WHY INTEGRATIVE CARE: PATIENT CENTERED MEDICAL HOME PROJECT- INTEGRATED BEHAVIORAL HEALTH SYSTEMS

PRESENTED BY:
THE BIG INITIATIVE, NATIONAL SBIRT ATTC, NORC, and NAADAC

August 6, 2014

Webinar Facilitator

Tracy McPherson, PhD

Senior Research Scientist

Substance Abuse, Mental Health and Criminal Justice Studies

NORC at the University of Chicago

4350 East West Highway 8th Floor, Bethesda, MD 20814

esap1234@gmail.com

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- PowerPoint Slides
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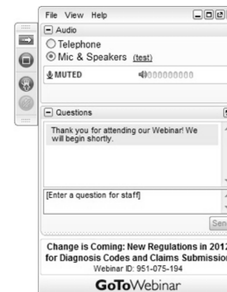
Ask Questions

Ask questions through the "Questions" Pane

Will be answered live at the end



Technical Facilitator

Misti Storie, MS, NCC

Director of Training & Professional Development

NAADAC, the Association for Addiction Professionals

misti@naadac.org

Presenter

Bill McFeature, Ph.D.

Radford University

billmcfeature@yahoo.com

Substance Use Disorder Stats-SWVA

- The last five years have shown an increase in drug/ poisoning cases with an overall increase of 91.4 percent since 1999 (Chief Medical Examiner's Annual Report, 2008).
- Western Virginia has 33.5 % of all drug-related deaths in Virginia.
- Narcotics were the most frequently identified (36.2 %) followed by anti-anxiety medications (15.6 %).

Substance Abuse Coalitions

Development of a consortium of coalitions representing healthcare, community service boards, social services, faith-based organizations, higher education, law enforcement, and recovery communities. Collaboration is critical.

"Continued Silo Effects and Fragmentation" of patient/client services will NOT produce significant impact.

Shortage of Behavioral Health Providers In Designated Rural Health Regions

- Shortage of behavioral health providers is a significant issue. Most States are dealing with a 5:1 ratio in terms of patient/client population to behavioral health provider (psychologist, counselor, and clinical social worker).
- The focus on FQHC systems and CSB's willing to accept sliding fee discounts and Medicaid
- MCO rates due to low reimbursement is essential to provision of quality care.

Health Homes for Enrollees with Chronic Comorbid Conditions

Section 2703 of the Affordable Healthcare Act allows States to elect this option under the Medicaid State Plan. This provision is an opportunity for States to address the need and support for the enhanced integration and coordination of primary care, behavioral health, dental, and specialty mental health and substance use, and long term services for persons across the lifespan with chronic illness.

SVCHS
June 2013

ACA — PATIENT — QUALITY MU — PRODUCTIVITY — PCMH

ACA = Affordable Care Act - Healthcare Reform
PCMH = Patient Center Medical Home - NCQA
MU = Meaningful Use - MAQ Dashboard

8/3/14

HERE'S YOUR ROLE:

Be an active team player

- Understand that you are a full partner in your own health care.
- You may choose a provider, or one may be assigned to you by our staff, if you wish.
- Learn about your condition and what you can do to stay as healthy as possible. Ask questions about your health.
- Follow the care plan that you and your medical team have agreed is best for your health.
- Set goals you can reach. Once you begin to see results, you and your team can discuss adding new goals.

Communicate with your medical home team

- Bring a list of questions to each appointment. If you don't get them answered the first time, bring them to your next appointment.
- If you don't understand something your doctor or team member says, ask them to explain it in a different way.
- If you get care from other health professionals, always tell your medical home team so they can coordinate the best care possible.
- Talk openly with your care team about your experience in getting care from the medical home.

