The Webinar will begin promptly at 12pm
Due to the number of participants, you will be automatically placed on mute as you join to ensure good quality sound. If you would like to comment or ask a question,
please use the "chat feature"

Send your questions to the host via the chat window in the Zoom meeting.

Q+A will open at the end of the presentation.

Follow-up questions?

Contact

⬇

Samantha Di Paola
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BEHAVIORAL HEALTH CONSULTATION: THE STRUCTURE OF THE VISIT

HMA **INTEGRATED CARE DC**

PRESENTED BY:
Marsha Johnson, LCSW
Suzanne Daub, LCSW

**Tuesday,
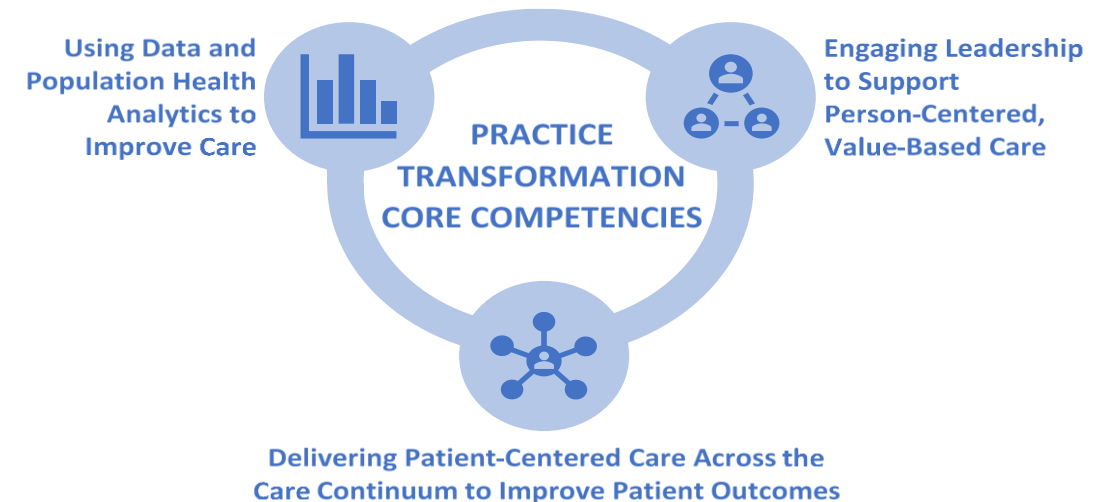July 26, 2022**
12:00pm – 1:00pm EST

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

WHAT IS INTEGRATED CARE DC?

HMA · **INTEGRATED CARE DC**

» Integrated Care DC is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

» Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:

Using Data and Population Health Analytics to Improve Care

Engaging Leadership to Support Person-Centered, Value-Based Care

PRACTICE TRANSFORMATION CORE COMPETENCIES

Delivering Patient-Centered Care Across the Care Continuum to Improve Patient Outcomes

» The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.

» All material is available on the project website: Integratedcaredc.com

» Educational credit is offered at no cost to attendees for select elements.

Short-Take Videos

Individualized coaching

Office hours

TA Curriculum Components

Website resources

Webinars

Telehealth TA

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» **Are you receiving our Integrated Care DC Newsletters?**

Check your inbox at the beginning of the month for the Monthly Newsletter and around the 15th for the Mid-Month Update.

» **Got ideas?**

Take this short survey to share suggestions and requests for trainings.
https://www.integratedcaredc.com/survey/

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Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

CONTINUING EDUCATION CREDITS

❖ Health Management Associates, #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. Health Management Associates maintains responsibility for this course. ACE provider approval period: 09/22/2021 – 09/22/2022. Social workers completing this course receive 1 continuing education credits.

❖ To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.

❖ Application for CME credit has been filed with the American Academy of Family Physicians. This session is approved by AAFP for up to 1 AMA Level 1 CME credit.

❖ **If you would like to receive CE/CME credit, the online evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar.

❖ Certificates of completion will be emailed within 10-12 business days of course completion.

Behavioral Health Consultation: The Structure of the Visit

» Welcome and Program Announcements

» Primary Care Behavioral Health Model (PCBH)

» The components of the PCBH visit
  » Introducing the behavioral health consultation to the PCP and the patient
  » Conducting a functional assessment
  » Evidence based interventions
  » Closing the loop with the PCP
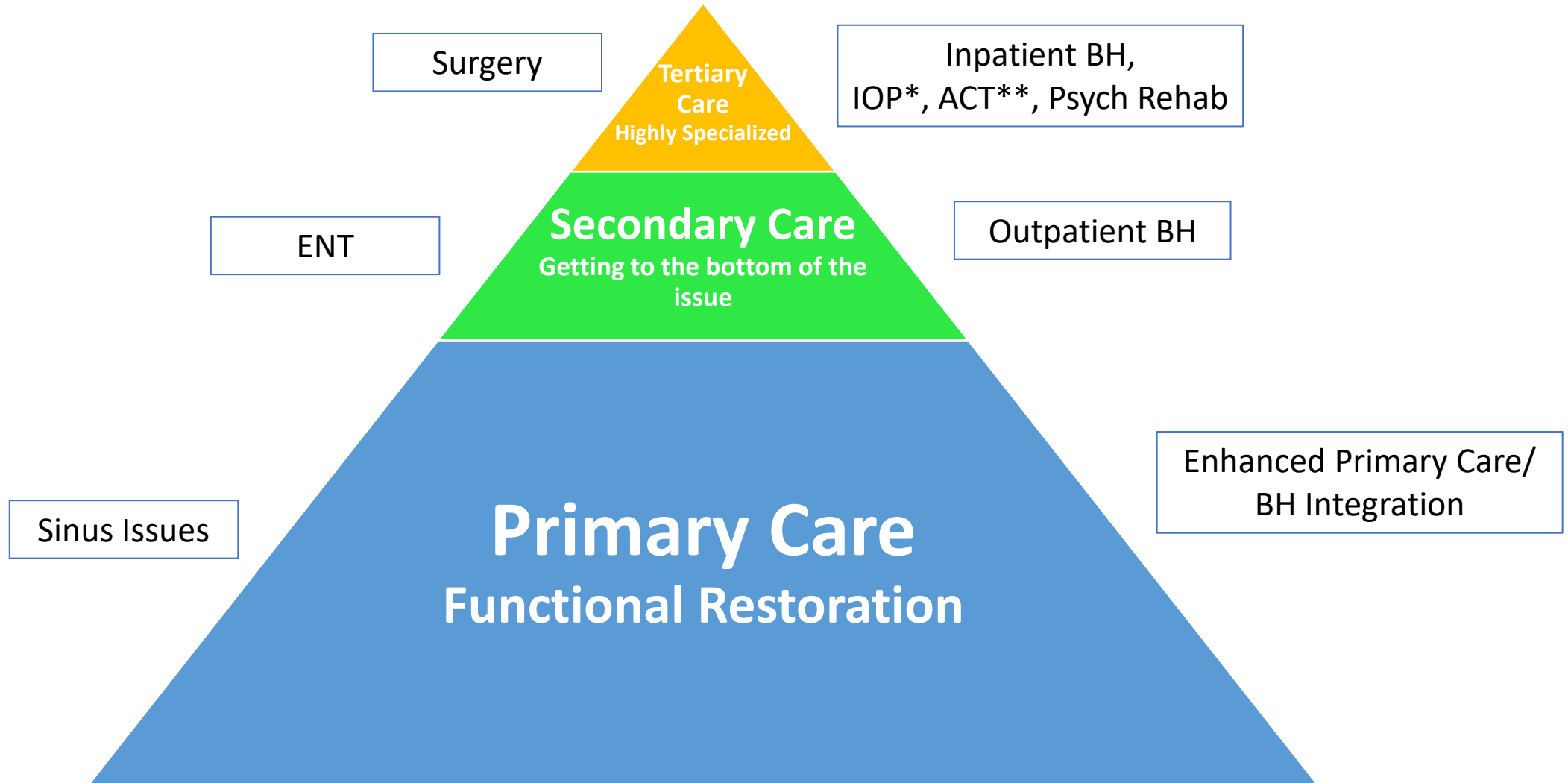 » Follow-up visit with workflow

