SHIP PCMH Transformation Team - Mentorship Webinar Series

Topic: Behavioral Health Integration in a Community Health Center's Patient Centered Medical Home

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Jeanene Smith: Hello and welcome to the second of our Mentorship webinar series. The topic is BHI with a focus on implementing this in a community health center or federally qualified health center (FQHC) in amidst the work that these clinics have been doing around PCMHs.

Our effort is really to get people connected, to share their implementation experiences, and have you all who have joined us be able to ask questions back and forth with these clinics. They are both going to give an overview first, so kind of their first of what they are doing, and then as Laurence said, then we will open up the lines. It really is to help build some partnerships across the state and help build, you know, it is like, "Gosh, I wish I knew someone I could ask a question about this." This helps to hopefully develop that network of help. I know Idaho's been doing a lot of work around BHI and having some collaborative efforts already underway, and this is just another way to facilitate that.

The overall mentorship framework that was developed by the subcommittee of the Idaho Healthcare Coalition (IHC) is available online if anyone is new to this concept and would like to get a little more details.

Just to remind folks, because now that we are past the end of September [2017] everyone who has not already gotten a 2014 designation and is considering an National Committee for Quality Assurance (NCQA) designation will need to be focusing on 2017. Just to remind you that this all falls under the Care Coordination and Care Transitions Standard under Competency B. You can get an elective two credits as you think about your scoring. For those clinics that are thinking about going forward on the NCQA standards, the NCQA is really trying to highlight this, as well as the state has been in sort of incenting these models of care. I know as well, as coming from Oregon myself, that that is just a key aspect to our model PCMH and is part of the Oregon Patient Centered Primary Care Home standards as well. As Federally Qualified Health Centers it is sort of—you guys have all been often the leaders in this over the years and continuing to refine and improve the model, and many of the rest of us are learning from you guys.

Today we have the two clinics, and I am going to have first the Health West representatives. Lyn McArthur is the behavioral health director in the Health West area of Pocatello, a predominant area in Region Six. She is joined by Doty Collins, who is one of their clinical social work specialists. After they've had about 10 or 15 minutes to go through their description of what they are doing, then we will have Tori Torgrimson follow, she is the behavioral health director in the family health services, primarily located in the Twin Falls area of Region Five.

I think the next slide has the questions; with that I will turn it over to Lyn and Doty. Take it away.

Lyn McArthur: Okay. Can you hear us?

Jeanene Smith: Yep.

Lyn McArthur: Okay; great. This is Lyn McArthur. As you said, I am the behavioral health director here at Health West. Doty is our behavioral health consultant. I think she is going to get us started off telling you a little bit about our setting.

Doty Collins: Our clinic setting, we are a community health center; we are an FQHC. Health West has eight clinics across southeast Idaho. This is the only one that we do integration in, so it is really kind of the pilot site for the program.

Lyn McArthur: We also have co-located BH care. We have five Licensed Clinical Social Workers (LCSWs) throughout our clinics. We are working on—integration was something that we added on top of an existing BH program.

When it comes to why our clinic decided to move forward with BHI, I believe it was in early 2014 we caught wind of integration and both and I our administrative team were quite curious about it. We thought it was integral to PCMHs and we thought it would be a great service to our patients here at Health West. We got interested in it. We signed up for, I believe it was a webinar that took place maybe once a week over the course of several months, and we learned about what integration was at a very simplistic level, billing for integration. We just got—it was sort of an Integration 101 type of experience, and that was something that we found very helpful. That training we did include both myself, as the director, also our chief medical officer, our director of quality, our CEO attended some of those meetings, and our grant writer also attended those meetings.

To really get a good understanding of exactly what integration meant we found that a lot of people, when they first hear about integration, they are quite confused, they do not really understand that it is something beyond urgent crisis in mental health care, and that there is a focus on medical conditions themselves. That was very helpful, to have the whole team onboard in terms of understanding what integration really was. That was in early 2014; over the course of that year we went through quite a few trainings. We tried reaching out a little bit to the listing agencies in Idaho that were already involved in integration. We did not get too far with that, and I will talk about that a little bit later because it is one of our lessons we learned from this process.