Twin City Medical Center
2195 Euclid Avenue
Bristol, VA 24201
276-669-5179
276-466-8870 (fax)

Hours:
M - F 8:30am - 7:00pm

For after hours call:
1-888-531-8354

Providers:
Bill McFeature, PhD.
Roy Andrews, D.O.
Gayle Bates, M.D.
Joan Mullin, FNP
Kimberly Murphy, FNP

www.svchs.com

Patient Centered Medical Home

Whole Person Orientation
Safety & Quality
Care Coordination & Integration
Personal Provider
Enhanced Access
Continuity of Care
Capacity & Accountability

TWIN CITY
MEDICAL CENTER
2195 Euclid Avenue
Bristol, VA 24201
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"Your Community Clinic"

Southwest Virginia Community Health Systems, Inc.

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Welcome to Your Medical Home....

A patient centered medical home is an approach to providing total health care with a team that includes health care professionals, family members, and you.

In your medical home, you and your team will work together as one. You will have a chance to talk about things that are important to you.

Together, you and your team can work on a plan that is created just for you. Working with your team will improve your overall health.

The Medical Home Advantage:

When you have a medical home there are many benefits.

- Comprehensive care means your team helps you address any health issue at any stage in your life
- Coordination of care occurs when any combination of services you and your provider decide you need are connected and ordered.
- Continuous care occurs over time with timely communication about services from your health care team.
- Accessible care allows you to start the interaction you need for any health issue with a team member through your desired method (office visit, phone or email).
- Proactive care ensures you and your provider will build a care plan to address your health goals.

During your appointment write down the names of your team members and make sure to ask your team for the after hours contact information.

Use This Checklist for Your Next Appointment:

- Make a list of any other health care providers you have visited. Write down their names, phone numbers, and the reason you have visited them.
- Take all of your medications, in their original containers, to your appointment. Be sure to include prescription, over the counter, natural and herbal medications, and vitamins.
- Take your insurance card or other insurance information with you to your appointment.
- Make sure you know the things that you are to work on before your next appointment.

A medical home uses a team approach to provide YOU with the health care that you need. YOU and your health care are at the center of your medical home team.

8/3/14

NCQA-PCMH Project- Level 3

PATIENT CENTERED MEDICAL HOME GOALS

1. Improve Access/Care Coordination
2. Improve Health Outcomes (PCP-BHC)
3. Cost –Effectiveness (Decrease in ER Visits and Medical Care Utilization)

NCQA-PCMH Process Level 3

PCMH 1: Access – Medicaid Plan/Self Pay Pts. Patient receives immediate (1- 3 days) access to a PCP (medical care visit) which will allow the provision of same-day appointments for both a medical care appointment and behavioral health visit (15 min or 30 min).

Ratio PCP (3 Patients) to BHC (1 Patient) Per Hour
Standard Full Capacity- 8-12 BHC Visits
Huddle Meeting 8:30-9:00 a.m.

9:00	Diabetic	15 Minutes	
	HTN	15 Minutes	**BHC-30 Minutes**
	Post Hospital-CAD	30 Minutes	Clinical Case Mgmt-Feedback to PCP
10:00	Seizure D/O	15 Minutes	**15 min HBA code**
	Diabetic	15 Minutes	**BHC-30 Minutes**
	Fibromyalgia	15 Minutes	Clinical Case Mgmt-Feedback to PCP
11:00	Lumbar DDD	15 Minutes	**BHC-30 minutes**
	Asthma/COPD	15 Minutes	**BHC-30 Minutes**
	Cervical Pain	15 Minutes	Clinical Case Mgmt-clinical reports
12:00	Lunch	30 Minutes	
12:30	Bipolar Condition	30 Minutes	**BHC-30 min**
1:00	Post-Hospital-COPD	15 Minutes	
	Diabetic	15 Minutes	**HBA Code-15 min.**
	COPD	15 Minutes	Clinical Case Mgmt-preauth
2:00	Post Hospital - cancer	30 Minutes	**15 min HBA code**
	CAD	15 Minutes	**BHC-30 Minutes**
	COPD	15 Minutes	Clinical Case Mgmt-Feedback to PCP
3:00	Post-Hospital-CAD	30 Minutes	
	Bipolar Condition	15 Minutes	**BHC-30 Minutes**
	CAD	**15 Minutes**	Clinical Case Mgmt-Phone Consultation
4:00	Initial	30 Minutes	
	Diabetic	15 Minutes	**BHC-30 Minutes**
	HTN	15 Minutes	Clinical Case Mgmt-Feedback to PCP

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NCQA-PCMH Process Level 3

PCMH 1: Electronic Access – Meaningful Use
A computer system with access to: eCW
1. Practice Management System (Chronic sx's)
2. Electronic Health Record
3. Web Patient Portal
4. Pharmacy Registry
5. Billing System- Carved Out BH/Partial Capitation.

