherapy and family therapy. That model has really been an essential model for us.

#### Slide – Lessons Learned

And of course the lessons learned. One of the things that I want to point out here is this thing around the primary care medication management. And one of the things we began to learn later in our evolution was we needed to be much more aggressive about primary care medication management, pay much more attention to it. The clinical information system with the focus that it can provide is also another essential part, as is leadership. [72:00] It has to become the way we do business. It's not just another side program that's just been added on at the last minute, and "Oh, we're kinda doing this on the side."

#### Slide – Depression Outcomes

Does it make a difference? Well, it certainly has in the case of CareSouth Carolina. Our depression outcomes have really made significant improvement. The national goal, when you look at this measure, which is that the Physician's Health Questionnaire score be reduced by 50 percent in a six month period. The national goal for this is only 40 percent. And we're very proud that we've been able to push up to 60, and pushing even 70 percent. I'm sorry, I forgot to change the dates and everything down here. I'm not all that good at some of these charting things. [73:00]

#### Slide – Equity Measures

We've also been sort of unique in that we're measure equity. And how we measure this is we look at the outcomes between patients who are non-White and patients who are White, with the outcome that we're expecting to be zero, there be zero disparity. And in the South we are really burdened with significant disparities in all of our chronic conditions. We do this for asthma, diabetes, hypertension control and also LDL control. But we're very proud of the fact that in our depression management we've literally reversed the disparity, as you can see in that little circled area that's right over here.

### Slide - The CareSouth Carolina Integration Model

We also have been really proud of this, the last year the HRSA Office of Rural Health policy actually included this on one of its six nominated programs for promising practices. [74:00]

### Slide – Challenges and Opportunities

I wanted to leave you with a little bit of our challenges. Like Marty, State Medicaid and managed care barriers continue to exist. Credentialing for these entities is all over the map and is a nightmare. There are still external system silos that are mammoth, particularly with Medicare and Medicaid. The United States is still not totally embracing an integrated model. And we have to remember that 42 percent of our patients with chronic illness are also severely depressed. These are not noncompliant patients, these are severely depressed patients, and I am so tired of hearing this word "noncompliant" in our healthcare industry. [75:00] Also last, EHR implementations. EHRs simply do not understand integration, and it takes an awful lot of adaptation, or at least it has in our case as we've gone through our implementation.

### Slide – More Questions?

Our Director of Behavioral Health at CareSouth Carolina is Liz Kershner, she's been faculty with the HRSA Depression Collaborative, and she's a jewel and is very prepared to share her extensive knowledge and her experiences. Feel free to call on her. (Liz.Kershner@caresouth-carolina.com)

That's it for CareSouth.

BILL REEDY: Thank you, Ann. A wonderful presentation, very helpful. We're going to open it up for questions now, and I'm going to ask Laura, do you want to select some questions?

LAURA GALBRAITH: Yes, we have 15 minutes left, we have quite a lot of questions. We will not be able to get to every one, but we will go ahead and dive in and see what we can do in terms of some follow up. Could each of the speakers starting with Judith speak just briefly about the role of substance use in the work that you're doing in terms of your model of integration? [76:00]

JUDITH STEINBERG: Yeah, so this is Judy. So when we use the term behavioral health we are using that as a global term that includes mental health care, substance abuse or unhealthy substance use, diagnosis and treatment, as well as support for altering unhealthy lifestyle behaviors. So we are considering it as part of the integration. Substance abuse diagnosis and treatment is part of what we are including when we say behavioral health integration.

MARTY LYNCH: In our case a similar answer. Substance abuse and use is a critical issue for especially our homeless population and many of our population that require integrated services, so we're doing our best. I won't say that we have adequate resources though. [77:00]

JUDITH STEINBERG: And I agree with that as well, it's not easy.

ANN LEWIS: This is Ann Lewis. Ditto. And where we get hung up though is when the need for rehabilitation or in patient hospitalization for these clients. It's very tough in South Carolina., we don't have a lot of resources at all available.

JUDITH STEINBERG: This is Judy. I think another barrier is that if you do have those resources and access to those services then the next barrier is the communication across those services. Getting information from the substance abuse treatment centers and rehab centers in a bi-directional way.

LAURA GALBRAITH: Great, thank you. Judy, could you speak to the quality measures? Several people were inquiring about what are those quality measure that you're using?

JUDITH STEINBERG: So we have—I presume that means the practice performance measures, and I gave the example of the depression screening for diabetics. [78:00] So there are a set of practice performance measures that are in different categories. So the way we rolled out our patient-centered medical home implementation was first by modeling the implementation of the components for patients with specific conditions, such as diabetics for adult practices and patients with asthma in pediatric practices. So we have a set of performance measures that are both process as well as outcome—especially for diabetes—around diabetes and asthma. But then the model rolls out to spread to other patient populations, and then ultimately to the entire practice. So the measures also include measures around prevention, and measures around transitions in care and clinical care management and continuity of care. [79:00] And in all of those measures, in all of those categories where there's a target condition, such as diabetes or asthma or hypertension, there's always a measure around a setting of a self management goal.

LAURA GALBRAITH: Great. Marty or Ann, do you want to—anything around quality measures or performance measures that you look at regarding the integration of behavioral health?

MARTY LYNCH: I'm going to say that we just have some standard depression scale measures similar to what Ann mentioned, but I'd also say that we are looking at that interaction between control factors for things like diabetes, hemoglobin A1C or blood pressure under control, and that interaction with behavioral health/mental health issues as well.