We got our grant writer involved and she started exploring grants that might be able to help us get started with our integration services. We did secure a grant and then we started advertising for our first BH consultants in 2015. I believe Doty started with us around May of 2015. We have been going at it for nearly 2.5 years. We still have a lot to learn, still making adaptations to fit our setting here, but we have made a lot of progress in that regard.

All right, I am going to give the floor back to Doty here to talk about our program today.

Doty Collins: As far as Lyn said, yes, we have done—we have made a lot of progress, we have had a lot of growth. As far as pro rata today, we are really soundly fully integrated. I am available—we have four medical providers, I am available for them most of the time throughout the day. I do take on a couple of regular traditional counseling patients during the day, but most of my day is spent going right into medical visits with the medical providers, and then I can also bring people into my office if I need to schedule a follow-up appointment, either with myself for some brief sessions or else I will schedule a follow-up with our other LCSWs if somebody needs traditional therapy.

I stay really busy and we do the best we can to just make sure we are meeting the needs of every patient that comes in that has any kind of emotional, mental, or behavioral barrier that they are trying to work through.

Lyn McArthur: Okay; great. In terms of our first steps and key strategies, our first step was really getting everyone educated, at least to understand what integration truly is. Our key strategies involve getting everyone on the same page; making sure we had a plan and some sort of introduction to what integration was to our entire team, not just administrative, not just the leaders on the team, but everyone who was involved. I think training went all staff, from reductionist to social workers, billing staff, everyone really needs to know what integration is all about, and I think that is really integral to taking on an integrative program.

I am kind of combining some of these questions together. Again, we had most of our team involved. This is something I will say is a key strategy, is to continue to educate your team about integration. As you hire more team members, you have turnover, it really is a different concept for a lot of new medical providers, for nurses, and constant education is really important to make sure that the team is on the same page.

Doty has been our only BH consultant. We would like to hire more in the future. One of the reasons we have slowed down with that is we are really trying to understand how to make her position sustainable moving forward, to gather data and be able to capture that data in our electronic medical record (EMR) to show that her services are beneficial. We know that they are, our providers know that they are, but we really need a better way to demonstrate that with numbers moving forward too.

One key strategy that I have found that is happened in our organization over the last year or so is that we have also gotten more involved at a statewide level. There was a network called the Idaho Integrated Behavioral Health Network (IIBHN) that was primarily centered for providers around the Boise area, which is about 3-3.5 hours away from us. Here in the southeastern Idaho region, in our region, which we are a couple of hours away from Tori, but we are the only integrated care team that I am aware of here. Finding colleagues to really bounce ideas off of, to troubleshoot how to secure the funding piece, how to make billing something that is returning on billing efficient is something we are still trying to work through. The IIBHN has allowed us to team up with others in the area to work with Medicaid, for instance, on allowing for billing of health and behavior codes. We are currently in process, negotiating with them about that.

I would say that one of the things looking back, one of the major lessons that we learned is team up with others sooner; not only do you learn a lot from their experiences and

they learn from yours; but beyond that, you can team up together to really interact with the other insurers and just ways of really making sure that integrated care is efficient.

Jeanene Smith: How—can you say how folks could get connected with the IIBHN? Is there information we could share?

Lyn McArthur: Yeah. If they want to send me an e-mail I can get them coordinated with the person who heads that up.

Jeanene Smith: Okay.

Lyn McArthur: I think that they would probably be willing to at least give some advice on how to team up with—what we have been doing thus far and then how they might on their own organizations based on their own state laws and things like that. But yeah, just shoot me an e-mail and I can give you a little more information about that. It is been very valuable to us. We were feeling pretty alone over here in Pocatello and kind of stumbling around at times to get our program started. Looking back, I wish that I had known about IIBHN earlier. That is one of the things that I definitely learned from this process, is seek out mentors immediately, before you get started, and maintain those relationships so that you can really go into the field as a team as opposed to working—you know, in your little section of the state, when someone else might be working on something different and you might be counterproductive to one another. I bet mentors can also learn from their mentees in this regard.

