THANK YOU!

- 100% of practices reported at least one core CQM
- More than 90% reported all three required CQMs

SIM THROUGHOUT THE STATE

- Ten collaboratives of Local Public Health Agencies and Behavioral Health Transformation Organizations funded
- Regional Health Connectors to be placed in every Health Statistics Region

SMALL GRANTS UPDATE

Notification letters sent on June 30th to all applicants
- Colorado Health Foundation: Budgets for all TCHF practices have been approved
- SIM/CMMI: 12 practice budgets have been sent to CMMI for final approval, 8 pending revisions
- Purchase Orders will be drafted following approval from CMMI
- Webinar will be scheduled shortly

PAYMENT REFORM

Payer MOU:
- Health First Colorado (Medicaid)
- Anthem Blue Cross Blue Shield
- Cigna
- Colorado Choice Health Plans
- Kaiser Permanente
- Rocky Mountain Health Plans
- UnitedHealthcare
PAYMENT REFORM

• Practices notified in May of which payers had committed to supporting their practice
• SIM Office working with Multi Payer Collaborative to refine and advance payment reform efforts based on practice feedback

SIM COHORT 2 APPLICATION

• Application will be released by end of November 2016
• Administered by University of Colorado
• Hosted on Shared Practice Learning Improvement Tool (SPLIT)
• ENSW practices are highly-encouraged to apply

CPC+ REGIONS

• Currently working with CMMI to create a dual-participation pathway, with the goal of offering intensive support focused on behavioral health integration, HIT, and business consultation to accelerate transformation in practices participating in both initiatives

WHY APPLY TO BOTH?

• Increase your chances of participating in at least one initiative (no wrong door)
• Maximize your support if accepted to both initiatives

STREAMLINED APPLICATION

• SIM applicants who previously applied to CPC+ will be prompted to upload a PDF of their CPC+ application and will complete an abridged set of questions
Genesis of Health Extension

- Temporary relationships (grants, time, etc.)
- Do not engage meaningfully and with respect
- Do not have people that represent the population being served
- Research priorities do not match
- Do not include community from the beginning
- Should call yourself U of Albuquerque
- You come to tell, to fix and to recommend
- Do not work WITH communities (in, on)
- Do not report back to community
- NMSU Cooperative Extension

PARTNERSHIP

Health Extension

OFFICE – Rural and urban

MODEL – AHC engagement in communities

PEOPLE - Coordinators who live in the community, possess community health improvement skills, and build bridges between communities and UNM-HSC

STRATEGY - For community health improvement; addressing social determinants, priority health conditions and healthcare workforce

HERO Characteristics

LIVE in community
LINK local health needs w/UNM & NMSU resources
IMPROVE local health services and systems
ENCOURAGE youth to finish school, enter health careers
RECRUIT and retain a local health workforce
BRING latest research, health care practices to community
STRENGTHEN community capacity to address local health problems
HERO Core Functions

- Technical Assistance
- Training & Education
- Facilitation
- Consultation
- Coaching
- Linking to HSC
- Advocacy

NEW MEXICO

<table>
<thead>
<tr>
<th>ETHNICITY</th>
<th>PERCENTAGE</th>
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<tbody>
<tr>
<td>Hispanic</td>
<td>44%</td>
</tr>
<tr>
<td>White</td>
<td>42.8%</td>
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<tr>
<td>Native American</td>
<td>9.8%</td>
</tr>
<tr>
<td>African American</td>
<td>2.5%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

The Social Health of the Fifty States: Where is New Mexico?

This combines in a single measure each state’s performance on 16 social indicators representing different stages of life.

Map of HEROs and their regions

Office for Community Health Core Team

1. Building Partnerships for Healthy Communities
2. Office for Community Health
3. Connecting Communities
4. Linking Communities
5. Supporting Communities
6. Engaging Communities
7. Sustaining Communities
8. Measuring Communities
9. Evaluating Communities
10. Planning Communities
11. Developing Communities
12. Educating Communities
13. Training Communities
14. Learning Communities
15. Advocating Communities
16. Promoting Communities

Map showing HERO hubs and their regions.
Adverse Childhood Experiences
Correlated with Chronic Disease in Adults

Childhood Abuse
- Physical
- Emotional
- Sexual

Adults in Home
- Mother beaten
- Mental Illness
- Alcohol or substance abuse
- Having been a prisoner

Temporary relationships
Do not engage meaningfully
Research priorities do not match
Should call yourself U of Albuquerque
NMSU Cooperative Extension

UNEMPLOYMENT

HOUSING

TRANSPORTATION

STRESS

FOOD INSECURITY
“Food Deserts” in New Mexico

Areas with Limited Access to Affordable and Nutritious Food

SOCIAL EXCLUSION

Temporary relationships do not engage meaningfully
Research priorities do not match
Should call yourself U of Albuquerque NMSU Cooperative Extension

Access to Health Services

COMMUNITY IS THE PRIORITY

Our Current Health System
MEN'S GROUP SESSION ON DOMESTIC VIOLENCE PREVENTION

ACA EDUCATION & OUTREACH SESSION AT ALAMOSA COMMUNITY CENTER

COMPUTER/HEALTH LITERACY CLASS

SESSION ON DIABETES
PEER-TO-PEER TEACHING AND LEARNING

HANDS-ON LEARNING

POPULAR EDUCATION
COMMUNITY BENEFITS:
- Model Partnerships
- Build new networks and relationships
- Economic development
- New paradigms
- Change way of thinking
- Innovation
- Local crop for community
- Build synergy
- Improve health outcomes
- Primary Prevention
- Early Intervention
- Inspire HOPE

PERSONAL BENEFITS:
- Bring the fresh crop to people
- Awareness of community resources, connections, relationships
- Bring consciousness
- Teaching moments between patients and farmers
- Community health sessions
- Cooking nutritional foods

Lessons Learned
- Review your DATA
  - Demographics
  - Social Issues
  - Health Issues
  - Asset mapping
- Make the right match
  - Culture
  - Language,
  - Personal, Professional background)
- Relationships take time
  - Presence
  - Effort
  - Being a part of
- Building Trust
- Documentation
- Making connections:
  - People
  - Organizations
  - Systems
- Relationships take time
- Communication
- Integration
- Collaboration
- Make the community needs and priorities your priority
- Document and Listen
- Practice Shared Resources
- Go beyond your comfort zone

PEARLS
- Bring EQUITY to communities
- Be Genuine
- Be Yourself'
- Be Bold
- Be Courageous
- Challenge the Status Quo
- Be HUMBLE

5 Essential Elements to Impact Communities
1. PLAN
2. LEADERS
3. PEOPLE
4. RESOURCES
5. ACTION

Basic Principle
Practice Needs:

- Health Educators
- Community Health Workers
- Technical assistance in business operations
- Build a network
- Referrals from PC to hospital or specialties
- Communication and Integration between systems
- Intersectorialidad

NEW IDEAS!