» Closing Remarks/Questions

1. Define primary care level of behavioral health as distinguished from specialty and tertiary levels of behavioral health care

2. Outline the components of the initial behavioral health consultation visit

3. Explain how to introduce primary care behavioral health to primary care providers and patients

4. Describe a functional assessment

Image permitted by DC Department of Health Care Finance

BEHAVIORAL HEALTH CONSULTATION (BHC): THE STRUCTURE OF THE VISIT

» The Primary Care Behavioral Health Consultation model (PCBH) is a psychological approach to **population-based clinical health care** that is simultaneously **co-located, collaborative, and integrated** within the primary care clinic

» The goal of PCBH is to improve and promote **overall health within the general population**

- Collaborative Family Healthcare Association, https://www.cfha.net/

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INTEGRATED CARE DC

Surgery

Inpatient BH,
IOP*, ACT**, Psych Rehab

Tertiary Care
Highly Specialized

ENT

Secondary Care
Getting to the bottom of the issue

Outpatient BH

Sinus Issues

Primary Care
Functional Restoration

Enhanced Primary Care/
BH Integration

*IOP – Intensive Outpatient Program
** ACT – Assertive Community Treatment

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THE BEHAVIORAL HEALTH CONSULTANT (BHC) ROLE IN PCBH MODEL: GATHER

Generalist: The goal is to have the BHC work with patients of any age and any behavioral concern, from anxiety or tobacco use to parenting strategies

Accessible: The BHC should be available to help the primary care provider at all times during the workday
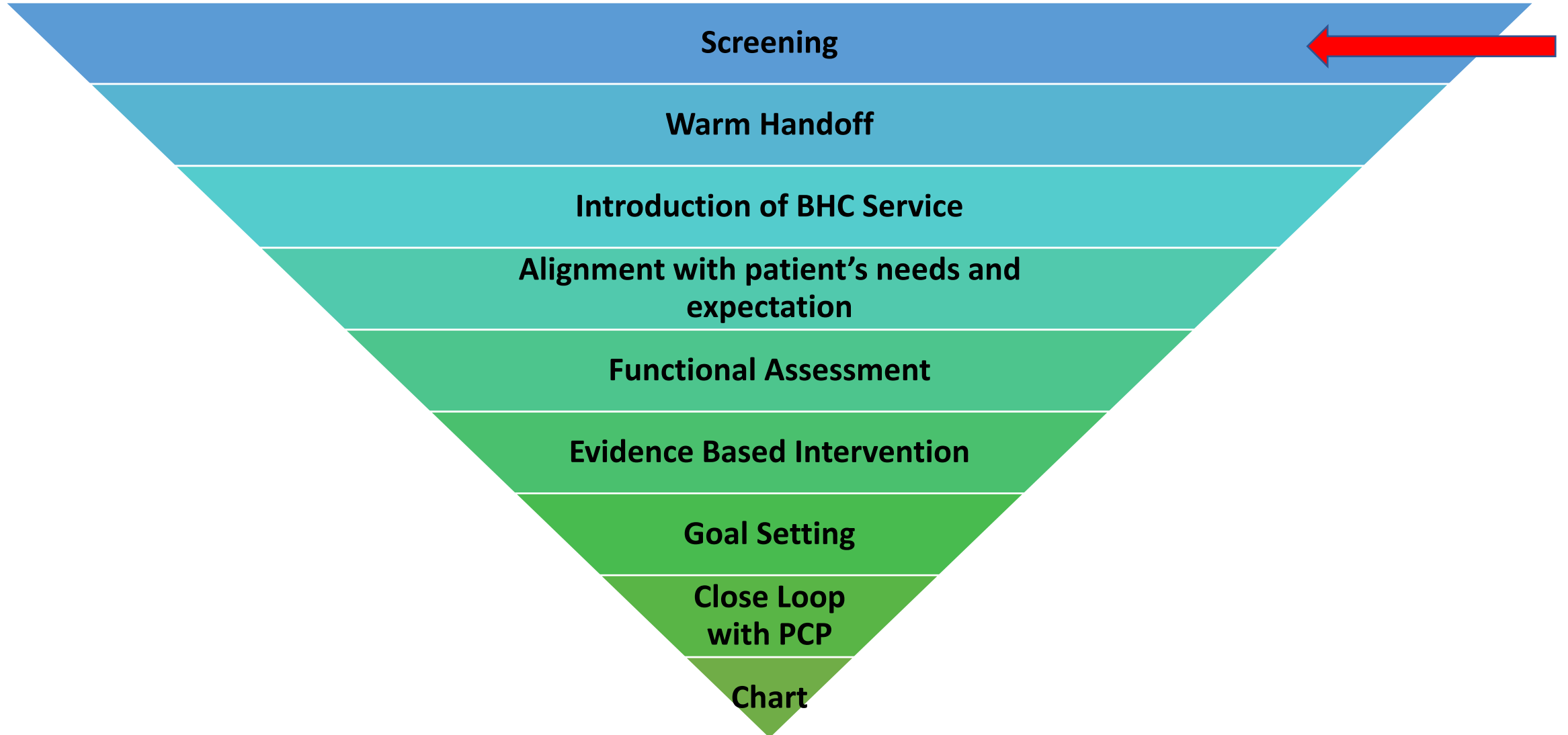
Team-based: The BHC is part of the health care team and participates in meetings and huddles about patient care

High productivity: To make this model work financially, the BHC must be able to see many patients each day. Many of these visits are short