That would be one of the things that I would say. We have learned that lesson, I wish we could go back and change it, but we are just adapting and changing things as we go.

I will also say that even though we did a lot of education with all of our providers regarding integration, we did not change our actual workflow in the clinic. Part of that is related to the fact that we have a clinic—we have a standard workflow so that doctors and nurses and providers know what to do, when, and how to do it. Integration was not a piece of that. We are now working on, in this clinic alone, as this is the only clinic that we have integrated services in, creating a new workflow, an experimental workflow, so that providers do not have the option to call us when they need it—as to call us in as needed. We have two providers that are excellent at doing that and then we have another two who really struggle to really visualize what true integrated care is.

We are hoping that by having that in, you know, our director of quality saying, "This is what you have to do. This is the workflow at Health West" that will gain some buy-in.

We are also working on increasing my own and Doty's education on medical conditions and making sure—I think that also lends more credibility to us with medical providers when we have more educational experiences related to very specific medical issues that might come up in integration.

Is there anything else you want to add, Doty?

Doty Collins: On the major lessons learned, I think that they did things for me as when I first started this it is like I am going to have just a very limited amount of time to go in with the provider, and then if I do get somebody in for a follow-up it is going to be a very limited

amount of time. The biggest thing I have learned is that is very valuable; we really can help people in that amount of time, and we get to help so many more people than we would if I were not here to go in and help—you know, help the patients and help them overcome any barriers they might have, if they need traditional counseling or even help them with barriers to coming in for follow-up sessions. I just think that this learning the value of what you can do in just a short period of time.

Jeanene Smith: Okay. With that let us switch over to Tori and hear her world at Family Health Services around these sort of same questions and then we will have lots of time for folks to go to some deeper dive questions back and forth. Tori.

Tori Torgrimson: Okay; great. Yeah, as you said, I am the director of behavioral health for Family Health Services. We have seven clinics, fairly similar to Health West in the numbers. We go out as far as the Burley area or Fairfield, lots of small rural clinics. We have had for years in our three largest medical clinics; we have had counseling services that were co-located at those medical clinics. We also have a specific separate office for some counseling as well in Twin Falls with a total of six clinicians. We also do some testing and things. The clinic that we decided to do integration with is our largest clinic in the Twin Falls area, so we just picked one to get the process started again, similar to how Health West looked at it.

Why we decided to move forward, you know, we had been talking about it for quite a while. We have been working on PCMH for years and it just never really took off; you know, getting it all together and everything organized. Underlining that, there was always this buzz of sooner or later we are going to have to figure out integration. We thought co-located was sufficient, but we all knew that it just was not meeting the needs or doing what the medical providers were needing. Then when we started really focusing more on PCMH, getting things to where they need to be, about two years ago we just committed more to that. In 2016, it was the leadership, the CEO and our medical directors, they just said, "You know what, we have got to go forward. If we are really committed to PCMH and we are committed to providing the type of care that it is describing, we have got to figure out a process where BHI is part of that." We started with that support at the top there.

I am going to kind of skip where we are at today and just kind of how my mind works and the steps that we took. My first steps, you know, for me it was just giving me—they said, "Let us look at some ideas," they kind of had me research it. I did do a lot of researching, and I guess I would say in this way with what Lyn and Doty were talking about, you do—you know, mine was over a year ago, theirs was two years ago, you do feel kind of alone. There was not a lot of resources at that point, so I had looked up all different possible avenues and things and I ended up getting just a huge mountain of different possibilities, models, ideas. No real clear consensus.

What I did learn from that, though, was consistently what in all the models, what they addressed was looking at the culture, and that is honestly where I started as far as picking the program, the outline that we were going to use for our BHI. For the culture, Family Health Services as a whole, but more specifically at that Twin Falls clinic, you know, we had had co-located for years. The providers did not really see that being very helpful. We had a hard time with communication. We had, just as I was looking over the models I brought to the team, and we all agreed that the best fit for us—we did pick a

specific model, and that was the primary care behavioral health model where we are just slowly integrated. We do not have—we are a little bit different; the people in there that are at the medical clinic, they do not have any hours where they are doing the traditional counseling. We are focusing solely on the integrated piece and being there as with the medical providers.