Rationale

- 32 of 33 counties — health professional shortage areas
- 29 of 33 counties — primary mental health care shortage areas
- Physicians/100,000 population: 194 (NM) vs. 226 (US)
- 49th nationally in dentists per capita
- NM population: 23% Medicaid & 21% uninsured 21% uninsured
- 5th largest state in area
- 45th in population density

Rationale (Continued)

- NM: 1 medical school, 1 pharmacy school, 2 physician assistant schools, no dental school
- 70% of practicing physicians over age 45
- Hispanics in NM: 44% of population but only 10.7% of physicians
- Native Americans in NM: 10% of population but only 0.7% of 3 physicians

Burciaga, R. "Training a Primary Care Workforce" 2009

Rationale (Continued)

- Health education and patient clinical education can reduce morbidity and mortality in patients
- Health care institutions and public health systems play a critical role in health literacy, because they can make it easier or more difficult for people to find and use health information and services.
- For the first time, there are national data that demonstrate currently available health information is too difficult for average Americans to use to make health decisions.
- Only 12 percent of U.S. adults had proficient health literacy

National Hospital Ambulatory Medical Care Survey

- Objective of the study was to evaluate the rate of health education provision by physicians, physician assistants, and nurse practitioners/certified midwives.
- Analysis of 5 years of data 2005-2009
- Data abstracted from 136, 432 adult patient visits with chronic conditions, such as: asthma, COPD, DM, hyperlipidemia, HTN, ISD and Obesity
- Findings: Health education was not routinely provided to patients who had a chronic condition. For all conditions assessed, rates of health education were higher among physician assistants and nurse practitioners than among physicians.

CDC: Preventing Chronic Disease Public Health Research, Practice and Policy
2003 National Assessment of Adult Literacy (NAAL)

- Only 12 percent of U.S. adults had proficient health literacy for explanation.
- Over a third of U.S. adults—77 million people—would have difficulty with common health tasks, such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart.
- Limited health literacy affects adults in all racial and ethnic groups. The proportion of adults with basic or below basic health literacy ranges from 28 percent of white adults to 65 percent of Hispanic adults.
- Although half of adults without a high school education had below basic health literacy skills, even high school and college graduates can have limited health literacy.
- Compared to privately insured adults, both publicly insured and uninsured adults had lower health literacy skills.
- All adults, regardless of their health literacy skills, were more likely to get health information from radio/television, friends/family, and health professionals than from print media.

(UHHS. Office of Disease Prevention & Health Promotion – Health Communications Activities)

Health Literacy

The ability to obtain, process, and understand basic health information and services to make appropriate health decisions—is essential to promote healthy people and communities.

Who are these health professionals?

A “Community Health Specialist” is a professionally – trained health worker from Latin America and other countries who bring a cultural, linguistic and professional competence much needed by our underserved populations. Although, these professionally – trained health workers from other countries may not have a U.S. recognized medical, pharmacy, or nursing license, these health professionals may still play a vital and much-needed and anticipated role on the healthcare teams in New Mexico if properly trained for a new role.

Who will employ them?

- Clinical settings:
  - Hospitals
  - Health centers
  - Private clinics
  - Dialysis centers
- Schools
- Faith-based organizations
- Community-based organizations
- Community Centers

Scope of Practice

1) Health education and promotion – focused on primary prevention / Clinical patient education
2) Health literacy/Health advocacy
3) Cultural and linguistic approach to management of chronic diseases (Stanford Model) through education and support groups

Expected Outcomes

- Healthier and health literate communities
- Improve health outcomes
- Decrease health disparities (inequities)
- Chronic disease management
- Aid in driving down health care spending
- Save money – by not having to re-train a new workforce
- Efficient, effective and rapid way of increasing the health workforce
- Build capacity within the general population on health promotion and disease prevention
- Increased care to our under served populations
Rethinking the Role of Behavioral Health in Managing Chronic Pain
Alex Schmidt, PhD, LMFT-A
Integrated Behavioral Health Advisor

Objectives

- Define the problem of managing chronic pain using the traditional biomedical model
- Describe methods for team-based care of chronic pain and other comorbidities at various levels of integration of behavioral health
- Create an action plan to refresh your ways of caring for patients with chronic pain in your practice

THANK YOU!
Biological pathology

Sensation of pain

Biological pathology

Sensation of pain

IS ANYTHING REAL?
Models of Pain Management

Traditional Pain Management

Actions  Lifestyle

Biological contributors

Holistic Pain Management

Life story  Patterns of thinking  Actions

Relationships  Lifestyle

Biological contributors

Traditional (Dualistic) Model vs. Emerging (Holistic Model)

<table>
<thead>
<tr>
<th>Traditional (Dualistic) Model</th>
<th>Emerging (Holistic Model)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical or psychological focus</td>
<td>Also considers social and environmental focus</td>
</tr>
<tr>
<td>More clinician-centered</td>
<td>More patient-centered</td>
</tr>
<tr>
<td>Limited benefits for limited time</td>
<td>Significant long-term benefits</td>
</tr>
<tr>
<td>Individual treatment modality</td>
<td>Individual + group treatments</td>
</tr>
<tr>
<td>Patient as recipient of treatment</td>
<td>Patient as partner in treatment</td>
</tr>
<tr>
<td>Potential dependency/complications</td>
<td>Limited dependency/complications</td>
</tr>
<tr>
<td>'Siloed' health system approach</td>
<td>Integrated health system approach</td>
</tr>
<tr>
<td>Neural plasticity disregarded</td>
<td>Neural plasticity vital for treatment</td>
</tr>
<tr>
<td>Individual health perspective only</td>
<td>Individual + population perspective</td>
</tr>
<tr>
<td>Ongoing/discontinued biomedical treatment</td>
<td>Time-limited biomedical treatment</td>
</tr>
</tbody>
</table>

Building the Case for Behavioral Health
New Patient with History of Chronic Pain
New Diagnosis of Chronic Pain
Establish Pain Management Contract
Change in Pain Characterization or Management Plan

Biomedical Yellow Flags
- Severe pain or increased disability at site of pain presentation
- Previous significant pain episodes
- Multi-site pain
- Non-organic signs
- Iatrogenic factors

Psychological Yellow Flags
- Belief that pain indicates harm
- Expectation of success of passive treatments
- Fear avoidance behaviors
- Catastrophic thinking
- Poor problem solving abilities
- Atypical health beliefs
- Psychosomatic perceptions
- High levels of distress

Social Yellow Flags
- Low expectation of return to work
- Lack of confidence in performing work activities
- Low levels of control over rate or quality of work
- Poor relationships
- Social dysfunction
- Medico-legal issues

What's the Goal?
Abolishing Pain
Adapting to Pain

(Tidy, 2014)
Emotional distress may:

- Predispose people to experience pain
- Precipitate symptoms
- Amplify or inhibit the severity of pain
- Be a consequence of persistent pain
Comorbidities
- Depression
- Anxiety
- Anger
- Poor cognition
- Sleep disorders
- Fatigue
- Sexual dysfunction
- Relational problems

Crafting the Role of Behavioral Health

The Role of a Behavioral Health Provider
- Enhancing case conceptualization by incorporating:
  - Quality of life
  - Functional status
  - Mental health comorbidities (e.g., depression, anxiety, PTSD)
  - Sociocultural context
  - Personal goals
  - Risk factors for opiate misuse or abuse
The Role of a Behavioral Health Provider

- Crafting interventions
  - Diaphragmatic breathing
  - Relaxation techniques
  - Physical activity
  - Healthy eating habits
  - Sleep hygiene
  - Activity pacing
  - Pleasant activity scheduling
  - Increasing family and friend support

Modalities of treatment
- Individual therapy appointments
- Brief interventions during medical visits
- Time-limited traditional sessions
- Family-centered appointments
- Group medical visits
- Coordination with community services

Re-Storying

Old Story
- Labeled as a complainer by family, friends, co-workers, etc.
- Feel rejected and failed by medical system
- Desperate for a solution with endless searching for a test or procedure that will fully explain and take away pain