Education: The BHC educates patients about health issues and the health care team about patients' psychosocial needs. The BHC supports the primary care physician in continued care of the patient
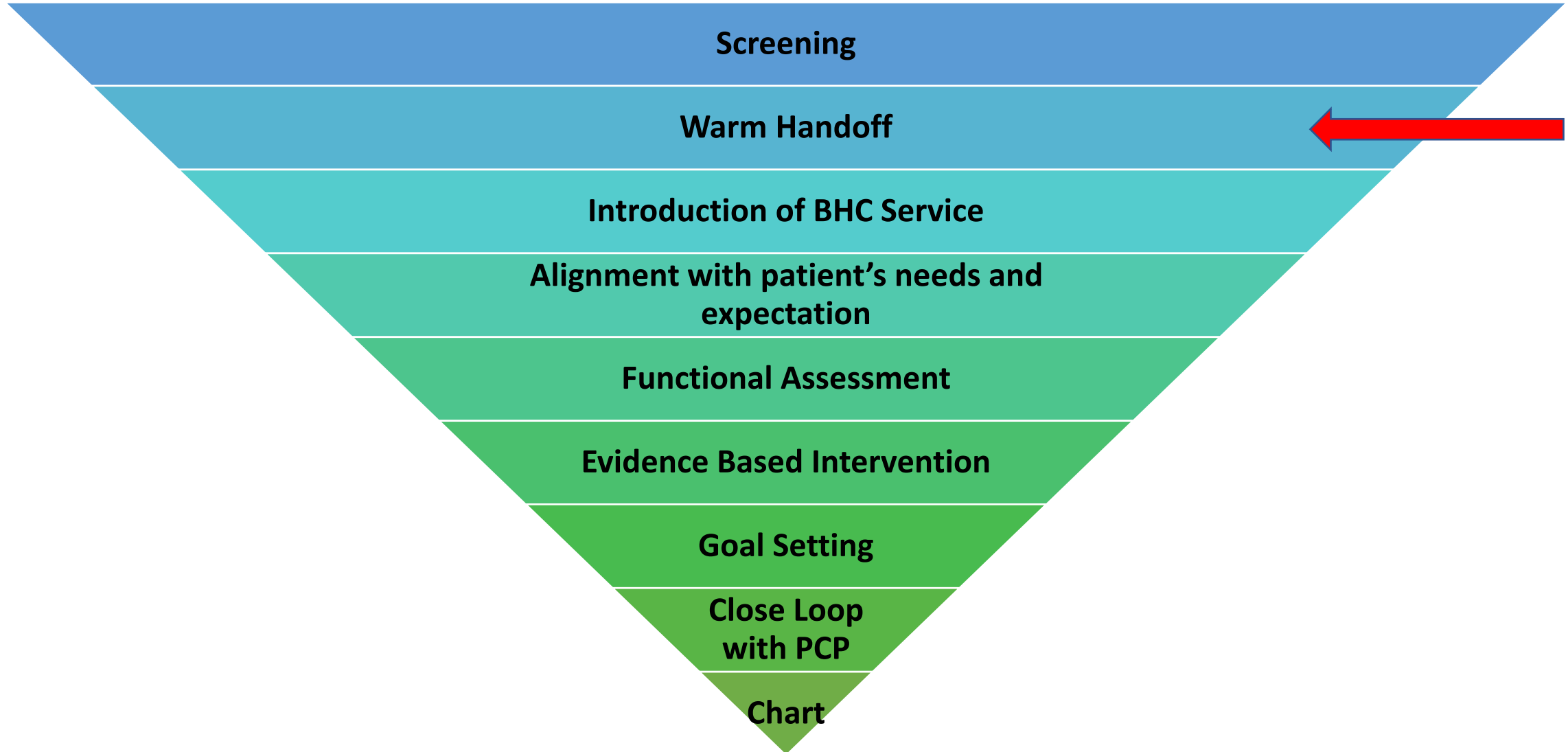
Routine: When making referrals to the BHC becomes part of the clinic's normal daily workflow

Reiter JT, Dobmeyer AC, Hunter CL. The primary care behavioral health (PCBH) model: an overview and operational definition. *J Clin Psychol Med Settings*. 2018;25(2):109–126.

PCBH VISIT STRUCTURE

Screening

Warm Handoff

Introduction of BHC Service

Alignment with patient's needs and expectation

Functional Assessment

Evidence Based Intervention

Goal Setting

Close Loop with PCP

Chart

» Patient Health Questionnaire (PHQ-9): www.phqscreeners.com
  - Most common screening tool to identify depression. It is available in multiple languages, accessible at phqscreeners.com

» GAD-7
  - A seven-question screening tool that identifies whether a complete assessment for anxiety is indicated

» CAGE-AID
  - A commonly used, four-question tool used to screen for drug and alcohol use. The CAGE is a quick questionnaire to help determine if an alcohol and/or drug assessment is needed

» The Mood Disorder Questionnaire (MDQ)
  - Includes 13 questions associated with bipolar disorder symptoms

» Primary Care PTSD Screen (PCPS)/PTSD Checklist for DSM-5 (PCL-5)
  - PCPs may use the five-item or the 20-item self-report questionnaire, accessible at
    o https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp
    o https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

≫ "Pre-Screen" (e.g., PHQ2, NIDA Quick Screen, TAPS)

- Handed out by the front desk for patient completion
- Pre-visit questionnaire collected electronically (patient portal…)

≫ Full Screen

- Medical Assistant (MA) with PCP follow up
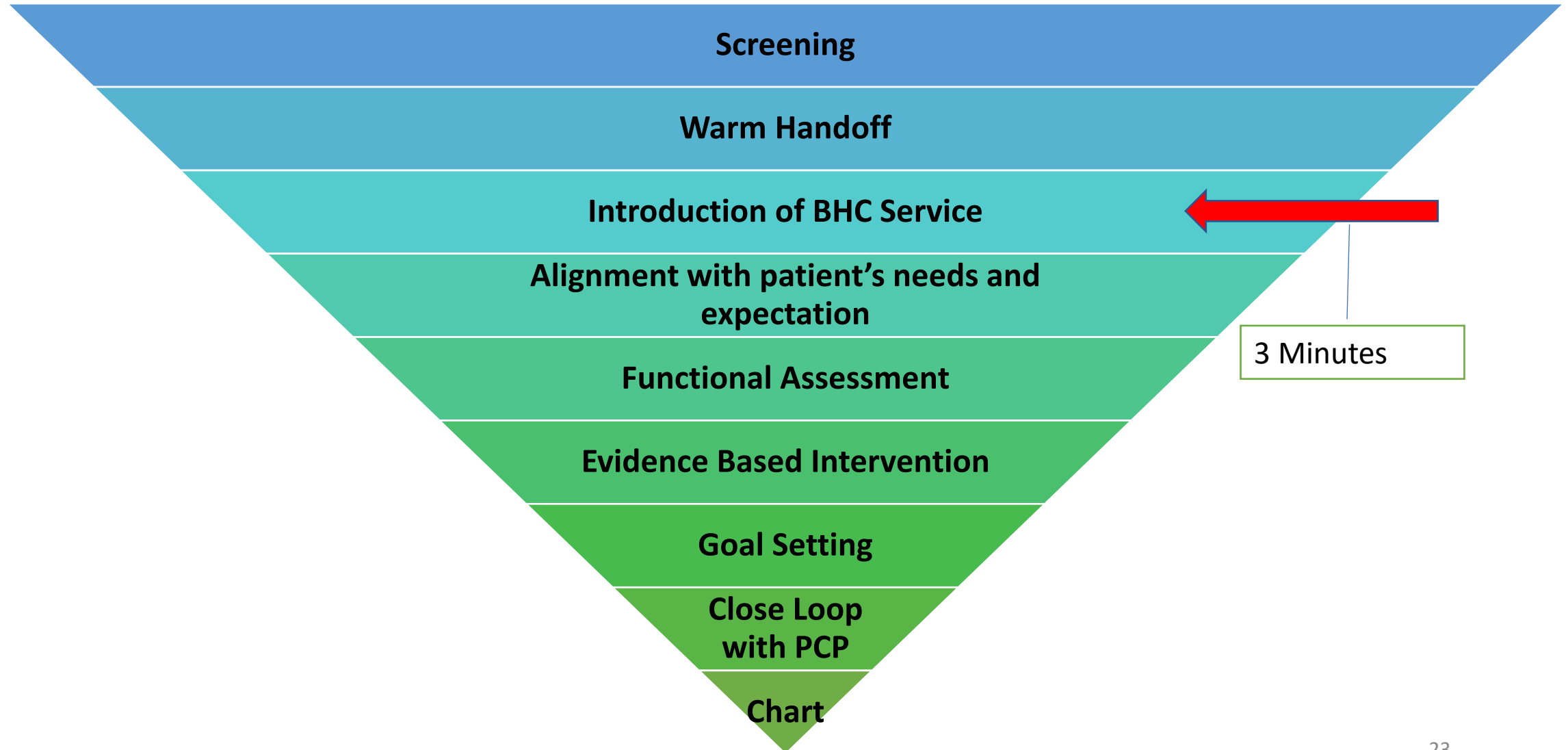- Behavioral Health Consultant (BHC) – while patient roomed or following a positive prescreen