NCQA-PCMH Process Level 3

PCMH 1: Continuity – Panelized/Managed Care Medicaid Contracts, Medicare, Commercial, and Self Pay.

PCP's panelized to follow co-morbid chronic conditions (Diabetes, Cardiovascular, Asthma/ COPD, Depression/Anxiety, and Substance Use Disorders).

NCQA-PCMH Process Level 3

PCMH: 1 Medical Home Responsibilities:
- Care Coordinator leads morning Huddle Meetings
- Care Coordinator will monitor the percentage of co-morbid chronic patients example- (diabetic with associated depression) with high frequency of medical visits, ER visits, hospital stays, and non-compliance to treatment.

SVCHS HUDDLE SHEET

DATE:__________ Providers: ☐ Andrews ☐ Murphy ☐ Bates

Appt Time	Last Name	Diagnoses	Tests Needed	Immunizations Needed	Preventive Screening Needed	Care Plan
		☐ Diabetes ☐ Obesity ☐ Asthma ☐ CVD	☐ AIC ☐ μalb ☐ CMP ☐ PHQ2 ☐ Lipids ☐ UTD	☐ TDaP ☐ Hep B ☐ Pneum ☐ Zoster ☐ Flu ☐ UTD	☐ DM eye ☐ Colon ☐ DM foot ☐ Mamm ☐ Asthma ☐ Pap ☐ UTD	
		☐ Diabetes ☐ Obesity ☐ Asthma ☐ CVD	☐ AIC ☐ μalb ☐ CMP ☐ PHQ2 ☐ Lipids ☐ UTD	☐ TDaP ☐ Hep B ☐ Pneum ☐ Zoster ☐ Flu ☐ UTD	☐ DM eye ☐ Colon ☐ DM foot ☐ Mamm ☐ Asthma ☐ Pap ☐ UTD	
		☐ Diabetes ☐ Obesity ☐ Asthma ☐ CVD	☐ AIC ☐ μalb ☐ CMP ☐ PHQ2 ☐ Lipids ☐ UTD	☐ TDaP ☐ Hep B ☐ Pneum ☐ Zoster ☐ Flu ☐ UTD	☐ DM eye ☐ Colon ☐ DM foot ☐ Mamm ☐ Asthma ☐ Pap ☐ UTD	
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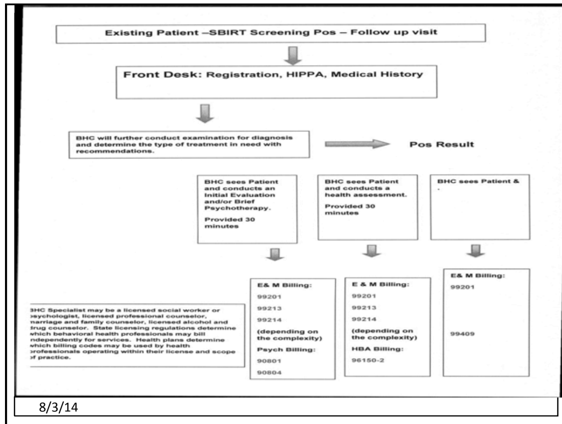
NCQA-PMCH Process Level 3

PCMH 1: Culturally Appropriate Services ---Hispanic
Southwest Virginia reflects a significant percentage of Hispanic migrant workers receiving both medical and brief behavioral health services receiving an interpreter.

NCQA-PCMH Project –Level 3

UDS/HEDIS and PCMH Vertical Integration Depression and Substance Use Practice

PCMH 1: Primary Care Team Approach--
- Front Desk- (Patient Registration)
- Health Status Examination (Wt, Ht, BMI)
- Pain Scale, PHQ-2, and AUDIT-C)
- If positive PHQ-2-referred to BHC.