New Story
- Possibility

Coordinated Co-located Integrated

<table>
<thead>
<tr>
<th>Coordinated</th>
<th>Co-located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accept referrals for individual or relational therapy, outside medical clinic</td>
<td>Accept referrals for individual or relational therapy, same location as medical clinic</td>
<td>Accept referrals for individual or relational therapy, as well as brief interventions during medical appointments</td>
</tr>
<tr>
<td>Potentially meet patient through warm hand-off</td>
<td>Likely to meet patient through warm hand-off</td>
<td></td>
</tr>
<tr>
<td>Communicate changes in patient’s clinical and functional status (phone, email, fax, etc.)</td>
<td>Communicate changes in patient’s clinical and functional status (phone, email, hallway consultations, case conferences, EMR, etc.)</td>
<td>Communicate changes in patient’s clinical and functional status (EMR, hallway consultations, face-to-face, etc.)</td>
</tr>
<tr>
<td>Coordinate with other community resources</td>
<td>Coordinate with other community resources</td>
<td></td>
</tr>
<tr>
<td>Offer some support to team members within office and promote staff wellness</td>
<td>Ease burden of team members through joint visits and support of fellow team members</td>
<td></td>
</tr>
<tr>
<td>Facilitate group medical visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Post-Intervention Reflection Questions

- Did this interaction both support the patient’s autonomy and allow me to demonstrate my knowledge and share my expertise?
- Does this intervention adequately account for the patient’s sociodemographic and cultural background?
- Did our interaction help to build and strengthen our partnership?
  Do I think the patient would answer similarly?

Brian, age 44
- Low back pain following a lifting injury at work
- 6 month follow-up appointment with his PCP
- Positive PHQ-9: 21/27 with no suicidal ideation
- Missed 3 days of work in last month → financial stress → marital tension → sexual problems
- Increased consumption of alcohol and marijuana
- Sleep-onset and sleep-maintenance insomnia
- Fear of repeat injury → reduced physical movement and 15 lb. weight gain
Conclusion

- Multidisciplinary, team-based care for chronic pain isn’t one option among many: it’s essential!
- For provider well-being
- For patient well-being

Implementing Telehealth: Lessons from the Field

Shandra M. Brown Levey, PhD

Objectives

• By the end of this session participants will be able to:

• Understand workflow related to implementing telemedicine
• Articulate helpful practices and common challenges in getting started with telehealth implementation
• Identify resources to find support related to telepsychiatry implementation start up

Experience: One Story of a Residency Practice

The University of Colorado's Helen and Arthur E. Johnson Depression Center, in partnership with the Department of Family Medicine, initiated a pilot project in May 2015 to leverage telepsychiatry into a primary care clinic with a large integrated behavioral health service, in order to more effectively treat the bio-psycho-social needs of patients.

Program Design

• Blended Model of Tele-Health Services and In-Person behavioral services to allow increased access
• Technology: Cloud-based virtual telemedicine platform, real-time, video-based (Vidyo/Zoom platforms)

- Step Model of Available Services:
  • 1) E-consult: Staff message through EPIC EMR for brief questions/chart review
  • 2) Provider-to-Provider Consultations: Scheduled or Brief Curbsides with PCP and/or BH Team Providers
  • 3) Co-Consultations: Provide Consultations with PCP and Patient to develop a Plan Together
  • 4) Psychiatric Evaluation: Initiate Plan, Document Recommendations for Continued Management
  • 5) Interdisciplinary Team Meetings: Discuss patients with high medical complexity
  • 6) Didactic Education

- Structure and Flexibility: Time is scheduled for consultations, meetings, and didactics & unscheduled time is available for curbside questions, warm-hand-offs, and supervision

- Coordinate with Behavioral Health Team: Psychologists, Social Workers, Health Coaches, Care Managers

Service Utilization

197 Psychiatric consultations provided between October 2015-August 2016
66% Psychiatry to Primary Care Provider “Curbside” Consults (Tele-health, Phone, In-Person)

Mode of Consult Delivery
- Telehealth: 21%
- Phone: 23%
- In-Person: 32%
- E-Messaging: 10%

Mental Health Diagnoses
- Depression: 34%
- Anxiety: 22%
- Bipolar: 27%
- Multiple: 22%
- Other: 7%
Lessons Learned

1) Professional Culture and Training Obstacles: From Silo to Team Based Care
2) Technology: Wireless Bandwidth Overload, Introduction of Technology into Patient Experience
3) Critical Workflow Components: Whose patient is this? Who initiates and refills medications, tracks labs, and manages emergency situations?
4) Evolving Protocols: "Everything in Pencil" to provide patient-centered care while addressing population-based health
5) Finding Sustainable Funding Models

Introducing Tele-behavioral health services to a Patient

• A few minute introduction and discussion
• Consent before first session
• Appropriate for telehealth?
  • No extensive exclusion criteria
  • Discuss with team
  • No acutely suicidal or homicidal patients
  • No patients with immediate hospitalization needs

Documentation

• Shared EMR with all team members and patient
• Not Behind the Glass
• Open Note System with Patients
• Can create referral structures for tracking
• Standard notes for shared system
  • No process or psychotherapy notes
  • No unnecessary details

Credentialing & Liability

• Licensure is needed in the state where the patient is located
  • Unless you are working in a federal system
  • Credentialing is largely dependent on the organization.
  • Credentialing by proxy JACHO
• Define liability within contractual agreements
  • Check in with malpractice providers
  • Create good clinical protocols
  • Work on consistent and clear communication

Technology

• Work to find the appropriate technology that allows you to be HIPAA compliant
• Journey not a destination
• HIPPA recommendations
• Flexibility to meet needs of patients and organization.
• Build in time and resources for troubleshooting

Scheduling

• Add in as provider to your system
• Train Front Desk and MAs to support technology and workflow
• Attach to other provider visits for co-consults
• Build in precepting time for scheduled and unscheduled consultation
• Limit 1:1
  • Small percentage of time
  • Good communication with PCP
  • Help increase PCP comfort with prescribing
  • Pass patient back to PCP
Finding Providers and Paying for it

• Connect with Providers you know in your area
• Discuss billing and liability arrangements with potential partners
• Funding
  • Grants can get you started, but they have a funding and sustainability cliff
  • Pay attention to opportunities that may present via MACRA
  • Resource sharing to pay for integrated providers

Discussion and Questions

Gunnison
• Pediatric Partners of the Southwest
• Mercy Family Medicine
• Roaring Fork Family Practice
• Teluride Medical Center
• Western Colorado Pediatric Associates
• Pediatric Partners Glenwood
• Pediatric Associates Prof
• Roaring Fork School Based Health Clinic
• Grand Valley Pediatrics

Kannah
• St. Mary’s Family Medicine Center
• Foresight Family Physicians
• Primary Care Partners
• Yampa Valley Medical Associates
• Juniper Family Medicine
• Community Health Clinic
• Mountain Family Health Center
• Northwest Colorado Health
• Rangely Family Medicine
• MidValley Family Medicine

Community Health Clinic
Dove Creek
Sandy Moore, IT
• 4 Providers
• 16 Staff
• EMR: Practice Partner
• 1500 Active Patients

Patient Empanelment

Empanelment is the act of assigning individual patients to individual primary care providers (PCP) and care teams with sensitivity to patient and family preference.

Empanelment is the basis for population health management and the key to continuity of care.

All for one & One for all

Challenges

• We did this LAST
• Is it worth the effort?
• Will it upset our patients?
• Who has time for this?
• (51 days to 3rd next appointment)
Successes

- Improved 3rd next appointment
- Easy to know what provider to notify
- “Not my patient”
- Patient Education: Get better care sticking with one PCP

Key Learning Points

- Start small
- Make a change that won’t cause problems
- Let others see “how cool” the change is

Next Steps

- What % of visits are with the PCP?
- What will it take to get to 80%?