Screening

Warm Handoff

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Functional Assessment

Evidence Based Intervention

Goal Setting

Close Loop with PCP

Chart

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Mr. Jones, I want you to meet another member of our primary care team, Sarah, who works with people on both physical and emotional health concerns. Sarah works with me to support the well-being of my patients and we work together to help my patients be as healthy as possible. Sarah works with patients to improve sleep, diet, stress, anxiety and depression.

Sarah, I am concerned that Mr. Jones has been sad and anxious lately, and this is making it hard for him to sleep. Mr. Jones, is there anything else you would like to add?"

✅ Reinforces team-based care

✅ Describes scope of care

✅ Provides examples of concerns addressed

⛔ Describes structure and frequency of the service

⛔ Describes intermittent nature of the service

» How do warm handoffs work at your clinic?

» Do you have established ways that the PCP introduces you?

» How effective are warm handoffs in your practice?

Screening

Warm Handoff

Introduction of BHC Service

Alignment with patient's needs and expectation

Functional Assessment

Evidence Based Intervention
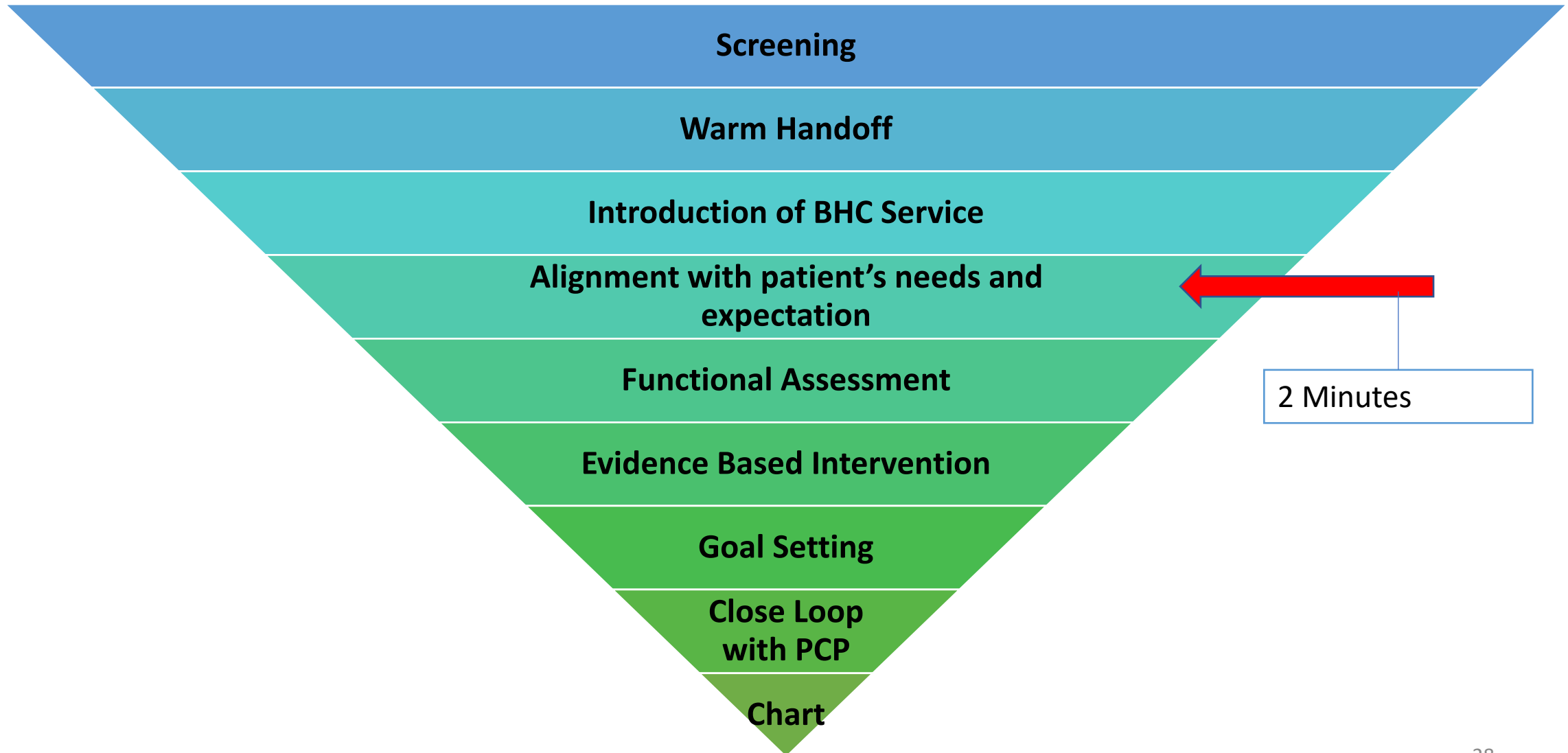
Goal Setting

Close Loop with PCP

Chart

3 Minutes

» Describe the role functionally

» Clarify your collaboration with the PCP

» Describe some types of concerns that the consultation model is designed to address

» Describe the structure and frequency of the service

» Describe intermittent nature of the service

HMA   INTEGRATED CARE DC
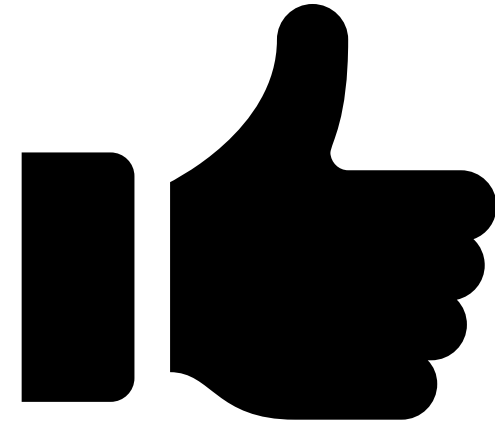
» My name is _____. I am a Behavioral Health Consultant and a member of the primary care team. I work with your primary care provider. What we discuss together is shared with your PCP because we work as a team. My focus is on supporting patients with their physical and emotional health. I work with people on sleep, eating, stress management and anxiety or depression. We'll meet today for about 20 - 30 minutes so I can better picture of what is going on. We may meet one or more times depending upon how you are doing, and you can always ask your provider for my support.

