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Frequently Asked Questions (FAQ)

These questions were submitted by attendees of the May 13, 2015 Webinar "*Exploring Low-Income Californians' Needs and Preferences for Behavioral Health Care*." Answers have been provided by experts in the field.

➢ Lessons from Santa Cruz Community Health Centers

Q. What are the various levels/types of behavioral health staff that Santa Cruz Community Health Centers (SCCHCs) hired? How many staff members does SCCHCs have focused on behavioral health on a daily basis? How is SCCHCs funding behavioral health staff?

A. SCCHCs has hired 4 full-time LCSWs. On average, these clinicians see 9 patients per day. However, its practice is to schedule 12 patients a day to account for a no show rate. This schedule is based on the integrated behavioral health model SCCHCs has developed which includes 30 minute therapy encounters, warm hand-offs and a practice called "Step-Ins" (other clinics often call these "same-days"). SCCHCs integrated behavioral health model has generated enough revenue to cover the salaries of its LCSWs; in addition, it has been able to dedicate a portion of its revenue toward the hiring of a BH medical assistant and a health educator.

The BH medical assistant possesses qualities and skills related to empathy, compassion and dedication to equity. She works 40 hours a week and supports 6 (4 FTE) BH Providers. She scrubs schedules, provides clinical documents and lab results to clinicians prior to appointments, makes calls to fill late cancels, follows up with patients clinicians are concerned about, steps in to exam rooms for warm hand-offs, assists in many of our group medical visits, and drives several community outreach projects.

The health educator offers direct service in the form of 20 minute appointments, classes and groups, (including warm hand offs to those services). In the appointments, classes and groups, she uses motivational interviewing, education, and goal setting to encourage nutrition, exercise and sleep improvements. She also offers community outreach and education to local schools.

Q. Can you describe the '30 minute model'? How long is the non-traditional intake using this model?

A. SCCHCs has embraced a model that includes 30 minute therapy encounters, warm hand-offs and a practice called "Step-Ins" (other clinics often call these "same-days"). Sessions are numbered from 1-12 and there is no change in the session length for any encounter. Generally clinicians have no more than 3 encounters scheduled back to back to create flexibility and allow them to see people for slightly longer sessions as needed; if the schedule runs behind, they can often catch up within a half day. SCCHCs also educates its entire staff and its patients about its behavioral health services model and its scheduling practices so patients typically know what to expect when they come to that first session. Patients are accustomed to a similar experience with their medical appointments.

SCCHCs typically spends 3 -10 minutes on the informed consent process and the rest of the session on identifying the focus of treatment. Having shared medical records and a medical assistant on the team supports clinicians in gathering patients' histories prior to each initial session eliminating the need to obtain that information verbally much of the time. It is important to note that some of the traditional intake/assessments have been payer driven, asking the patient many closed questions that may not relevant to the patient, and putting off 'treatment' until the 'assessment' is done, resulting in a high drop-out rate. In an integrated model, treatment happens in the first

visit, building the therapeutic alliance with the patient, and eliciting from the patient what is most important to them to focus on. Clinicians are always assessing throughout the course of treatment, however completing a formal intake is not the initial goal – it is to effectively engage the patient.

There is no "hard and fast" rule about 30 minutes. Because more time is spent with patients than in documenting (which is very different than in traditional mental health settings), clinicians can see 7-9 patients a day, and even if those sessions are 45 minutes, it only amounts to 6 hours a day of clinical time, allowing for plenty of time for documentation, and breathing room (important for therapists to 'calibrate' their instrument, which is themselves). Every system is different, and the most important consideration in making decisions about scheduling and session length is having a Director of BH who is a clinician who can weigh in on this decision.

Q. Within the context of a primary care clinic, is there a distinction between behavioral health consultations and psychotherapy as treatment? If so, does Santa Cruz Community Health Centers do both?

A. There is a distinction between BH consultations and psychotherapy as treatment, though often this distinction is not reflected when we use the term 'integrated BH'.