Foresight Family Physicians Grand Junction

- 5 of Providers – 2 D.O and 3 mid levels
- 20 of Staff
- EMR: E Clinical Works
- 4345 Active Patients

Area of Focus Overview

- Integrating a Health Coach into an Integrated Behavioral Health Practice

Challenges

- Space availability
- Multiple schedules (example: Multiple providers, lab, behavioral health schedules)
- Communication between the entire care team on who the patient might to see during the visit

Successes

- Freeing up time for the providers to focus on the medical aspect of the visit.
- Another avenue to help build relationships across our medical neighborhood.
- Implemented a smoking cessation class
Key Learning Points
• Need for a bigger building (where do we go)
• Need for flexibility in schedule and maximizing the limited time allowed with each patient
• Defining roles across the care team (especially on complex patients)

Next Steps
• Continue to experiment with space
• More Group Visits (weight, smoking, NADA)
• Developing specific health coach workflows

Juniper Family Medicine
• 5 of Providers
• 7 of Staff
• EMR: Athena
• 3560 Active Patients

Area of Focus Overview
• Hiring an LCSW

Challenges
• Wait...what does an LCSW do?
  ▫ Licensed Coloradan Super Whacker?
• Who should she see???
  ▫ For how long
  ▫ She's in my room!
• How is this documented???
  ▫ Progress Notes in EMR

Successes
• Behavioral Health Care and Follow-up for suicidal 10 year old.
• Counseling services for patient experiencing complicated grief.
• Linking disabled patient to handicap accessible housing to avoid homelessness.
• Advocating with school system for patient being bullied at school.
• Working with HIT to develop care plans

Key Learning Points
• Behavioral Health needs to be available in the moment! We decided to avoid filling Behavioral Health clinician’s schedule with counseling sessions so Behavioral Health clinician could be available for warm handoffs and brief interventions.
• Documentation different in medical record vs traditional mental health note.
• Learning how to define and introduce LCSW

Next Steps
• Continue to work on developing care plans in EMR
Mountain Family Health Centers
Gary Schreiner PhD Behavioral Health Manager, Alex Vincent QI Manager

- 24 providers
- 161 Staff
- EMR: NextGen
- 15,000+ active patient

Areas of Focus
- Patient specific huddles with teams
- Registries
- Warm Hand-Offs
- New patient education of available services

Challenges
- Acceptance by medical staff on the usefulness of behavioral health
- Measuring the efficacy of BH Services
- Maintaining a consistent workflow.
- Reporting from multiple areas of documentation
- Accessibility

Successes
- BHPs are accessing patients more than the past, approximately 400 pts a month
- Medical is utilizing BH services, increased trust
- Pts are feeling more comfortable seeking out BH services
- BH is being consulted on a wide range of issues
- BH is providing education to staff and patients
- Registry utilization for follow-up or to reach out to patients that were not seen while the were in the visit
- More reporting capability

Key Learning Points
- Behavioral health providers are utilized more frequently when intentionally present in medical areas instead of still in an office
- Behavioral health providers must be assertive with staff and patients
- Working in conjunction with Care Coordination and Quality Improvement is essential to ensure timely action of changes and follow through
- Education around behavioral health issues and screening is more likely to be accepted by medical staff if presented by a behavioral health provider

Next Steps
- More medical staff education
- Determine an appropriate schedule for population health outreach registries
- Begin looking at improvement of patient engagement and PHQ scores

Northwest Colorado Health
Diana Hornung, Medical Director
Lilia Luna, BH Coordinator
Stephanie Einfeld, Director of Performance Improvement

- 8 Medical Providers, 4 BHCs
- 175 Staff Members, 50 CHC
- EMR: eCW
- 5473 Active Patients
**Empanelment**

- **Core Teams**

- **Backup Teams for Steamboat**

**Empanelment: Current State**

- Using the 4 cut method, our practices are currently 95% empaneled.
- Success indicators have been developed and we have a plan for communicating these to the team.
- Team continuity is at 81% and 77% for our 2 sites!

**Empanelment: Partnering with Patients**

- Our challenge has been how best to communicate this partnership with our patients.
- How do we include the patients from the beginning of the partnership?

**Action Plan: PDSA**

- Training on Mr. Potato Head


**Implemented a PDSA**

- PDSA focuses on partnering new patients with a provider team. Panel manager and Patient Care Reps will own this PDSA.
- One month cycle with the panel manager tracking and giving report outs.
- New scripting was developed to aid in this effort.

**Key Learning Points**

- This takes time
- An engaged physician champion and practice manager are key
- We still have a lot to learn
- Focus on the benefits to the patient

**Next Steps**

Study the results of our Plan and Do phases, and then Act!
Area of Focus Overview

Designing workflow for:

- Chronic Pain
- Behavioral Health Screening and Integration

How to incorporate technology into the screening process.

Challenges

- We are using a tool called Phreesia for point of check-in data gathering.
- Agreeing to workflow across all Primary Care Partners divisions.
- Working with Phreesia development team to make sure the electronic options we wanted to implement were technically possible.
- Implementing and training a new workflow for providers and staff.

Successes

- Joint Task Force.
- Consensus on workflow.
- Technology supported proposed workflow.
- Gave us an opportunity to review clinical guidelines and update protocols.
Key Learning Points

- Consolidate efforts – work as united Team, including appropriate providers, staff and IT.
- Understanding the capabilities of Phreesia.
- Verify clinical guidelines.

Next Steps

- Finalize technical “build” for Phreesia.
- Schedule second phase of training for providers and staff.
- Begin development of behavioral health services for patients identified through screening.

Tammy Dunker, Manager

- 2 MD, 1 Do, 1NP
- 1 RN, 3 MA’s, 3Front desk, 1 COS
- EMR: Meditech 5.67
- 1850

Group Weight Loss

- This program was free to anyone in the community
- Weigh-ins were every other week with ticket given and drawing at each monthly meeting
- Emails were sent to participants with reminders, encouragement, and recipe ideas
- 1st meeting we had a walk with the Doc at high school track. 2nd meeting our physical therapy department presented on exercise, 3rd meeting was with a certified nutritionist.

Successes

- We had 92 people sign up, 33 people made it to the end and a total of 227 lbs lost in 3 months.

Co-Location Mind Springs

- We asked Mind Springs to come once a month to see clients here in the clinic
- We hoped that this would create more anonymity with our town being so small
- To give a better location for patients with disabilities or transportation issues easier access
Successes
- Having Mind Springs in clinic has opened the communication between our providers and Michelle.
- Patients with difficulty getting to Mind Springs office have been able to be seen here in the clinic even on days that weren’t Mind Spring’s day.

Challenges
- Keeping people engaged
- Having one set person as a care coordinator
- Getting access to specialists for our Medicaid patients

Key Learning Points
- People in our community are slow to change
- Takes us longer to implement change with our limited resources

Next Steps
- We are regrouping right now with our Care Coordinator piece.
- More awareness of the services that we are able to provide.
- Working on our population management
- Looking into Telehealth for our Specialist/Medicaid problem

Thank You
- I would like to publicly acknowledge Dr. Morse of Surgical Associates and Dr. Vance of Western Orthopedics
- They are the only specialists that come to Rangely to see our patients.