✓ Reinforces team-based care

✓ Describes scope of care

✓ Provides examples of concerns addressed

✓ Describes structure and frequency of the service

✓ Describe intermittent nature of the service

» Write an intro in your own words

» Share it with co-workers and your practice coach

» Practice it (a lot)

Screening

Warm Handoff

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Functional Assessment

Evidence Based Intervention

Goal Setting

Close Loop with PCP

Chart

2 Minutes

» Dr. Llera is concerned that you have been quite sad and worried lately. Are you concerned about this?

» Do you want help for this now?

» Do you have any questions?
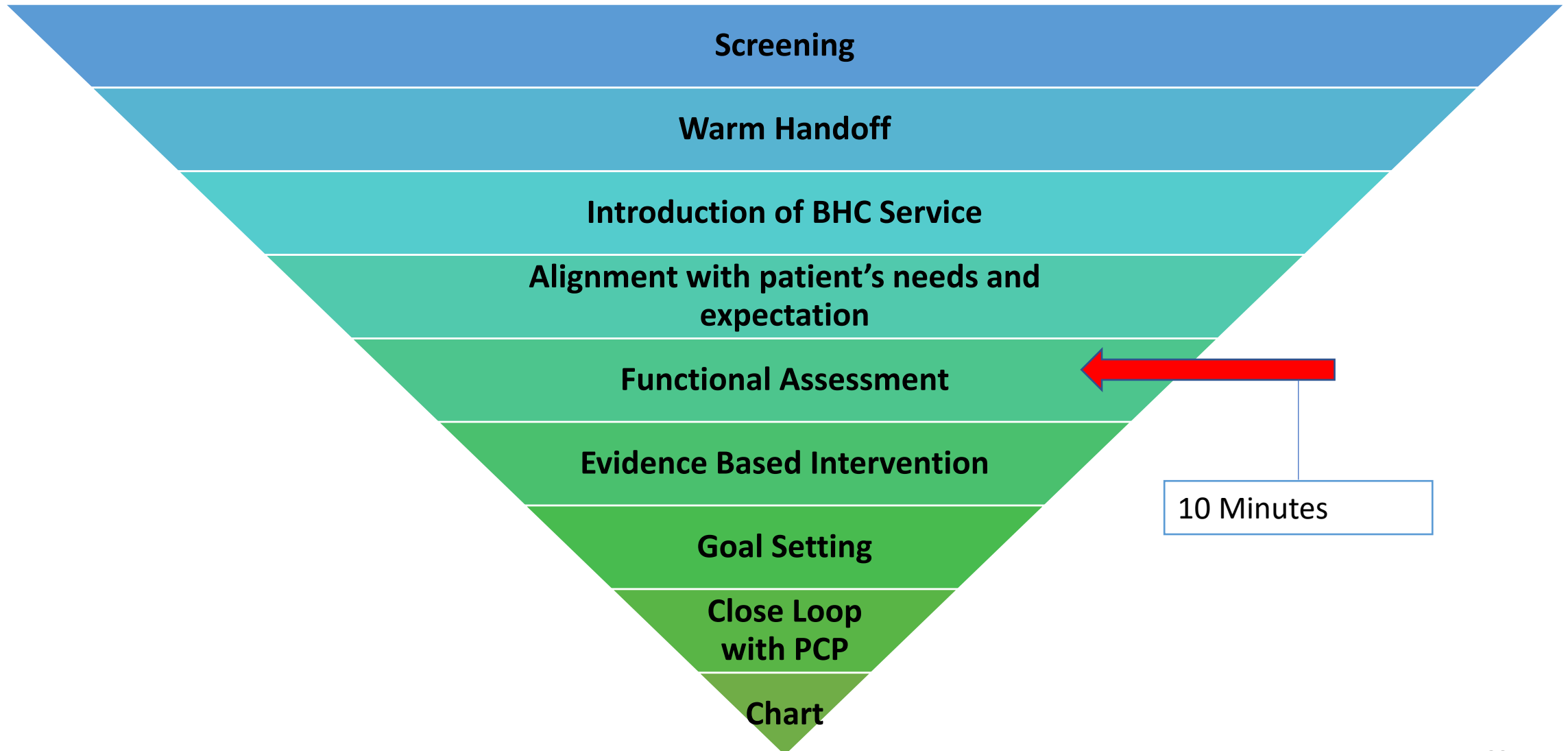
Resources and information for functional assessment in addition to patient interview: PCP, EMR, Screening & Assessment Measures

» Nature of Problem. Clarify the target problem

» Hx of problem

» Duration

» Triggering Event

» Frequency/Intensity

» Related factors that may alleviate or exacerbate
  » Physical, emotional, behavioral, environmental/social, cognitive
  » Sleep, pain, depression, avoidance of activities, negative thoughts

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Evaluate for functional impairment in the following areas

|			
Sleep	Appetite/eating	Energy	Concentration
Pain	Mobility	Family and friends	Physical activity
	Work – School - Volunteer	Enjoyable activities	

Further screening/assessment tools as needed

» PHQ-9

» GAD-7

» PCL

» Brief Addiction Monitor (BAM)/AUDIT-C

» Caffeine, Drug, and Alcohol Use

» Medication Compliance

» Suicide or homicide risk (if necessary)

» Tell me about a typical weekday/weekend

» Is there anything I haven't asked you about that you think is important for me to know?