Typically when organizations refer to BH consultation, or title their BH clinicians 'BH consultants' they function more as health coaches, doing brief, 15-20 minute interventions with patients, to focus very specifically on changing a specific health behavior. In this model, patients are seen between 1-3 times, and this is not considered 'therapy'. Patients do not self refer; only primary care providers (PCPs) can refer. Additionally, the PCP is considered the 'customer' in that the BH consultant's job is to be helpful to the PCP in their goals for the patient.

Alternatively, 'integrated BH' can also mean integrating more traditional BH practices into primary care. In this model, BH clinicians use all their skills as therapists, and do provide therapy to patients. Many times sessions are shorter (30-45 minutes) and there might be limits on the number of visits (sometimes 8-12), however the core of the service provided is consistent with what is called 'therapy' including what is referred to as 'psychotherapy'. The type of therapy provided (Cognitive Behavioral Therapy, insight oriented, psycho-dynamic, Dialectical Behavior Therapy, Eye Movement Desensitization and Reprocessing, supportive, etc.) is based on patient preferences and belief systems, the clinician's clinical judgment and skills, and the context of the resources (re: time limits, frequency limits, etc.).

Q. Does SCCHCs have an in-house psychiatrist or a consulting one? What is the frequency of usage of that service and what other situations do you use that service? Has SCCHCs changed their use of consulting a psychiatrist in its integrated care model? Does the organization use them more or less? Are PCPs stepping up and doing more medication management?

A. At SCCHCs, PCPs have historically handled quite a bit of the psychotropic medication management and continue to do so. They seek training frequently in this area because access to psychiatry is limited. SCCHCs is looking into a more formalized oversight/supervision role where one of its PCPs with specialized training in this area can offer guidance in this area.

Many times when a PCP determines that a psychiatrist is needed, a BH provider can help assess if a patient would follow through with that treatment. In SCCHCs experience, there have been times when patients are not in a place where they are ready or willing to engage with treatment, for a variety of reasons. Sometimes this causes tension between the PCP and the BH clinician because treatment goals need to be adjusted and PCPs aren't always receptive to the BH clinician's assessment. Many are and in that case, the collaboration has been smooth.

When psychiatric care is needed and the patient is ready and willing to engage, SCCHCs' clinicians use creative approaches to increasing access to care. These include linking patients with psychiatrists in the community if

they have resources to pay out of pocket, utilizing tele-consult services provided by Beacon (the MCO Specialty mental health plan), and advocacy to increase access to county mental health services.

Q. Did you consider looking at using telehealth to deliver behavioral health services in these settings? Have you had any experience providing behavioral health services using telehealth?

A. SCCHCs has not used telehealth to date but is considering using it for psychiatry and will pursue that option more fully in fall 2015. Currently, the SAMHSA-HRSA Center for Integrated Health Solutions has a training module designed to help safety net providers and rural health clinics understand and adopt telehealth behavioral health services. The module is divided into six sessions, and provides the tools and resources necessary to identify and implement a telebehavioral health program. Each educational session includes a Q&A component with telebehavioral health experts, and associated resources for further exploration and information.

Q. Has the SCCHCs program been billing exclusively the psychiatric codes (90791, 90832, 90834) that require a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis? Or has the organization used Health Behavior and Assessment Intervention (HBAI) codes in order to conduct health management visits?

A. SCCHCs has been using the codes listed above that require a DSM diagnosis. It does not manipulate its clinical treatment with billing in mind; it offers services to all patients and if the patient does not meet criteria for DSM diagnosis, billing is done in alignment with the service provided. SCCHCs has adjusted its budget to account for uninsured and under-insured patients and other types of encounters that may not meet criteria for claims.

Q. What protocols is Santa Cruz Community Health Centers using with County when they have someone stable who meets criteria for mild/moderate to transfer to you? Do they have a good system for this? Is there a collation to help?

A. SCCHCs is currently in discussions with the County about developing a more seamless care transition process. Protocols are not in place at this time. SCCHCs uses Registered Nurses and its BH medical assistant to assist with care transitions and is actively working to improve this process.

Q. How is the process going with referrals to and from the county for schizophrenia or seriously disabled patients needing super intensive support?