With that, and equally with Doty and Lyn, I would say that the education is huge, regardless of how you choose to go about it. Really we did not—it was just kind of a go, so we were trying to—we figured out, "Okay, this model is kind of good" but we did not quite know how to do it. We started with a pilot program. We picked one medical—one physician and then a PA that team to work with—we created an integration team, which was really just that pod is what we have; we had three pods in that clinic, so we just picked that one pod, and myself, and we just kind of started small, working out workflows and things. It was really small, and we did that on purpose so that we could try and work out some of the kinks as a culture as a whole of the clinic, where do we need to go, what fits, really getting the input from everyone there. Because my whole focus was this service is supposed to be integrated with the medical team, so we wanted that to work.

Going along with that, with the steps, at the same time we had decided to update that medical clinic and so we were fortunate enough that currently we have more of a bullpen floor plan, so for us it is called the behavioral health consultant. Where our behavioral health person is located is right in the middle of the medical clinic. All the doctors, PAs, any of the medical staff can see us, grab us, and work with us that way.

Kind of going with when you look at key strategies—I think that is also going parallel and combined with your finance, and that was—we said, "All right, we want to do this, but financially." At the time we did not have a grant, we did not have anything to support it; we really piecemealed it a bit in the beginning. We have five clinicians in our counseling office in Twin Falls. Well, actually four; we have the psychologist and then four counseling clinicians, so the four of us all agreed to take one day, and so we were able to cover that medical clinic for 32 hours. The administrative staff was willing to let us give up one day, financially kind of take that as not being billable time at this point, you know, with not bringing in a lot of revenue basically. We are using the staff that we already had, not having to have the cost of hiring a new person, benefits, and all of those things.

We put that out slowly. I started for a few months until I felt like we had a good workflow, all of the staff, we were on the same page, we were able to get the other medical providers in that clinic onboard. Then I took one other clinician and then she took on and we kind of just slowly rolled it out from there so that everyone was on the same page and able to work together.

Training too, like Lyn was saying, I totally agree that training all of the staff, you know, it is not just that one clinic, it is just your whole agency, because this is a shift in the way you think about services and how services are being provided. What we did—one of the things that we did -- was on Mental Health Month—I think that is May. I do not know, I always forget. But anyway, Mental Health Month; we, throughout that whole month, had specific key points of what integrated behavioral health means, what are the benefits, what our roles are. I am fully aware that by next year we will probably have to do some updates or, you know, it is a continuous process because you are trying to educate

people on so many different levels what their piece means and just going over that information.

Where our program is today—well, key strategies too, again, we are getting started, and our pilot program was one, financing was another, you know, long-term, and that is connecting what are other people doing, we are looking at possibility of grants and things. We did connect with some other FQHCs and things right in the beginning, but again, it was not very organized. I agree with Lyn, at this point it is, and the IIBHN is really helpful. Connecting with that or myself as well, if anyone wants to e-mail me who I know and ideas, I know that IIBHN is also connecting with the health districts, so workers from the health districts. Also just contacting your State Healthcare Innovative Plan (SHIP) person, they—if they do not know, they should have easy access to reach out to the people who were involved with IIBHN, just in case you lose the e-mail or something like that. But I agree right now, financially with the grants and then looking at, okay, working on a state level how can we make this sustainable and how can we help provide feedback on our specific rural areas. We do hope, you know, to expand it, just like Lyn had said, and that is more down the road.

Our program today, so with doing four different people four days a week, financially it made it doable for us. There is obviously some barriers there, where communication is difficult. You know, a different person every day, there is—I think communication is the big one and, you know, when you do a change and making sure that everyone knows about that change. We did get some funding to staff a full-time person, so we have just gone through the hiring and hope to have that person starting in about a month or so. because I do think with what we hope to accomplish, having a full-time person, being consistent, starting to work more specifically on identifying at-risk people and persons is really important and being full-time.