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1. Pursue Every Opportunity

2. Incremental Change

3. Go With Your Strengths

Yampa Valley Medical Associates
Michele Lewis RN BSN, Nurse Manager

- 10 Providers
- 21 staff members
- EMR: Allscripts Pro EHR
- 11,000 Active Patients

Area of Focus Overview
- REFERRALS TO BEHAVIORAL HEALTH

Challenges
- EMR automatically dropped behavioral health referral in to note when a PHQ2 was ordered—even if provider did not intend for referral to be placed.
- With the placement of so many orders it became difficult to sort through the referrals and determine which ones were real.
- BHC requested all referrals to be printed to help with confusion which added another step and complicated the process.
Successes

• Reworked how referrals are entered into EHR.
• Now Dr/Nurse has to manually enter referral so all electronic referrals are legit.
• BHC (Leah) can now work off of electronic referral list- we quit printing the referrals!
• Referrals are addressed within 2 business days and EHR is kept up to date.

Key Learning Points

• Make EHR work for you not against you!
• Keeping referrals in electronic form is easiest for tracking and helps to prevent patients from falling through the cracks
• EHR helps BHC address referrals in a timely manner

Next Steps

• Expand to other referrals processes for in-office referrals – such as diabetes care management

MidValley Family Practice

• 1 of Providers
• 6 of Staff
• EMR: GE Centricity
• 1300 of Active Patients

Grand Valley Primary Care
Grand Junction
Melynda Brown, Office Lead

• 16 Providers
• 32 Staff
• EMR: Allscripts
• 27,018 Active Patients

Shared Decision Making

Challenges

• Identifying Patients
• Documenting in EHR
Successes
- Created a custom brochure to send to patients
- Providers are all on board
- Workflow works for identifying and communicating with patients

Key Learning Points
- It is important to be flexible
- Change can be difficult

Next Steps
- Roll out procedure to all providers
- Review and adjust procedure as necessary

Mercy Family Medicine
Tamra Lavengood
CPC Coordinator/Clinical Performance Coordinator
- 20 providers
- 70 Staff
- EMR: Meditech/LSS (Transitioning to EPIC 11/16)
- 17,000 Active Patients

Area of Focus
- Developing Behavioral Health Provider Position
  - Credentialing Process
  - Billing Process
  - Charting Process
  - Job description: Supervisor for Behavioral Health

Challenges
- No job description for LCSW in outpatient clinic setting
- Credentialing had to be done through corporate
- Not able to charge for services
- Not a confidential area in LSS to chart
- Had to develop job description for BH Supervisor

Successes
- Obtained $40,000 small grant
- Leadership support due to CPC
- Currently have .5 FTE for BH provider
- Posting now for fulltime (1.0 FTE) behavioral health provider
Key Learning Points

- We have learned that Behavioral Health care management goes hand in hand with physical care management (CPC data)

Next Steps

- Excited to see new role with a BH supervisor
- CPC+ integrated direction with vendor participation
- Physician Assistant working on PhD for Behavioral Health aligning her dissertation with clinic focus

Pediatric Associates Prof., LLC

- 10 Providers (NP, PA, DO, MD)
- 2 Integrated Behavioral Health Therapist, Through the Center for Mental Health
- 25 Staff members
- EMR: athenahealth
- 8120 Active Patients

Milestones of Focus Overview

- Data Driven Improvement Using Computer-Based Technology
  - Practice completes and submits baseline assessment to determine data capacity
- Empanelment
  - Achieve and maintain empanelment to providers and care teams.
- Population Management
  - Increase effective follow up for patients receiving Mental Health services in our integrated setting.
  - Implement Maternal depression screen with local OB, to achieve best practice guidelines.

Challenges

- Only one year in athenahealth. Working on getting data moved from one system to the other.
- Learning what reports to use to get accurate data.
- athena is able to risk stratify, but uses a Medicare based format. This does not work well for our Medicaid population.
- Increasing buy-in for why risk stratifying is important to staff and clinicians.

Successes

- Coordination with our local OB for Maternal Depression screenings.
- Interface build between athenahealth and Patient Tools to capture discreet data fields within Athena.
- More effective care management for high risk populations.
- Improved follow up process for patients receiving behavioral health services.

Key Learning Points

- Increase knowledge of athenahealth and it's reporting tools.
- Look into processes that will impact outcomes. Tighten up processes.
Pediatric Partners
Brian McGill, Clinic Director

- 5 Providers
- 16 Staff
- EMR: Office Practicum
- 5,000 Active Patients

Improve Patient Care

- Practice Transformation
  - Achieve NCQA PCMH designation
  - Re-defined Under Care of Team
  - Achieve 70% empanelment
- Behavioral Health
  - Implement HIPAA compliant telehealth technology.
  - Confidence in referring to therapists for further care.
  - Integrate Behavioral Health into the practice
- HIT
  - Develop process for reporting and reviewing SIM CQM data quarterly @ practice level.

Challenges

- Available Resources in Area
  - Who are they?
  - Demystify credentials
  - What services can they provide?
    - What services do our providers want?
- Billing/Reimbursement
  - Most resources don’t accept Medicaid
  - Families can’t afford to pay out of pocket
  - How is added service compensated and sustainable?

Successes

- Care Teams re-defined and in Place
- Successful eVisits Completed and Reimbursed
- Receipt of grant funding to enhance Telehealth efforts.
- Bi-Monthly SIM Team Meetings
- RMHP Support

Key Learning Points

- Integrated Behavioral Health Remains Elusive
  - Available resources not well known or organized
  - The need does not relate to the reimbursement
  - Traditional models may not be our answer

Next Steps

- Continue to work seek answers and find a way to integrate behavioral health.
Mission: Care independent of payer source
Provide all newborn and Pediatric Hospitalists services
13,000+ Active patients 0-21 years
45% Medicaid, 5% CHP+

7 Pediatricians
3 Advanced Practice Providers
40 Staff including in-house billing, front office, LPN/MA nurse support, RN Admin
2 FTE Behavioral Health Consultants (BHC’s)
1/5 FTE Registered Dietitian Consultant (RDC)
EHR (Pediatric): Office Practicum

2 years of Integrated Behavioral Health
Evolving Team-Based Care with BHC’s, RDC’s, and Nurse Champions
Open Access 6 days/week
Focus on rising to the top of our licenses
Focus on healthy boundaries within practice
Population Management in Diabetes Medical Home, Asthma Medical Home, & Medically High Needs Medical Home with Nurse and MD/PNP Champions

Meet & Greet all new families, support parenting
Developmental support and “closing the loop”
Typical developmental support
Academic school support
Chart with BHC created templates and track data with BHC “fake” CPT’s
How will we practice before this ?????
Identified missing system components in allowing us to deliver team-based care in a frugal streamlined practice where protecting time for huddles can be a challenge and there is tremendous e-communication.

Identified that there were a small number of families and patients that were stressing the office systems without changing patient outcome.

Out of this arose the Complex Care Staffing (CCS) & Collaborative Care Plan (CCP).

Any staff person can refer to Nurse Admin to create staffing

CCS typically includes one Provider/Admin Nurse, Front Office, & BHC. Care issues are determined with plan for supports, coordination needed, and next steps put in place.

Many referred patients/families have needs identified and care coordinated at this level.

If additional partnership is needed, a CCP is set up with a provider, the CEO, our Admin Nurse and BHC if indicated, to meet with family and create a written plan.

I think health care is more about love than about most other things. If there isn’t at the core of this, two human beings who have agreed to be in relationship where one is trying to help relieve the suffering of another, which is love, you can’t get to the right answer here.