» What have you tried to do so far to improve or solve the situation?
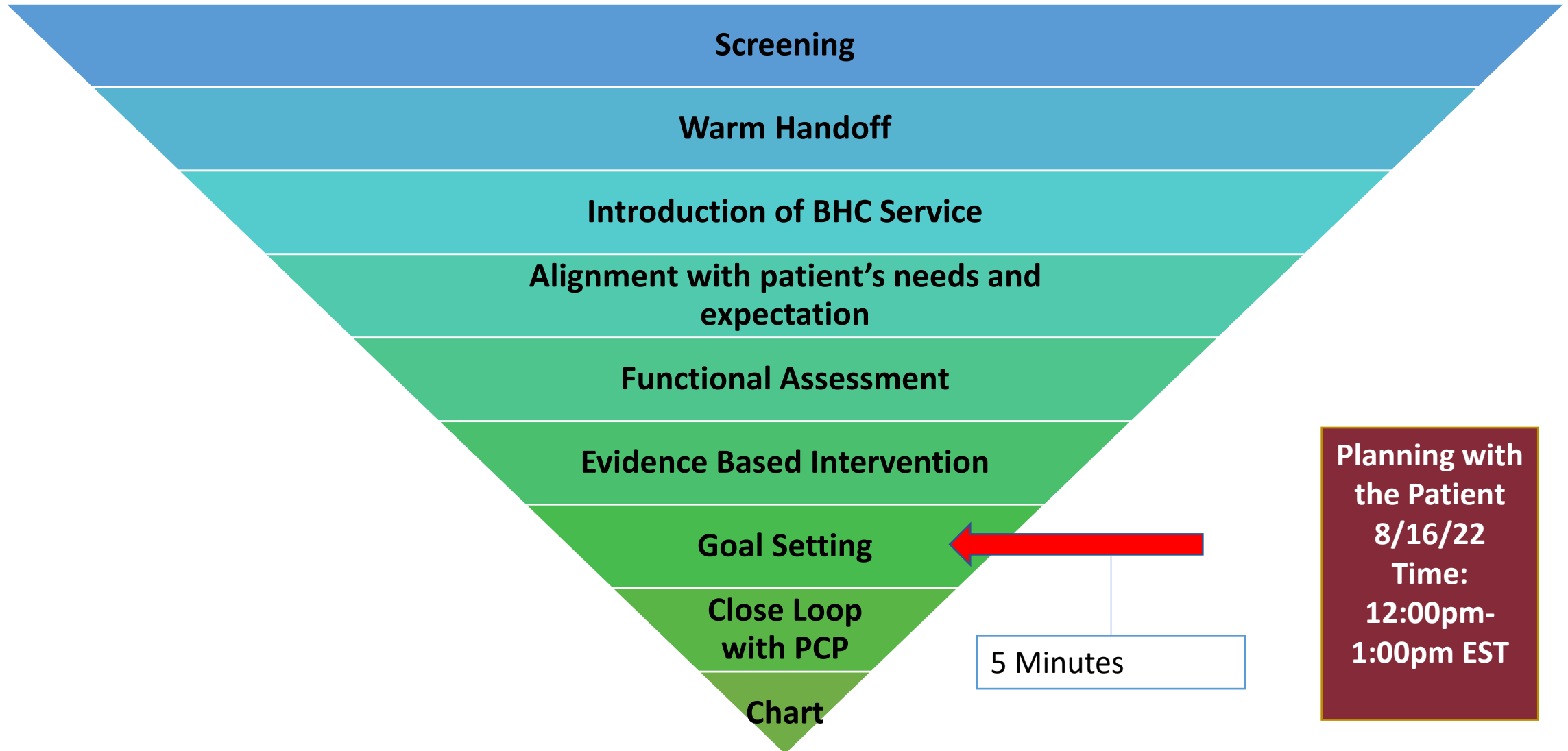
BH INTERVENTIONS FOR PRIMARY CARE
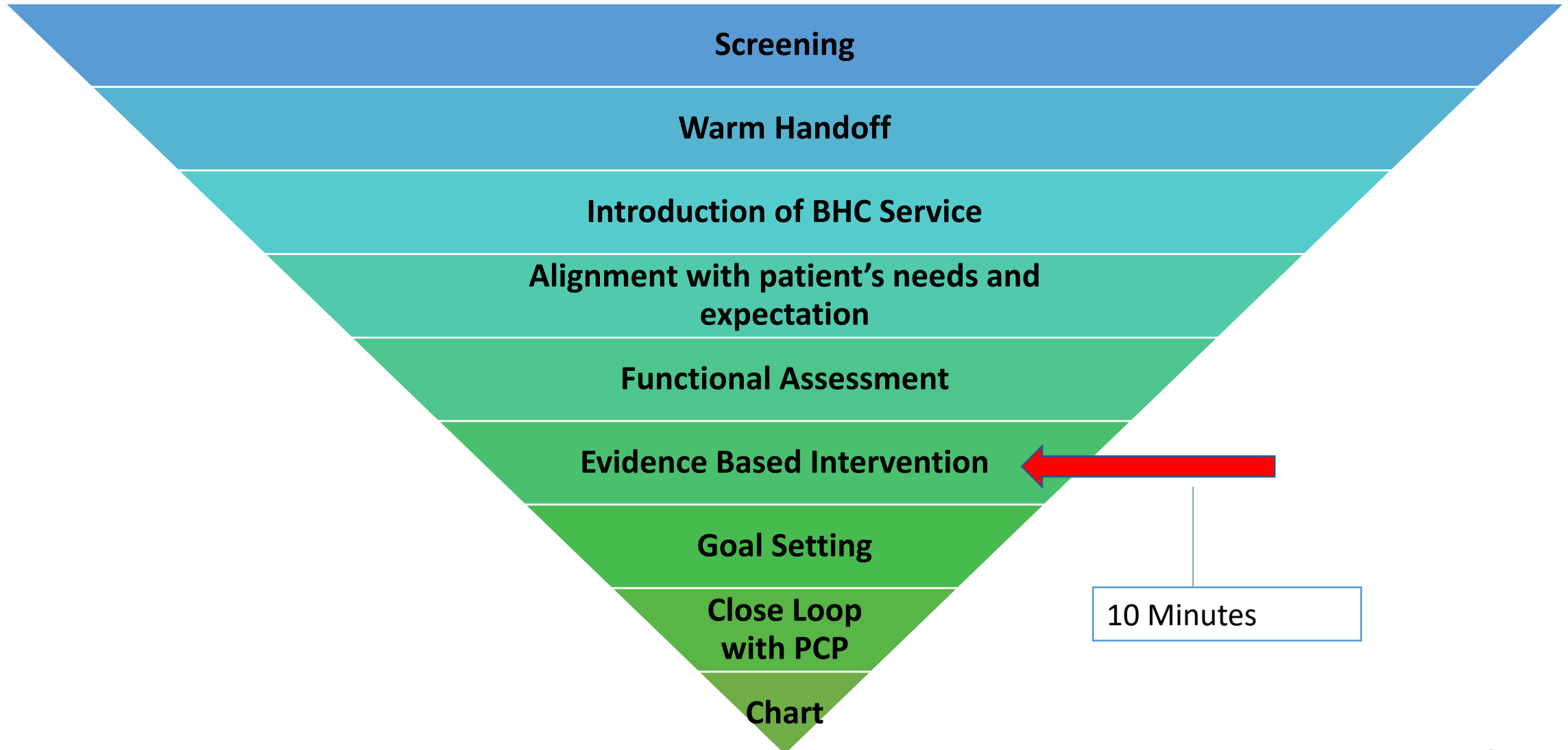
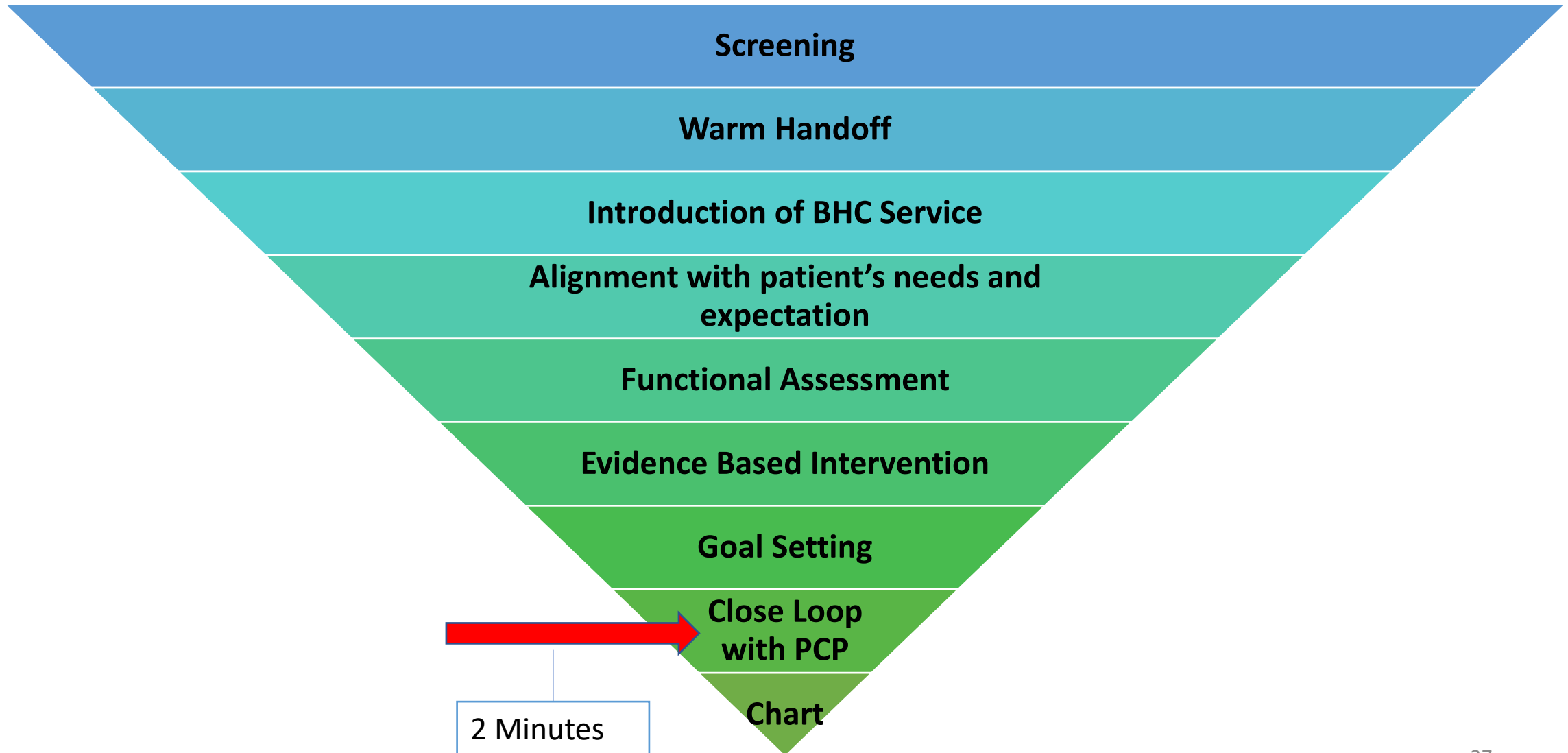>> **Evidence Based Interventions for primary care:**
- Motivational Interviewing
- Problem Solving Treatment
- Cognitive Behavioral Treatment
- Emotion Regulation Skills/Coping with Trauma Skills
- Stress Reduction Skills
- **Focused Acceptance and Commitment Therapy (f-ACT)**
  - **Sept 20, 2022**
  - **October 18, 2022**