At the same time, I wouldn't change the way we did it, because now I have the majority of my counseling staff, mental health staff, know about the program; they understand what we are trying to do and they are fully supportive of what our primary goals are, and so they can help, you know, spread the word and support us through that process.

One difference that we do have, because we are not co-located at that clinic and we focus specifically on integration, our BH consultants meet the patients primarily in the exam room. There is an office to the side we could use for patient overflow or anything like that; we just do not use it very often. That was a strategic decision we made, because again, looking at the culture of that particular clinic, we are so used to co-located that out of sight, out of mind for that clinician, so if they did not see us they were not really going to use us. By meeting the patient in the exam room for the population in that particular clinic, it helps reinforce what we are trying to do and it reinforces that it is part of the medical services and kind of provide that cohesion. If it will evolve different to some different point I do not know, we are really, again, just looking at the here and now and what would help and what makes the most sense.

I do not know—let us see. I think I covered the major—yeah?

Jeanene Smith: Yeah, it does. Are there major lessons you want to add before we open it up to questions?

Tori Torgrimson: I guess for major lesson, taking it slow. You know, the whole concept can be so large and overwhelming and it is totally okay to do it your own process, take small steps. You can evolve down the road at any point. I would just kind of repeat and mirror what Lyn had said, not to do it by yourself. You know, we were—we had—I think we had a couple more people we were working with than what Lyn had, but it is overwhelming. Even now, a year later, there is a lot more structure and persons you can connect with, and we are all very open to connecting and talking.

Jeanene Smith: Great. With that I think we will go ahead, Laurence and Grace, and go ahead and open up the lines. I did see that Jennifer was on, who really was helpful in connecting me with folks for these—this series and the next one coming up. Did you want to add anything, Jennifer, if you can hear us, about the Idaho Behavioral Health Network?

Jennifer: Yeah. Actually we had started that IBHN back in Treasure Valley about a year-and-a-half ago and I got—Lyn and Tori were saying we had actually about four months ago, maybe six months ago, we had asked the public health department to do the facilitation of the group so we could create three hubs, one in region one and two, three and four is the second one, and the third one is up in region five, which Lyn and Tori are sort of our main people that have been utilizing that hub over there. If anyone else wants additional information about IIBHN, between Lyn, Tori, and myself we can definitely get you the information, depending on which area you are in.

Jeanene Smith: We can probably add your contact information, if it is all right, Jennifer, onto this slide deck before it gets posted up on the portal for folks, too.

Jennifer: Yeah. The other thing is, we have been—which was great, was Lyn's organization and Tori's organization and several others have participated in several of our trainings that we have had over the last year from two-day/four-day intensive training to webinar-based trainings. We would open that up to anyone that can make those trainings as well.

Jeanene Smith: Are they occurring regularly? Are you guys—you will be putting out announcements to those participating regions of the next training?

Jennifer: I already have the trainings already out. The webinar ones are the ones—as people are interested they would just need to contact me.

Jeanene Smith: Okay; great.

Tori Torgrimson: This is Tori and I just want to piggyback off of that, that—I am glad Jen mentioned that, because honestly, without Jen's support and being able to get funding for the training, that was a huge help for us, because that is how we were able to get everyone trained with just some very specific clinical skills so they could understand the difference between the two. If there is anyone participating right now that has that ability, I would really strongly encourage you to consider it, because it is very invaluable. Getting that training any other way is really expensive.

Lyn McArthur: This is Lyn and I just wanted to add that I totally agree, Tori. You took the words right out of my mouth; Jen has been invaluable in this process and has really helped develop our program here.

One other thing that I wanted to add, and I will be quick about this, but I think for someone looking at starting integration in the clinic the importance of hiring the right person is so huge. A lot of therapists are accustomed to traditional psychotherapy and there is a lot of pushback in terms of having briefer sessions and focusing on behavioral things without necessarily delving into specific mental health issues. I will say as you are considering developing your own programs, really stop and take a look at what characteristics that therapist really needs to have, even if they do not have a lot of experience in integration. Because working in a rural area, we had no applicants with experience in integration; we really had to do a lot of training here, but we had to have the right person who is open and receptive to changing their minds that at what their job might be.