A. SCCHCS works to offer as many services as possible 'in house' to meet the needs of its patients. It is developing a care model for its most vulnerable patients and this includes patients struggling with severe functional impairment secondary to mental health problems. Simultaneously, it is building connections with other community agencies committed to addressing this need with the goal of developing seamless pathways for patients to access intensive services as needed. There is currently a gap in intensive outpatient services for mental health stability in the County and SCHHCs is taking an active role in addressing this gap.

➢ Economic & Financial Models to Sustain Integration

Q. Is it reimbursable directly?

A. The short answer is yes, particularly for a state like California that has chosen to expand Medicaid. Reimbursement is also tied to the type of payment system that the clinic is operating under. For clinics who are paid by a prospective payment system (PPS) rate such as Federally Qualified Health Centers (FQHC) or FQHC Look A-Likes, reimbursement for services is dependent upon the type of clinician providing the service. Licensed Clinical Social Workers (LCSWs) and Licensed Psychologists can bill the PPS rate for behavioral health (BH) visits. In some states, like California, same day appointments (when a patient sees the medical doctor and the BH clinician on the same day) only one visit is reimbursable, however, the Managed Care Organization (MCO)

and/or the MCOs Specialty mental health plan may pay the Fee for Service (FFS) rate for the same day visit. There have been some questions raised about the impact of this on reconciliation; FQHCs should check with representatives from the California Primary Care Association (CPCA) or regional consortia on this issue. For clinics that are not paid through PPS, BH visits are covered by the MCO or the MCOs Specialty mental health plan at the FFS rate. These clinics may also seek reimbursement for services provided by Licensed Marriage and Family Therapists (LMFTs), in addition to LCSWs and Licensed Psychologists. Additionally some MCO/Specialty mental health plans may reimburse for unlicensed master's level clinicians, such as Associate Social Workers (ASW) and MFT Interns.

Q. What about clinics who say they can't afford it?

A. There are many clinics out there demonstrating that it is affordable. Clinics should develop financial projections that consider the interplay behavioral health care delivery model, staffing ratios and scheduling practices.

Q. How are you able to bill for behavioral health and medical visits on the same day? How do you make this model work financially under FQHC where there is a two visit in one-day barrier to billing?

A. As stated above, sometimes the MCO/Specialty mental health plan will reimburse for same day appointments at the FFS rate; although this is not equivalent to the full PPS rate, it does provide some level of reimbursement. Typically same day appointments constitute no more than 15-20% of a BH clinician's visits, so even when not those visits are not reimbursed, BH clinicians' services can still be cost neutral or profitable. If a clinic is highly concerned about this, they certainly could prohibit same day visits, although this is not a patient-centered practice. If this concern is keeping a clinic from hiring BH clinicians, then it may be better to prohibit same day visits than to not hire BH clinicians at all.

Q. How do the MFTs bill under the FQHC?

A. As noted above, MFTs cannot bill in California at FQHCs, however some MCOs or the MCOs specialty mental health plan may pay an FFS rate.

Q. Can you define the prospective payment system (PPS) rate?

A. The PPS is a method of reimbursement designed specifically for clinics that are designated as FQHCs or FQHC Look A-Likes by the Federal Bureau of Primary Care. The rate is based on a number of factors and is different for different organizations, and even for different sites at the same organization. Under federal law, the PPS payment formula sets a minimum per-visit payment for Medi-Cal patients seen by an FQHC provider. Each FQHC has a different PPS rate based on its historical cost of providing care. A recent Foundation brief, *Transforming California's Safety Net through Value-Based Care,* explores these issues in depth and their impact on care.

➢ Clinical Practice Integration

Q. How would you start the conversation with the behavioral health team, PCPs and management to start the process of full behavioral health integration? How do you engage PCP facilities to incorporate behavioral health into their practices?

A. The first important step is to gain a high level of commitment and buy-in from the organizational leadership, including effective organization-wide messaging around this change, inclusion in the strategic plan or equivalent, and inclusion in other leadership goals such as quality improvement.
The second step is to hire a Director of Behavioral Health. Without a visionary, collaborative director of BH, who is on the senior leadership team (thereby modeling commitment to integration at the executive team level), hiring a few BH clinicians will not likely succeed in creating an integrated system.