WHAT is the Behavioral Health Consultation Service?

The Behavioral Health Consultation Service is a program being made available to patients in our Primary Care Clinics as a part of overall good health. This service offers help when habits, behaviors, stress, worry, or emotional concerns about physical or other life problems are interfering with someone's daily life. The referral is made by your medical provider.

WHAT Should I Expect When I See the BHC?

You can expect the BHC to ask you specific questions about your physical symptoms, any emotional concerns you are experiencing, your behaviors, and how all of these might be related.

As with all health care providers, communication with the BHC may not be entirely confidential. Although every effort will be made to protect your privacy, BHCs have the same reporting obligations as medical providers. There is one electronic health record where health information is shared between primary care team members that provide your treatment.

WHO are the Behavioral Health Consultants and WHAT Kinds of Problems Can They Help With?

The Behavioral Health Consultants (BHCs) are Licensed Behavioral Health Providers with specialty training work as members of the primary care team. This team approach allows us to consider physical, behavioral, and emotional aspects of health. For example:

1) BHCs can help reduce symptoms associated with chronic medical conditions or help you cope better with these conditions, such as migraine and tension headaches, fibromyalgia, diabetes, asthma, COPD, hypertension, and irritable bowel syndrome.
2) BHCs can help develop plans for behavioral change programs, such as smoking cessation, weight loss, alcohol use, exercise or other lifestyle modifications.
3) BHCs can also help with emotional or behavioral problems such as family or relationship difficulties, excess stress, bereavement, depression, anxiety, or anger problems.

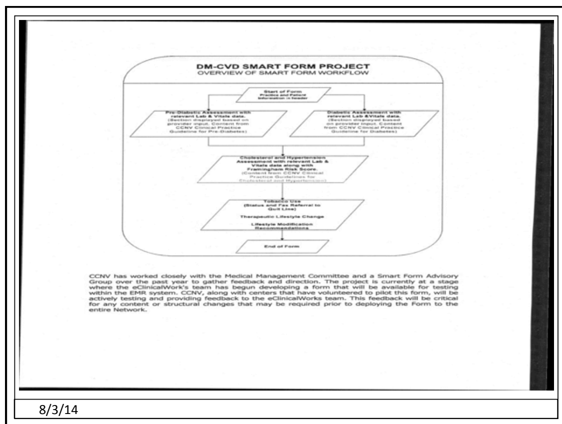
NCQA-PCMH Project –Level 3

Horizontal Integration- PCP-BHC Coordinated Care - PCMH 2: Management of Patient Population

1. Care Coordinator/Huddle meetings -30 min- each morning (Psychologist, Counselor, Clinical Social Worker, Substance Abuse Counselor, and Health Coaches).
2. Screen and monitor both general patient population (80%) and high risk chronic conditioned patients-- 2 or more chronic conditions (20%).

NCQA-PCMH Project –Level 3

PCMH 2: Clinical Data- Integrated Behavioral Health - eCW-Smart Forms (Diabetic(A1c), CAD (BP and Lipids), Tobacco Use and Dependency Practice Guidelines, Chronic Pain Practice Guidelines, Depression Practice Guidelines, and AUDIT-C or CAGE-AID for screening for substance use disorder.



NCQA-PCMH Project – Level 3

PCMH 2: Comprehensive Health Assessment -- Patient - Self Management Skills/Health Literacy - Primary Care Philosophy-PCP-BHC

Objective: Taking control of your health is the best way to maintain a healthy lifestyle, by working with your primary care team, you can take control of your body to improve your health and live a better life.

Patient Self- Management

Patient Name: ______________________ **DOB:** __________ **Date of Visit:** __________

Taking control of your health is the best way to maintain a healthy lifestyle. By working together with your provider, you can take control of your body to improve your health and live a better life. Choose which goals you will work on between now and your next visit to improve your health. Please try to stick to 2-3 goals today.