Jennifer: This is Jennifer. Lyn, I totally agree with what you are saying. One of the things that at least that is the same with Health Partners, we have been trying to develop—one of the reasons why we had developed those training series was really to help with the workforce development, to draw interest from clinicians to do this type of work, but it is very different and you have to really be built to do it. That is the biggest reason why we were trying to do this training push in the last year. Then, also working with an internship program that is specifically built around integrated BH and specific to the primary care BH health model.

Jeanene Smith: Are you guys using the new BH care coordination codes at all? Are those allowable yet in Idaho?

Jennifer: Are you talking about the G-codes that they just recently opened?

Jeanene Smith: Yeah. Right.

Jennifer: The problem with those G-codes is that you have to have a psychiatrist involved in a lot of those billings. Really, like when I looked at it, there is a lot of problems because you have to use a specific model, which is more like a collaborative care model that has a very expensive psychiatrist attached to it. It is about, I think it is a one-month—you can only use it one time a month and it is about $160.00 for that code.

Jeanene Smith: Compared to your FQHC rate it is not necessarily useful or it doesn't add that much more dollars. Well, it would be helpful in a non-FQHC potentially, right? Or not?

Jennifer: If you have the ability to have a psychiatrist. It might be feasible, but it is still not extremely lucrative by any means. It might be able to cover some costs, though.

Jeanene Smith: Okay. Right.

Lyn McArthur: I will add to that too. In the Pocatello area, which I think Pocatello and the surrounding towns we have a population of probably around 70,000 and we have two psychiatrists who do outpatient work here. Hiring a psychiatrist at a rate that an FQHC can afford, with such demand, just is not a reality at this point in time.

Jeanene Smith: Right.

Jennifer: Yeah. Those codes are really built around the UDUB model, which is the collaborative care model, which means it has the psychiatric component. The ones that have like the PCPCH model, which is really around the behaviorist that works side-by-side with the PCP, that it was not really geared towards that model.

Jeanene Smith: Right. Unless you are doing some kind of telehealth psychiatry type of thing, which is any of that going on at all in Idaho yet?

Jennifer: I think in pockets, unless Lyn or Tori, you guys know more than I do, but it is in pockets, it is not a great deal right now.

Lyn McArthur: I can speak to that a little bit. We do have the technology available to do that. One of the issues we have, however, is in order to bill the telehealth codes there has to be a face-to-face contact with the provider the first session. If we are hiring a psychiatrist in the Florida who's licensed in Idaho but they are linking in, then we would have to get them here regularly to meet with new patients. The logistics of it, again, are just really, really difficult. But it is something that we have looked into, and if the rules change we likely will do some telehealth, but right now it is just—it is not really workable.

Jeanene Smith: Okay. It looks like we have a question.

Grace Chandler: Sarah, your line is unmuted if you'd like to ask your question.

Sarah: My question was to Tori and Doty about the billing for the consultation. Are you guys billing for that, or is it a free service?

Tori Torgrimson: This is Tori. Right now we are not billing. The health and—and there is—that doesn't mean not everyone. There is two different parts to it and it depends on the diagnosis that you have. The primary diagnosis is a medical diagnosis that is health and behavior codes, and currently—actually the group of us, Jen, Lyn, and I, we are on a team that is trying to work with Health and Welfare and get that where we can bill it. They just were not open to social workers or even psychologists, the way the state had it organized. So we are working on figuring that out.

The other end is if it is a primary diagnosis of a mental health condition you really have to follow Opium's rules for billing for it, and those would be the psychotherapy codes and things. Right now with an integrated model, it just really does not fit, you know, to do a whole hour to do an assessment and then another for detailed treatment plan, just to be able to provide three or four follow-up appointments.