Many clinics have found that identifying a "champion", one PCP who can lead and compel peers to embrace the inclusion of BH in healthcare is an effective approach to starting the process of PCP engagement. Highlighting the research and data that supports the prevalence of need and link it to your own clinic experience/population can also be an effective strategy.

Additionally, having highly skilled, enthusiastic BH clinicians who are excellent relationship builders, with patients, staff and medical providers is imperative. Integration is a team sport, and without clinicians who are good at, and enjoy, being on a team, it is pretty tough to change culture. For those organizations that have BH clinicians who have been working separately from medical, in a more traditional model, they may or may not want to, or be able to, transition to something new. It is useful for the organization to decide if they are willing to keep clinicians who do not have the willingness or ability to make the change, or if they feel they must part ways.

Q. What is balance between training PCPs to do more "behavioral health" vs bringing in behavioral health resources into the primary care practice so the PCP sends the patient to that resource? Is there a preferred way to deliver behavioral health services or should each practice figure it out for themselves?

A. There is no one model of integrated behavioral health that will work for all clinics or primary care practices. It is important to recognize which approach will work best for your practice and community, given local resources and health care landscape. The SAMSHA/HRSA Center for Integrated Health Solutions has a wealth of information on the various models and approaches that primary care and behavioral health organizations are embracing.

Having said that, there is an enormous amount of research, including the Langer survey highlighted in this webinar, indicating that patients prefer receiving BH services at the same place they receive their medical care. Additionally, communication between treating professionals is significantly improved when they are working at the same organization, and documenting in the same electronic health record.

It is also important for PCPs to become increasing comfortable and skilled in pharmacology treatments, and in evidenced based communication skills such as motivational interviewing. However, therapy is a highly skilled and licensed practice, with clinicians obtaining 6-10 years of schooling, 2-4 years of interning before board licensing, and years of practice. In the Langer survey we identified that patients preferred talking to a counselor, likely because of this skilled training. It isn't possible to equate a PCP doing 'more behavioral health' with hiring licensed behavioral health clinicians.

Q. What is the recommended number of FTE's per 1000 patients?

A. This question depends on each organization's vision of integrated care. If an organization would like all patients to see BH for prevention, early intervention, treatment for mild, moderate and severe BH conditions, then the ration is likely 2 BH clinicians to 1 PCP. A very different looking healthcare system! If the organization would like BH clinicians to only see those with very severe, impairing conditions, the numbers would be closer to 1 BH clinician to 3 PCPs, and of course, there is everything in between. The math is complex, however some important factors to consider as you develop the model: the prevalence of the conditions you would like the BH clinician to treat in your population, the average number of visits needed for this treatment, and the target productivity of the BH clinician. With that math equation, you can get close to the number of clinicians needed per 1000 patients.

Q. What ideas do you have for recruitment of behavioral health clinicians? Have you had challenges with hiring effective, bilingual clinicians?

A. Ideally, recruitment for BH clinicians is 'integrated' at the HR/leadership level with recruitment for PCPs. There are similar shortages, so most organizations have significant time and resources toward PCP recruitment,

including relationships with medical schools, hiring outside recruitment firms, referral bonuses for current employees who successfully refer providers, etc. It is important that the pay is market rate or better, although the research tells us it isn't the most important thing for decision-making, it must be in the ballpark to show value. Putting energy into a relationship with local MSW programs can be very helpful in recruitment, especially if part of the benefit package includes financial support and clinical support for licensure. In behavioral health coaching models, some clinics have found success in training clinicians from other sectors such as Emergency Medical Services (EMS).

Despite challenges, clinics should make every effort to deliver culturally responsive and linguistically appropriate behavioral health services. This includes hiring employees who have language and cultural congruency with the patient population. There should also be professional translation and interpretation services available, as well as training for providers on the social factors, attitudes, cultural stereotypes and stigmas that can influence their patients, particularly those with mental health and substance abuse issues.