Please choose the goals you are willing to work on to better manage your condition.		Check All That Apply
	Goal 1: I will exercise (walk) _____ minutes______ days per week. If I notice chest pain, shortness of breath or chest tightness, I will seek medical attention.	
	Goal 2: I will schedule an appointment to get a pap smear.	
	Goal 3: I will follow a low fat diet to reduce my cholesterol.	
	Goal 4: I will take a baby aspirin or enteric-coated aspirin every day.	
	Goal 5: I will stop smoking.	
	Goal 6: I will take my medicine every day as instructed by my doctor.	
	Goal 7: I will work to reduce stress.	
	Goal 8: Other:	

Plan______________________________

Nurse or Provider Signature:

Southwest Virginia Community Health Systems, Inc. Cardiovascular Self-Management

Take All Medications Properly

Exercise **Diet** **Quit Smoking**

20 / 20

Reduce Salt Intake **Have Annual Eye Exam** **Personal Goal**

It is recommended to maintain a controlled blood pressure less than 130/80.
Today your blood pressure is ____________________.

It is important to have low cholesterol. It is recommended to have a Total Cholesterol less than 200 and LDL Cholesterol less than 100.
Your Total Cholesterol is____________ Your LDL Cholesterol is ____________.

NCQA-PCMH Project-Level 3

PCMH 2: Population Management --

Integrated Behavioral Health Services: Preventive Care and Chronic Care Monitoring.

PCP –BHC Coordinated Care-Same Day Service. Triage patients with specialty mental health/ substance abuse/dependency issues for more intensive wrap around services.

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PCMH 3: Patient Integrated Care Plan -

SBIRT-Evidenced–Based PCBH Practices for High Risk Co-morbid Chronic Patient Population using Brief CBT, Solution- Focused, and BH Consultation/ Psycho-education.

Universal Standard Screening for Behavioral Health / Alcohol and Drug issues at each medical visit.

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PCMH 4: Care Coordination-High Risk Groups – for example: diabetic-depression-substance abuse/dep cases.

"Care Coordinator" works closely with the multidisciplinary healthcare team in the primary care setting focusing on health coaching and coordination of care for high-risk, chronically ill patients and those with co-morbid conditions and in collaboration with local CSB's

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PCMH 4: Psychotropic Medication Management- Continuum of Care --

1. PCP-BHC Coordinated Care –General
2. Contract with TelePsychiatry Psychiatrist or psychiatric nurse for CMI patient population in shortage areas.
3. Triage with local CSB's for specialty mental health services, CMI. CSB's required to have PCP referral for CMI patient.

NCQA-PCMH Project- Level 3

PCMH 5: Extracted Integrated BH Data –
Utilizing Smart Forms that capture Integrated Care Data (comorbid medical and behavioral health conditions) associated with high risk patient populations that reflect significant medical care cost.

Embedded Behavioral Health provider

Coordinated Care between medical care providers and embedded behavioral health providers within these settings have shown significant improvement in overall health outcomes.

NCQA-PCMH Project- Level 3

PCMH 6: Measure PCP-BHC-CSB Coordinated Care Performance Data – Required PCP Referral needed by CSB's.

1. Major Psychiatric Disordered Dx rate within the general patient population is approximately 20 % and coordinated effort between primary care and specialty mental health/substance abuse/dependency services.

ACG System : Illness Burden and Pricing of Bundled Service Product

The ACG is a packaged software that uses the diagnosis codes and pharmacy data, to categorize patients by level of sickness. Using both UDS measures and ACG integrative care data. For instance, patient diagnosed with Diabetes Mellitus (A1c- 8.1), uncontrolled, Hypertension, BMI of 39, and (LPN) administers PHQ-2 and Audit-C. Smart Forms capturing integrative care data used for determining partial capitation rates.

QUESTIONS?????

THANK YOU!

8/3/14

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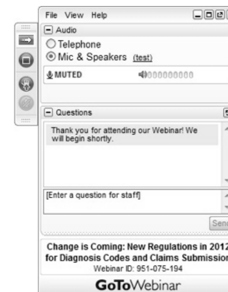

In Our Last Few Moments…

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- CE Quiz
- Recording
- Free Ces
- Survey
- Follow-up Email

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ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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