-Donald Berwick MD Pediatrician, former administrator for CMS

Contact Information:

M. Cecile Fraley MD
Pediatric Partners of the Southwest
Email: cfraley@ppswdurango.com#970-375-0100
Roaring Fork School Health Centers
Keeping our students healthy and ready to learn.
SIM Learning Collaborative
Fall 2016

- # of Providers = 1 FNP, 1 PA, 1 LCSW, 1 RDH
- # of Staff = 4
- EMR = From Centricity to Athena
- # of Active Patients = 744 as of 6/30/16

Kids struggle to “do school” if they...
- are sick
- feel depressed or anxious
- have attention issues
- are sleep deprived
- abuse drugs or alcohol
- are being bullied or rejected by peers
- have an empty stomach
- feel unsafe at home or at school

There is a research-based link between students’ physical, social, and emotional health and their ability to learn.

2015 HEALTHY KIDS COLORADO SURVEY RESULTS
ROARING FORK SCHOOL DISTRICT
RE-1
- Purposefully hurt themselves without the intent to die in past year=12.3%
- Mental health perceived as not good for past 30 days=49%
- Feel sad or hopeless almost every day of past two weeks=17%
- Seriously considered suicide=12%
- Attempted suicide=8%
- Ever smoked a cigarette=23.3%
- Ever used an electronic vapor product (e-cig)=44.2%
- Ever drank alcohol=45.4%
- Ever used marijuana=10.2%

Roaring Fork School Centers Programs
- Primary acute and chronic disease management
- Preventive health exams
- Adolescent reproductive health services
- Nutritional health – individual and group
- Patient Care Coordination services
- Mental health coordination, screening and counseling services on-site.
- Oral health services - cleaning, fluoride application and sealants
- Health education- Individual and Classroom-based
- Medicaid/CHIP+ Outreach Services- Certified Application Assistance Services to increase Medicaid/CHIP+ enrollment and function as a Presumptive Eligibility site
- Medical and social referrals to specialists and community organizations
Performance Measures of different projects

<table>
<thead>
<tr>
<th>CDPHE</th>
<th>SIM</th>
<th>NQICollN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
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<tr>
<td>WUE/Developmental Screen</td>
<td>Undevelopmental Screen</td>
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<td>Depression</td>
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<td>STI Screening</td>
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<td>Risk Assessment</td>
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<tr>
<td>Additional Risks</td>
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</tbody>
</table>

Roaring Fork School Health Centers
Healthy kids learn better

Kris Hubbell, Quality Coordinator

- 8 Providers
- 27 Total Staff Members
- EMR: Athena
- 9,374 Active Patients

Population Management...
“It’s like herding cats...”

- Increase percentage of behavioral health screenings and related CQMs
- Reducing care gaps by utilizing EMR generated reminders.

Challenges

- Sending initial auto-generated campaign messages were not well received by patients. Needed to re-evaluate how messages were sent.
- Standardizing workflows for distribution of psychosocial screening tools. Identified inconsistency in utilization and documentation amongst care teams.

Successes

**Depression Screening**

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016 (year-to-date)</th>
<th>2016 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18</td>
<td>26</td>
<td>30</td>
</tr>
</tbody>
</table>

**Campaign calls**

- Reminder for Adult HCM visit call generated over 100 appointments requests
- CQM – Adult Annual Preventative Visit
  - Currently - 81%
Key Learning Points

- 5 providers
- 65 employees
- eClinicalWorks
- 4,750 active patients

Data Driven Improvement

- SIM Clinical Quality Measures
  - NQF 2597 (SUD Screening)
  - NQF 1401 (Maternal Depression)
- Comprehensive Behavioral Health Registry
  - PHQ-9, GAD-7, AUDIT, DAST-10

Challenges

- NQF 2597 (SUD Screening)
  - No protocol or workflow in place for screening
  - Costly to embed AUDIT/DAST and time consuming to implement additional screenings/follow-up
- NQF 1401 (Maternal Depression Screening)
  - No protocol or workflow in place for screening
  - Costly to embed EPDS
- Comprehensive BH Registry
  - No protocol or workflow in place for review
  - Costly to create
  - Time consuming to review on weekly/monthly basis

Successes

- NQF 2597 and 1401
  - SIM Small Grant to embed AUDIT, DAST and EPDS into eCW SmartForms
  - Positive screenings are flagged in patients chart for BHC referral and registry capture
- Comprehensive BH Registry
  - Contracted eCW Solutions Consultant to create comprehensive BHC registry using eBO Report

Key Learning Points/Take Aways

- Having a malleable EHR is essential
- SIM and CPCi are not synonymous, but the extra work is important and well worth it
- Screenings and follow-up are time consuming and can quickly overwhelm resources. Having protocols, workflows, and registry were very important for us
- Hiring a second BHC was crucial
Western Colorado Pediatric Associates

- 22 Providers
- ~70 Staff
- EMR: Allscripts Touchworks
- ~17,000 Active Patients

Raul De Villegas-Decker, Psy.D.
Director of Integrated Behavioral Health Services

**Challenges**
- Large practice
- Changes have multiple ripples that affect all staff and workflows – internal coordination is important
- Clinical needs vs. Administrative needs
- Limited resources
- Sustainability

**Successes**
- Leadership support
- Small steps with big picture/goal in mind
- Patient progress motivates change – Patient success stories
- Flexible staff mindset: Focus is on patient care not ease of workflow
- Staff/Job satisfaction has improved
- Effective use of community resources
- An increasing understanding of behavioral health and its impact on physical health
- Parents/family's view of the practice is more positive

**Key Learning Points**
- A service is dependent on a few and can be hard to sustain. A program is dependent on many and demands a sustainability plan.
- Hiring/grouping the right staff is critical to developing a successful program
- The focus should be on the clinical outcomes of the whole person, not just developing a new referral source.

**Next Steps**
- Increase our parent/family participation in services offered
- Incorporate Behavioral Health concepts into various Task Forces in the practice

**Round Table: Role Discussions**

**Care Manager/Care Coordinators**
- Kris Hurst, MA, BS, CCM

**Front Office**
- Katie Insoles, MS, CPMQ, CTPS

**Back Office**
- Cathy Green, RN BSN

**Medical Providers**
- Andy Keith, MBA

**Behavioral Health Providers**
- Alex Schmidt, PhD, LMFT-A

**Office Managers**
- Britte Fugleved, MBA
Sharing Behavioral Health Data in Primary Care: Myths and Realities

David Hayden, LPC, CACIII, MBA
Vice President of Quality and Compliance
Mind Springs Health

Three Laws govern disclosure of Protected Health Information (PHI) in behavioral health:

- HIPAA – 45 CFR 164.08
- Colorado Regulation: 502-1.21.170.3
- PART 2 – 42 Code of Federal Regulations (CFR) 2.31

Colorado Law

Mirrors HIPAA and 42 CFR Part 2

Limits term of patient consent to two years.

42 CFR Part 2 Rules Governing Disclosure Substance Use Disorder (SUD) Information

Restricts the disclosure of PHI for SUD diagnosis, treatment and referral

Each disclosure must contain a notice prohibiting re-disclosure.

Attendees will gain an understanding of:

- How HIPAA and other statutes limit behavioral health disclosures to primary care
- Strategies and considerations for coordinating care with external behavioral health providers
- Strategies and considerations when coordinating care with embedded behavioral health providers

Caution: I am not an attorney and this material is not legal advice.
**Why is 42 CFR so restrictive?**

- Unauthorized Disclosure
  - Loss of housing, child custody, insurance, medical care, employment
  - Fear of three consequences becomes a barrier to seeking treatment

**CFR 42 Part 2 allows disclosure of SUD information without patient consent for:**

- **Medical Emergencies:**
  - May disclose to medical personnel for serious threat to the health of any individual, which requires immediate medical intervention.