Q. What is being done to encourage PCPs to assist or decrease their fear with prescribing and/or managing psychotropic meds for patients?

A. It is important to learn about what keeps PCPs from prescribing in order to design effective interventions. Qualitative interviews and/or surveys with open ended questions may be useful tools for discovery. Throughout the process it is important to respect providers' hesitations and fears, and involve them in the solutions. Solutions may include targeted Continuing Medical Education (CME), having a psychiatrist on staff, or contracting with a psychiatrist to provide consultation. Building partnerships with other community-based organizations that have full-time psychiatrists on staff can support these engagements.

Q. How are the organizations who have already integrated behavioral health handling integrating the medical record with regards to behavioral health charting and confidentiality? How do providers share patient information and deal with confidentiality?

A. There are no legal or ethical barriers to treatment team members in the same organization charting in the same electronic health record. Organizations can include this information in the patients initial consent to treat (which should include all services the organization offers such as medical, dental, BH, health education, etc.) by adding a statement that lets patients know that the organization provides integrated care and all documentation is in the same medical record. It is very important for quality, safe care that providers' charting is 'integrated'.

For the most part, there are still barriers, some legal and real, others more perceived, when it comes to sharing confidential data and integrating medical records across organizations. This tends to require a range of approaches that respond to the specific challenges the circumstances present. Sharing substance abuse treatment data is often the most challenging among providers. It is always best to try to obtain patient consent first, and often, that will remove most, if not all, legal and perceived barriers, at least in terms of the communication among and between providers. Finding ways to share and store information that accommodates clinical workflows so that it is used easily and timely by providers is also important. Some approaches providers use include: faxing authorized records back and forth; developing a universal release or consent form that is then approved for use by all the providers involved in the collaborative care and signed off by local county counsels; generating summary care documents that are placed in paper charts or electronically, on dashboards, outside the EHR; or uploading documents, to separate excel files that can be downloaded and then accessed by providers in different agencies/facilities once they have received appropriate levels of patient consent.

➢ Measurement

Q. How do you do behavioral health psychological assessment? Do you screen for depression, anxiety, substance use? How do you do it in workflow? How do you document and bill for it?

A. Most organizations that are integrated screen for high prevalence BH conditions, such as depression, anxiety and substance abuse. Providers typically use the PHQ-2 & PHQ-9, GAD-7, and Duke Health Profile for mental health screening; SBIRT, CAGE AID and AUDIT or AUDIT-C are often used to screen for substance use/misuse. These tools can also be used to monitor patient progress. It is also important to use screening tools for children specific to that population. The screening tools page on the SAMSHA/HRSA Center for Integrated Care Solutions website has a more complete list. The Institute of Medicine has also developed a report, *Capturing Social and Behavioral Domains and Measures in Electronic Health Records*, that includes a review of key domains and screening tools.

Clinics may give the patient the screen at the front desk and ask them to fill it out in the waiting room; some have the medical assistant administer it. Providers should consider language and literacy in this process. Some organizations with developed technology capacity have patients complete the screenings on tablets.

Q. What data (measures) do you use to report on the success of your behavioral health integration model?

A. Measures should include those that are important to clients and demonstrate positive outcomes and results for the client. One approach is to identify and draw measures that can demonstrate outcomes from the following domains: prevention; access; assessment; treatment; continuity of care; coordination of care and patient safety and experience. Targets for achieving positive outcomes in the metrics/data selected for measurement should be clearly identified and treatment approaches adjusted if targets are not being achieved. If possible, data should be collected in a central repository and evaluated on a regular basis and used as part of a quality improvement process. Some clinics may consider using a registry function for ongoing population management. Identifying, developing consensus for and accountability around measures between other providers/partners is also important. This includes other direct service partners/providers you may be working with as well as the health plans with which you are working.

Q. In terms of data from the survey, were there any particular health measures that were of most interest between the clinicians and behavioral health?