>> **ICDC Short Takes and Webinars https://www.integratedcaredc.com/**
- Problem Solving Treatment
- Cognitive Behavioral Treatment
- Emotion Regulation Skills/Coping with Trauma Skills
  - Grounding in the Body
  - Experiencing emotions
- Brief Intervention for Adults Part I
  - Motivational Interviewing and mindfulness
- Brief interventions for Adults Part II
  - Behavioral activation, distress tolerance skills and problem-solving therapy
- Stress Reduction Skills
  - Mindfulness
  - Imagery
  - Deep breathing/diaphragmatic breathing

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INTEGRATED CARE DC

Screening

Warm Handoff

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Functional Assessment

Evidence Based Intervention

Goal Setting

Close Loop with PCP

Chart

5 Minutes

Planning with the Patient 8/16/22 Time: 12:00pm-1:00pm EST

Close the loop with the PCP

- SBAR
  - Situation – 1 sentence
  - Background – 1 sentence
  - Assessment – 2 sentences
  - Recommendation – 2 sentences – what you will do, what the patient will do, what the PCP will do
- PCP Communication Tips
  - Prepare ahead what you are planning to say
  - Speak in bullet points
  - Use plain language
  - Resist the urge to provide extensive background
  - Focus on your assessment and the follow up

Example
- S: Sarah's family life is very stressful, and she is overwhelmed by this. She is socially isolated and has little support.
- B: She has had mild depression in the past but has not needed treatment.
- A: Her depression is situational, and she and I both agree that she will try to make some behavior changes and see if this helps. No medication is indicated at this time. Social isolation is a big driver of her mood.
- R: In the past, Sarah was active in her church, but lately she has not had the energy to get involved. She would like to try and get support there and agrees to attend this Sunday. She is going to ask her sister to come with her.

"John is a lovely and warm 63-year-old man. He is married and has three children. His wife is quite ill at the moment, and his children are also having a hard time in their lives. One of them is in a relationship where there is domestic violence, and the other is selling drugs. It's no wonder he has a lot on his mind. As a child, John was abused, and he also drank quite a bit as an adult. He quit drinking about 5 years ago, which is an amazing strength. Developmentally, I'm afraid he is quite immature, and I can't quite discern at this point if this is because of his history of substance abuse, or if it is more about his childhood experiences. He does not participate in any kind of recovery program, which I think could be good for him. He's not sure, though. He's not really sleeping well, which really impacts his mood, but I'm worried that a sleep aid will trigger his substance use. At this point, I will need to continue to assess and I'm going to see him again next week."