- **Research Activities:**
  - Need an ethics committee review, no re-disclosure of PHI, informed consent.

- **Audit and Evaluation:**
  - Government or payer auditors who agree in writing not to re-disclose.

**Am I subject to 42 CFR Part 2?**

- Do I “hold myself out” as a “Program” that provides SUD treatment, diagnosis, or referral?
  
  - Is my “Program” federally assisted?
  
  - If you address SUDs, safest path is to assume that you are a “Program” absent legal guidance otherwise.

**Unaddressed Addictions**

- Ineffective Care

**Required Elements of a patient authorization to disclose PHI**

- An SUD Program authorization must reference 42 CFR Part 2

**What do I need in order to disclose PHI to contractors?**

- Separate entities are allowed to share PHI with contractors if a legal agreement to protect confidentiality is in place.

- HIPAA requires a Business Associates Agreement (BAA)

- 42 CFR requires a Qualified Service Organization Agreement (QSOA)
SAMHSA’s Three Levels of Healthcare Integration

**Coordinated Care**
- Separate sites, agencies, and EMRs

**Co-located Care**
- Separate agencies & EMRs
- Separate agencies, same EMR

**Integrated Care**
- Same site, same agency, same EMR

---

**Coordinated Care**
Separate Agency – Separate Site – Separate EMR

- Primary Care Team and Behavioral Health Therapist (BHT) or behavioral health team communicate across separate sites.
- This model is well suited to persons diagnosed with severe mental illness & multiple other conditions.
- Patient authorization is needed for disclosure of any PHI that is subject to 42 CFR Part 2.
- Most effective means of disclosure is through the Health Information Exchange (HIE).

---

**Co-located Care**
Same Site – Separate EMRs

- BHT is employed by a separate agency, but located at the same site as primary care.
- This may be a BHT embedded in a primary care team – or primary care team and behavioral health teams in separate offices in the same building.
- Patient authorization is needed for any disclosure of 42 CFR Part 2 SUD information.

---

**Co-located Care**
Same Electronic Medical Record

- BHT is employed by a separate entity, but participates fully as part of the primary care treatment team.
- A BAA and possibly a QSOA is needed for communication between BHT and primary care team.
- Patient authorization is needed for SUD disclosures between BHT and the parent behavioral health treatment agency.

---

**Integrated Care**
Same Agency – Same Site – Same EMR

- BHT is fully integrated into the primary care team.
- No patient authorizations or BAAs/QSOAs needed for communication between the BHT and other primary care team members.
- Patient authorization is needed for disclosure of 42 CFR Part 2 information to external agencies.

---

**Cultural Considerations for coordination between BHTs and the Primary Care Team**

- Progress notes versus psychotherapy process notes.
- BHTs should document more on progress and less on process.
- Treatment and social history on diagnostic and psychiatric evaluations.
- These are more likely to contain sensitive behavioral health information.
- Benefits of influence by embedded BHTs.
- Acceptance of behavioral health conditions as biologically-based.
Great News!
Upcoming Changes to 42 CFR Part 2 will:

- Allow for general disclosure to the HIE, the patient’s team of treating providers, and/or provider and payer entities.
- Require more specifics about what facility is releasing information, and the type of information to be released.
- Give patients the right to an accounting of disclosures.
- Allow providers greater flexibility in determining when a "bona fide medical emergency" exists.

Behavioral Health Information Exchange Through an HIE

Jacque Jones, QHN Clinical Director

Colorado’s Two HIEs

QHN’s Regional Connectivity

- >93% of the Medical Providers
- >80% of the Healthcare Organizations

QHN – Stakeholders

- **Focus: Mind Springs Health (MSH)**
  - Largest mental health provider in service area
  - 13 outpatient locations
  - One inpatient facility (32 beds)
  - Served 21,420 in 2015: 1,147 inpatient; 20,273 outpatient
- Other key stakeholders: primary care providers

Methods of Exchange

Provider receives report via the HIE

**Process:**
- MSH updates patient consent in QHN to share data
- MSH sends report to HIE
- Report is pushed to authorized providers (EHRs!)
- Includes re-disclosure notice
Methods of Exchange

Providers designated on patient consent have access to MSH results in the QHN Patient Summary view.

Process:
- MSH updates patient consent to share data
- MSH sends report to HIE
- Report is sequestered in HIE longitudinal health record
- Only accessible by those with consent

Methods of Exchange

Mind Springs providers query the QHN HIE to view patients’ clinical information from other healthcare providers.

Process:
- Providers from MSH request QHN Patient Summary access
- Encounters, diagnostics, reports, etc.
- Soon to have subscription and alerts!

Consent Management in QHN

From Behavioral Health Practice

Consent type
Data to be exchanged and to whom
For how long

Consent Management in QHN

What do Providers See?

Sample Clinical Care Report (CCR) from Mind Springs Health
• Health Information Exchanges are an excellent way to facilitate clinical information sharing to improve care and care coordination.

• It takes time and trust relationship building - It’s easy to say the obstacles are too great, the focus must be on what’s right for the patient to improve the standard of care – *Data only moves at the speed of trust!*
Data and community-sized problems

• HIE in Colorado is working toward solving data sharing and interoperability challenges.

• Health data isn’t just a clinical list of medications and problems—it’s a sketch of a person’s life.

• Does not replace provider relationships—HIE enhances them!

Benefits of HIE

Data collection and aggregation
• Relationships
• Results and encounters
• Data quality and reuse

Care Coordination
• Longitudinal record
• Alerts and notifications
• Secure messaging

CORHIO and QHN: Colorado’s two HIEs

CAII - Colorado Advanced Interoperability Initiative

CAII Grant Overview

• Application April 2015
• Expand the availability of data
  • Ambulatory
  • Long Term Care/Home Health
  • Behavioral Health
• Obtain data using various methods
  • Encounter Based CCD
  • MDS/OASIS → CCD
  • Others not off the table
• Explore Behavioral Health consent models
  • Patient vs. provider
• Awarded July 2015 – two year program

Goals of Behavioral Health Projects

Improve the community standard of care
• Securely exchange behavioral health information
• Integrate into the patient longitudinal health record
• Support care coordination with electronic access to information
• Reduce patient risks with more information accessible
• Providers get the “full picture” of patient’s care
• Increase adherence to treatment of physical disorders
2011 Regulatory Changes for Behavioral Health Information Sharing in Colorado

- This revision allowed behavioral health professionals to follow the information sharing best practices utilized by their colleagues in the medical profession, namely:
  
  Share mental health data under the guidance of HIPAA, using the same protections as the guidance for exchange of physical health.

- Colorado’s Office of Behavioral Health consolidated eight volumes of rules to one volume and added language to reinforce that HIPAA and 42 CFR Part 2 are to be followed.

CORHIO

- Patient-directed consent: patient updates technology
- Specific providers, specific dates

QHN

- Patient-directed consent: provider updates technology
- Specific providers, specific dates

After the 2011 State Statute Change

**HIPAA and Opt-Out through HIE**
Exchange of Mental Health information (w/o consent) for treatment, payment and operations by authorized users with a need to know.

**Patient Consent to Release Information**
All other Behavioral Health information requires Patient Consent in order to exchange.

Mental Health Center of Denver

Enriching Lives and Minds by Focusing on Strengths and Well-Being

Private, not-for-profit 501(c)(3) community mental health center providing mental health, substance abuse, housing, educational and employment services.