A. The Langer survey focused on patients and did not ask about their health goals or outcomes. However, the survey did show that patients with chronic conditions, those with 6 or more visits in a year, and those who rated their health fair or poor wanted to talk with a behavioral health professional. This suggests a real area of opportunity for clinicians and behavioral health to work together to improve chronic disease management and to monitor utilization and related behavioral health and physical health outcomes.

➢ Coordination and Partnership

Q. Can you comment on the bifurcation of mild to moderate vs. moderate to severe for Medi-Cal members?

A. The funding, administration and oversight of the Medicaid system for those individuals with mild to moderate versus those who experience more severe mental health conditions has been bifurcated, resulting in a service delivery system in local communities that is often siloed and separate. With the expansion of the Medi-Cal program in California under the Patient Protection and Affordable Care Act (ACA), Medi-Cal managed care plans were assigned responsibility for delivering mental health services to the "mild to moderate" population; many of these plans contracted with a Specialty mental health plan to implement and manage this benefit. Counties, under the state's Medicaid Section 1915b waiver, retained responsibility for providing specialty mental health services to those with severe mental health conditions. One of the challenges that has arisen is a lack of

clarity around defining plan vs. county responsibility for patients based on the severity of their illness. Plans, counties and providers at the local level will need to work together to make access to BH services seamless for the patient and family.

Q. Complex Care Coordination is an activity that is often overlooked. Is complex care coordination (not the same as case management) being provided on site or at the plan level by the insurer?

A. Many clinics are working to embed complex care coordination in the primary care setting and find having this capacity at the point of care versus the plan level is more effective. There is a proposed Health Homes for Patients with Complex Needs Initiative under development at the Department of Health Care Services; see the concept paper for a fuller discussion of the model. One of the challenges is that care coordination itself may be happening in silos - primary care providers, behavioral health providers and plans all have coordination functions, but coordination across systems is still not occurring for the patient.

Q. Are you aware of other Health Plans that are embracing the inclusion of behavioral health clinical leadership at the Chief Level?

A. Some Medi-Cal managed care plans have hired Directors of Behavioral Health. Two notable examples are Inland Empire Health Plan and LA Care. This is an important step toward integration at the plan level (much like the suggestions above regarding integration at the provider level). To our knowledge, a comprehensive scan of plan practice in this area has not been conducted.

➢ Miscellaneous

Q. Does the Foundation fund innovative community models for behavioral health? Could you expand on this if you do?

A. The Foundation has developed a grantmaking initiative, *Advancing Primary Care and Behavioral Health Integration through Community Collaboration*, that is designed to advance innovative models at the system level (versus the individual provider level). This requires primary care providers, mental health providers, substance use providers, Medi-Cal managed care plans, specialty mental health plans and county agencies work together to understand the demand for behavioral health services in their community; develop strategies for optimizing and growing their collective clinical and community capacity to meet behavioral health needs; and taking advantage of emerging policy opportunities at the state level. This grant opportunity is by invitation only, but the Foundation is interested in learning about existing community collaborations (comprised of the partners listed above) who may want to be part of a learning network to share strategies and best practices.

Q. What is the one priority issue within integration that payers, CHC leaders, and researchers should pay attention to in the coming year? In other words, if you could direct payers, CHC leaders, and researchers to do one thing this year to support integration, what would it be?

A. There are a number of state and local policy opportunities being developed that have the potential to advance integration. These include:

1. Continued implementation of mental health benefits for the "mild to moderate" population through Medi-Cal managed care.
2. Proposed development of a new substance-use services continuum through the Drug Medi-Cal Organized Delivery System waiver.
3. Proposed development of a Section 2703 Health Homes demonstration program.
4. New care delivery and financing strategies for advancing integration in the next Medicaid Section 1115 waiver.

5. A Statewide Strategic Plan to Reduce Mental Health Disparities.

Stakeholders should be meeting and working together to plan for how to effectively implement these opportunities in their local community. They should be gathering data on their patient population, its level of need, their systems' capacity to meet this need, opportunities to share or leverage existing resources to meet patients where they are at, community-wide training and capacity needs, and strategies for shared data collection and measurement. They should also look within their communities for successful integration models and care delivery innovations that could be spread to other sites.