How would you make this communication better?
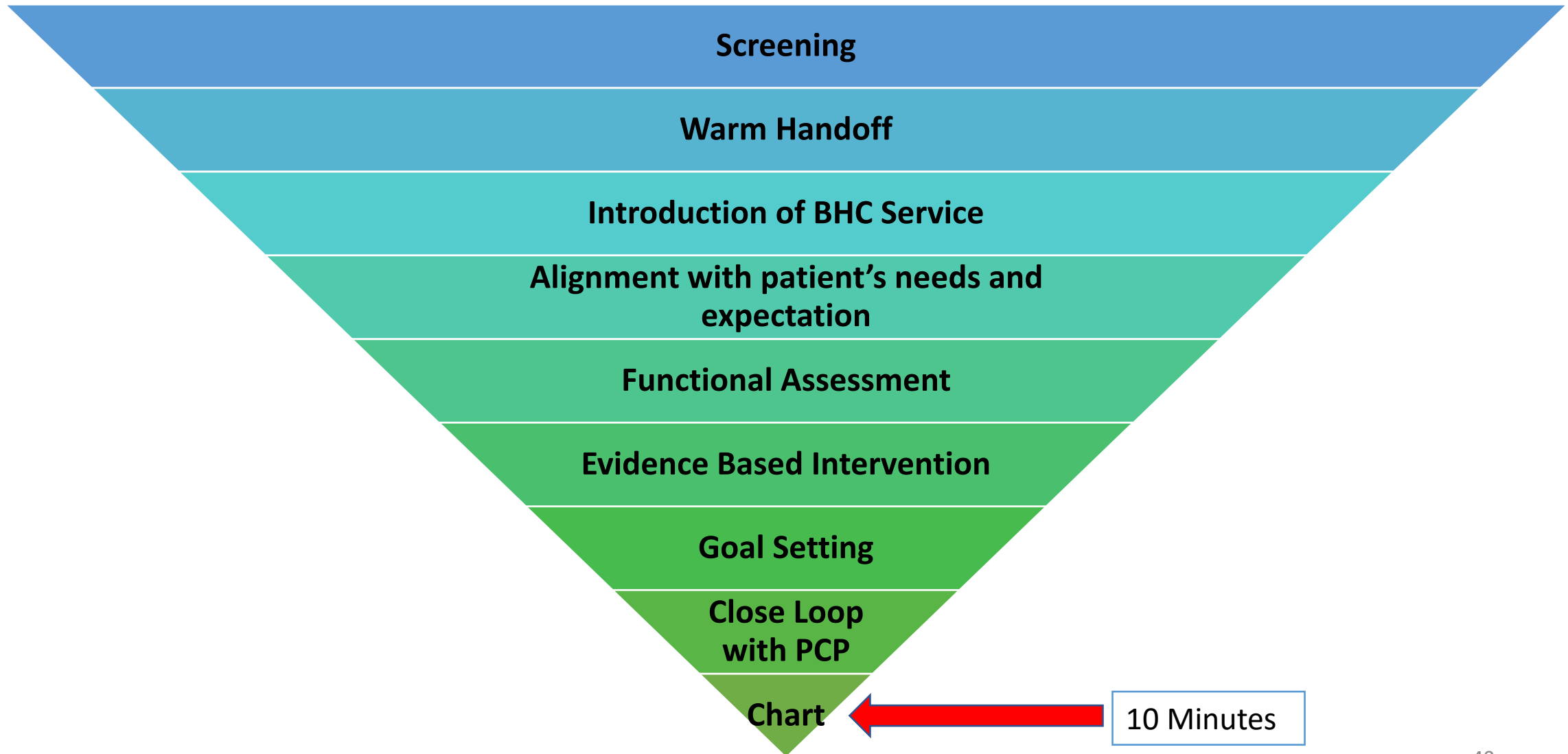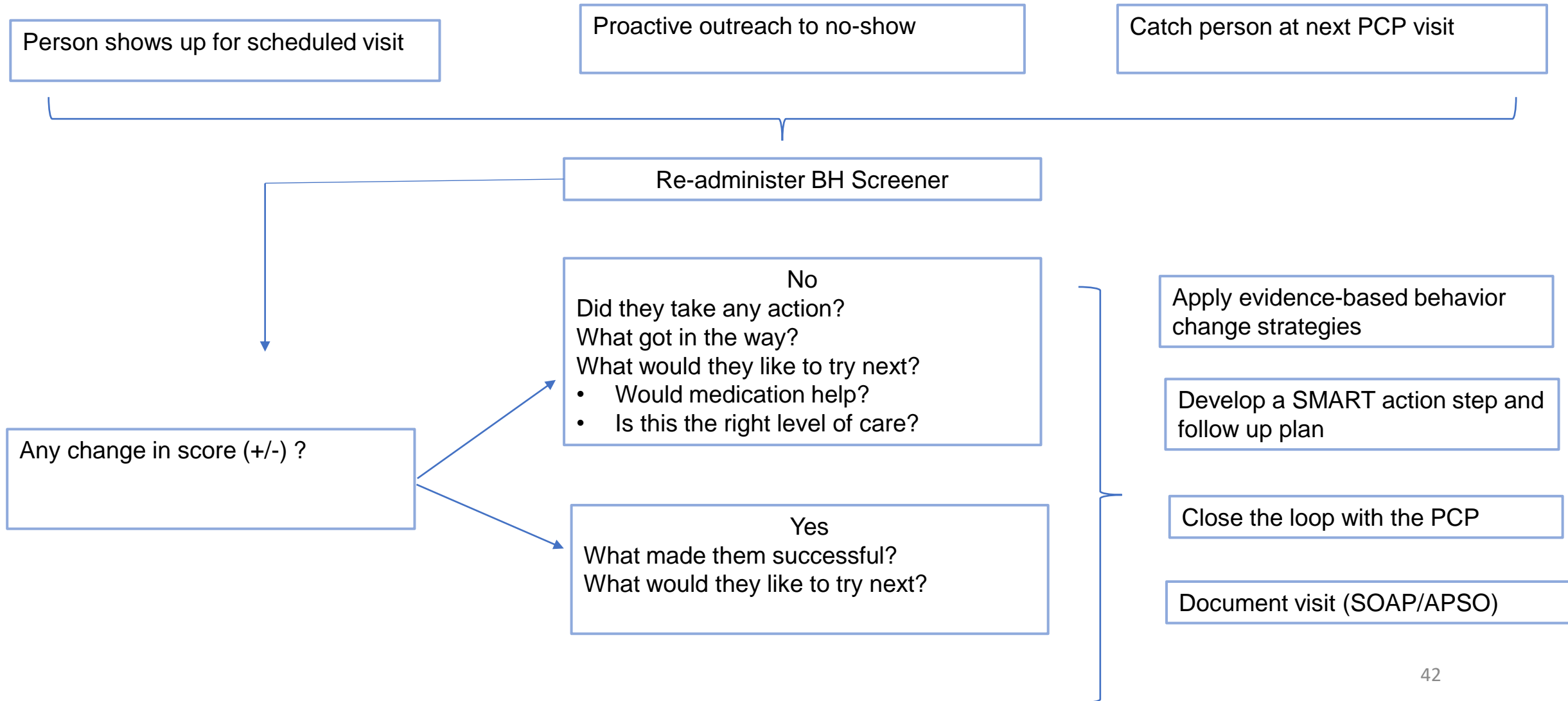
Document a PCBH visit
- SOAP/APSO
    - Subjective
    - Objective
    - Assessment
    - Plan
- **The note is not for you**, it's for the primary care team

Between now and when we see you next…

Check out Neftali Serrano, PsyD speaking on SOAP Note Tips For BHCs on YouTube: https://www.youtube.com/watch?v=e8QHqSxaYdo

Person shows up for scheduled visit

Proactive outreach to no-show

Catch person at next PCP visit

Re-administer BH Screener

Any change in score (+/-) ?

No
Did they take any action?
What got in the way?
What would they like to try next?
- Would medication help?
- Is this the right level of care?

Yes
What made them successful?
What would they like to try next?

Apply evidence-based behavior change strategies

Develop a SMART action step and follow up plan

Close the loop with the PCP

Document visit (SOAP/APSO)

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Q&A

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Suzanne Daub, LCSW
sdaub@healthmanagement.com

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» Please complete the online evaluation! **If you would like to receive CE or CME credit, the evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar.

» The webinar recording will be available within a few days at: https://www.integratedcaredc.com/learning/

» **Upcoming Webinar:**
- *Consent Management Series 1: Consent to Share Substance Use Disorder Information: The Basics*, August 4, 2022, 1:00pm-2:00pm EST
- *PCBH Part 2: Behavioral Health Consultation: Planning with the Patient*, August 16, 2022, 12:00pm-1:00pm EST

» For more information about Integrated Care DC, please visit: https://www.integratedcaredc.com/

» Reiter JT, Dobmeyer AC, Hunter CL. The primary care behavioral health (PCBH) model: an overview and operational definition. *J Clin Psychol Med Settings*. 2018;25(2):109–126.

» Robinson, P. J., & Reiter, J. T. (2016). *(2nd ed.). Springer International Publishing. https://doi.org/10.1007/978-3-319-13954-8*