- Mission: Enriching Lives and Minds by Focusing on Strengths and Well-Being
- 10k people actively receiving services at any given time; 640 FTE employees
- More than 35 community sites;
Behavioral Health Exchange Pilot

Partners:
• Mental Health Center of Denver
• Signal Behavioral Health Network
• FEI Systems (Consent2Share)
• CORHIO

Goals:
• Embed in clinics that serve total of 300 patients (adult and children)
• “Touch” 100+ clients
• 30+ clients enact consent
• Engage with 3+ external provider organizations

Method:
• Replicating a model for dissemination of the Consumer Recovery Measure (through Personal Health Record)
• Engage Peer Support Specialists to work with clients
• Signal BHN will create video/printed materials

Success:
• External providers report that access to MHCD information resulted in more impactful care
• Patients report better interactions with external providers (in terms of integration of BH and PH care)
• Education and sign-up workflow are streamlined such that they can be launched to other CMHCs
QHN Stakeholders- behavioral health data sharing

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Consent Management in QHN

What do Providers See?

Sample Clinical Care Report (CCR) from Mind Springs Health

Discussion and Questions?

Please contact us at:
Marc Lassaux
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303-746-3161

Once Consent is saved, summary of consent is displayed

Protected data is displayed in the Patient Summary Documentation clinical section

Consent type
Data to be exchanged and to whom
For how long

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BACKGROUND

• In April 2015, the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) became law.
• It seeks to move Medicare closer to its goal of tying 80 percent of traditional Medicare payments to quality by 2016, and 90 percent by 2018.
• Repealed Sustainable Growth Rate (SGR) - How you were paid each year
• MACRA created the Merit-Based Incentive Payment System (MIPS), which merges several quality programs, including MU & PQRS, for eligible providers.
• If Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year.

MERIT-BASED INCENTIVE PAYMENT SYSTEM - YEAR 1

Here's how it breaks down:
• A single MIPS composite performance score will factor in performance in four weighted performance categories on a scale of 0-100.
• QUALITY replaces PQRS. Accounts for 50% of total score.
• RESOURCE USE/DST replaces VBM. Accounts for 10% of total score.
• CLINICAL PRACTICE IMPROVEMENT ACTIVITIES accounts for 15% of total score.
• ADVANCING CARE INFORMATION replaces Medicare MU 25% of score.

OBJECTIVES

CMS QUALITY PAYMENT PROGRAM – Value-Based Contracts
➢ High-level understanding of MACRA MIPS AFM
➢ Identify the four domains of MIPS and first-year scoring
  • Quality (PQRS)
  • Resource use (VBM/GDR)
  • Clinical practice improvement activities (PCMH)
  • Advancing care information (MAC)>
➢ Discuss and identify ways to implement each domain in your practice
➢ Identify the four domains, strength and weakness, within your practice.

Who Will Participate in MIPS?

Years 1 and 2
Physicians (MD/DO and DMD/DDS), NPs, PA’s, Clinical nurse specialists, Certified registered nurse anesthetists.

Years 3+
Secretory may broaden eligible Clinician groups to include such as:
Physical or occupational therapists, Speech-language pathologists, Respiratory therapists, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals.

DOMAIN ONE QUALITY MEASURES 50% - YEAR 1

• Not just for Medicare: multi-payer applicability.
• MACRA identifies five quality domains (i.e., clinical care; safety; care coordination; patient and caregiver experience; population health and prevention).
• ECs select six measures, as opposed to the currently required nine measures under PQRS, to satisfy the Quality category.
• CMS proposed expanded measure options to allow ECs to select the six measures that are most applicable to their specialty.
WHAT CAN YOU DO NOW?

• Practice managers can go through the list of proposed quality measures on the CMS website and identify which measures your practice can meet. Measures for all specialties.

• Going forward, physician practices should strive to remain informed about this evolving field by checking the CMS website.

• Pediatrics Measures Children’s Health Insurance Program Reauthorization Act (CHIPRA)

1. CHIPRA Pediatric Quality Measures Program
2. CHIPRA Core Set of Children’s Health Care Quality Measures
3. Pediatric Quality Measure Program
4. Healthcare Effectiveness Data and Information Set (HEDIS) Measures
5. Meaningful Use Stage 2 Pediatric Recommended Core Measures (UCOM)
6. National Quality Forum
7. Physician Consortium for Performance Improvement (AMA-PCPI)

DOMAIN TWO RESOURCE USE - COST 10% - YEAR 1

• CMS will compare your practice’s resource use, or cost of care, for specific episodes, to other practices in your region.

• There is no need to report this measure; CMS will calculate it automatically using claims data.

• CMS proposes to calculate several episode-based measures for inclusion in the resource use performance category.

WHAT CAN YOU DO NOW?

• Review practice clinical guidelines used by your clinicians for consistency around evidence-based disease management

• Engage/activate patients and families for self-management

• Review your total cost of care

• QRUR reports

• Review ED visits and readmission data

• Automate the practice functions and streamline workflow

• Know your payer contracts for expected measure compliance—practice facilitators can assist the practice
DOMAIN THREE CLINICAL PRACTICE IMPROVEMENT ACTIVITIES 15% - YEAR 1

- Clinical practice improvement activities are meant to improve the physician practice for patients.
- Each practice can select activities from a list of more than 90 options that includes flexible office hours and patient scheduling, care coordination, population health management and patient safety.
- Providers can submit this data in a variety of ways.

| Population Management | Participation in ACO models such as Million Hearts Campaign | Medium |

WHAT CAN YOU DO NOW?

- Become a PCMH Medical Home 2017 standards improved
- Review the list of Clinical Practice Improvement Activities on the CMS website and understand what activities in your practice can qualify.

| Care Coordination | Implementation of practices/processes that document care coordination activities or a documented care coordination process that includes patient engagement
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| Care Coordination | Implementation of practices/processes to develop regularly updated individual care plans for all adult patients that are shared with the beneficiary or caregiver.
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| Care Coordination | Implementation of practices/processes to support transition that include documentation of how a MIBM eligible clinicians or group can track a patient’s condition.
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WHAT CAN YOU DO NOW?

- Map your practice’s progress towards achieving Meaningful Use Stage 3 requirements and make sure you are using a certified EHR. (Base Score)
- Providers/clinicians may have the opportunity for bonus points for submitting quality measure data using certified EHR technology.
- Develop and encourage your patient portal.
- ECs could potentially be measured on how the use of health IT contributes to the overall health of their patients, i.e. tie patient health outcomes with the use of health IT.

TABLE 2: Base Score Modified Primary and Alternate Proposals Advancing Care Information Objective and Measure Reporting for Modified Stage 2 (On or After 2017)

Discussion

IDENTIFY THE FOUR DOMAINS, STRENGTH AND WEAKNESS, WITHIN YOUR PRACTICE
Discussion

IDENTIFY WAYS TO IMPLEMENT EACH DOMAIN IN YOUR PRACTICE

REFERENCES


Panel Discussion:
Measuring Behavioral Health in Primary Care

Christie Williams, LCSW
Sandy Moore
Community Health Clinic/Dove Creek
Alex Vincent, PCMH CCE
Mountain Family Health Centers
Glenn Kotz, MD
McValley Family Practice
Alex Schmidt, PhD, LMFT-A
Rocky Mountain Health Plans

Round Table: Special Topics

Gunnison
1. Grant Writing
2. Care Management
3. Community Resources in Rural Areas
4. Effective Communication with Payers
5. CPC and Preparing for CPC+
6. Q&A with MGMA

Kannah
7. Q&A with a CHTA
8. Reducing Stigma in Integrated Behavioral Health
9. Q&A with DPN
10. Q&A with Mind Springs
11. Q&A with CORHSO
12. Pediatric Integrated Behavioral Health