ANN LEWIS: Yeah, and I'll just add to it real quick. We think that one of the contributing factors to improving the care for these patients with chronic conditions is having this access to integration behavioral health for depression, anxiety and so forth. [80:00] And when I mentioned that measure around the confidence of the patient, how confident are they that they can manage their healthcare, it's a very good measure. And you can find a lot of information on the web around that, not only just asking that one singular question, but also there's some more extensive and detailed questions that can be asked that kind of grill down to it. But I would really encourage folks to think about using a confidence or an activation measure also.

LAURA GALBRAITH: Great, thank you. [81:00] There are a couple of questions that relate to kind of integration of kind of some of the tools that we use, be it our treatment plans and shared

records across an EHR potentially, as well as things like confidentiality and kind of how do we share information and have both shared information for clinical decision making but then also for the purposes of billing and electronic medical records. So I don't know if each of you wanted to say a word about that.

JUDITH STEINBERG: So this is Judy. So having good information exchange, access to information in the medical records, and to use that information in the development of a coordinated integrated plan, are important elements that we are using in our model. That's not to say that it's easy to accomplish that, and I do think that that's where some of these regulatory barriers—some of which are more perceived than real, but there are real ones as well—will hamper the ability to do that health information exchange. [82:00] In Massachusetts very recently there was announced a new health information exchange that allows information to be transferred across different electronic medical records. So this was just announced, and practices will soon be signing up to be able to be a part of that health information exchange. How the regulations, privacy regulations, will fit with that, or will adjust to that, I don't know yet.

MARTY LYNCH: Yeah. And for us, certainly we want both sides in the same EHR so it's useable. I think just rolling out with that the time factors are important, whether it be paper or electronic, and we've really relied for some of the most complex folks on face-to-face interactions in the provider team, whether it be hallway or in a team meeting, or a huddle. [83:00] And I think across agency I'm going to have to go back and check how well we do when we go in and do partnership programs with our nonprofit partners and our county partners. I know we have at least some sharing, but I don't know if it's total.

ANN LEWIS: And this is Ann. I think both Judith and Marty have pretty much described. One of the principles that we actually began on is the fully-integration medical record. We had a lot of pushback in the beginning, that the mental health records needed to be separate and locked in the drawer of the mental health counselor, but we persisted.

LAURA GALBRAITH: That's great, that's what it takes, a can-do attitude. Several questions have come up about different levels of care professionals and how you're using them in the integration of behavioral health. People like peer support specialists, peer medicine and community health workers were all mentioned in terms of how you might be using them. [84:00]

BILL REEDY: Judy, you want to comment first?

JUDITH STEINBERG: Well, we include that as part of the model, so that practices can choose to use community health workers or peer partners at different levels of staffing as they need it, but we really do leave that up to the practices to decide how best to do their care coordination and support for their patients. And basically, the way that it gets supported is really through the payment reform, so that there's that extra payment for care management and services that are not covered under fee for service. But it's up to the practices.

LAURA GALBRAITH: They have flexibility then?

JUDITH STEINBERG: That's right.

MARTY LYNCH: Yeah, and in our case I mentioned some about our teams earlier. I think there's a couple places that the non-professional staff comes into play. [85:00] One is we do use case managers that are non-MSWs or non-RNs. They might have a bachelor's or might not, but often they have some experience with the service population, so they're a little closer to peers, and we train them. We also of course have—maybe some of you are using chronic care support groups that include some of our behavioral health patients that follow Kate Lorig's model from out of Stanford here, where there are peer leaders in these support groups. What else? And we're using these chronic care assistants that typically are—or clinical care assistants to help with the panel management, but are certainly not professionals, but well able to handle databases and help with education and tracking. And there's probably more, but those are a few. [86:00]

ANN LEWIS: This is Ann. We've got a pretty extensive program with community development, with the community health outreach workers, and doing an awful lot of in-the-community work. Health fairs, all sorts of things with local businesses and industries. And one of the things that our community's had to get sort of used to is that we wanted depression screening integrated. So all of our community health workers have been well trained in doing that type of screening, we embed it with every single opportunity that we possibly can. When possible they actually participate in huddles, they have direct access to many of the team huddles. But that's been a very, very valuable tool. And when you're out in the community just doing a health fair or a screening with a local business or industry, it becomes routine to talk about integrated behavioral health issues like depression/anxiety. [87:00] So these community health workers are gold in our organization.

LAURA GALBRAITH: Great. Thank you so much. I think it's going to be very interesting, kind of the evolution of how we use paraprofessionals in behavioral health integration and patient-centered medical homes and other integrated models. Well, we only have about two minutes left, so I'm going to go ahead and end our questions. Before I do I'm going to allow Bill Reedy to have the last word here. I just want to remind folks that a recording as well as the slides will be made available online within the next day or so, as well as a transcript within the next week, and to make sure to complete the survey at the end. We do read all of your feedback and appreciate your ideas and how useful this information was for you. With that, Bill? [88:00]

BILL REEDY: Thank you, Laura. I'd just like to thank our panel of presenters for outstanding presentations I think. You really provided a great deal of informative information for all of us, thank you. To all of our attendees, thank you for your attention and participation. Feel free to recommend this webinar to other staff members or other colleagues. It will be available for on-demand viewing at the Center for Integrated Health Solutions website. So we at the National Association of Community Health Centers and the Center of Integrated Health Solutions thank you all for your attention and participation. We would ask you, as you start to close out of this session there is an evaluation form, we'd ask you to please make sure you take a moment to fill that out, it helps us to use that information to continue to improve our activities with you. Thank you again, and have a wonderful day. Take care.

**END TRANSCRIPT**