We are looking at trying to advocate to have some flexibility there and follow some other models with other states, but because for our clinic we decided not to do any co-located services. It is just purely the integrated model. Because we could not bill for Medicaid or anything that yet we have decided to hold off until all of those other—especially with the health and behavior codes, until that is been determined and figured out.

Jennifer: This is Jennifer. All of our clinics that have an embedded BH person in primary care, there is a difference between the consultation codes and doing an actual billable intervention code. Just as Tori was saying, all of our consultations are free. If they are in a hybrid clinic where they are doing psychotherapy, that is that follows along with the

Medicaid requirements, Medicare requirements, and other commercial payers around billing for psychotherapy; but most consultations, which are like warm hand-offs or very short sessions with a patient that has had no consent, those are free services to the patient. It is slightly set up different compared to Tori's clinics; ours are all fee-for-service, not FQHC. We wanted to make sure that the Primary Care Providers (PCP) felt like they could go to the Behavioral Health Clinic anytime and we did not want any billing restrictions for consultations for them to go to them.

Jeanene Smith: Can you folks all kind of talk about how the providers, you said there was—I know I think it was Tori said—or was it the other site? The providers have some mixed responses to this. Can you guys sort of address, you know, provider acceptance, reaction? Are they seeing the benefits? Talk a little bit about what clinics should expect at first and some tips to help them get the providers on board.

Doty Collins: This is Doty. It has varied so much with all of our PCPs. Like Lyn said earlier, we have a couple that just have been really open to it and really utilize my services a lot. There is a couple that have been just—the understanding of the difference between a behavioral need and an emotional and mental health need has been something that we have been working on. I think just really continuing to train them. I try to provide some training during our clinic meetings to kind of help them to be more open-minded and understand a little bit better everything they can use me for, instead of thinking of just traditional—more traditional types of therapy or traditional therapy, just in brief sessions so that they are understanding a little bit more about the medical end of it and the things I can do to help them - to like cut their time and to help them so that they do not have to spend a lot—you know, any more time with patients explaining behavioral change and things like that. That is a lot of what we have worked on.

Lyn McArthur: I will also add to that. We have a dental clinic here, and all the staff at the dental clinic, they really want a consultant. It is interesting listening to them, but I think they more readily see how behavior change is so important to dental health, that they see how Doty can complement that. We have been playing with that a little bit more. I do not know how that will work long-term in integration, but that is just been an interesting thing to observe.

We also thought, you know, maybe some providers might have had some exposure when it comes to younger providers, just out of school; however, I haven't seen that consistently. It is been hard to predict who is going to be more open and who is going to be less open. I think there is a little bit of a turf war that happens sometimes and Doty is just inserting herself, rather than making it an option, is really what we have been working more at recently, of making this part of how we function here at Health West. And again, I wish we had done that from the beginning, I think it would have been more efficient. But training before you even start—before you even start your program—well before you start your program, and getting—I would—we did not do this, but even getting a medical provider involved with interviews to give more credibility from the beginning with the consultant would be helpful.

Jeanene Smith: Lyn, do you anticipate that the residents, because the residency clinic is one of your Health West clinics, so is there some potential educational crossover there to get those new trainees into your model?

Lyn McArthur: There is some crossover. We have a psychologist working in that clinic who actually worked as a consultant in Denver for years before she came, so she does a lot of consultation with the residents, and they seem more open. But we had, you know, one of our providers now, who tends to be more resistant, was part of that program. I think overall it will help, but there will be those providers who need just a little more encouragement and Health West has even talked about at some point if someone is not willing to get on board then maybe they are not a good fit at Health West. I think that is a hard thing for medical providers to grasp, and if they do not go with this model maybe they should not work here. It has not come to that, and I do not think it will. I think where we have enough support from our administrative staff now that if it comes down to that, this is the way we are functioning, moving forward.

Jeanene Smith: Are there other questions of folks out there that want to type in? Your lines are open. In the meantime, until we see somebody speak up or raise their hand—have you guys adjusted how you do huddles in your clinics because of the BH specialist work? Or is there a way that you look across your population differently because of the work in the integration efforts you've done?

Tori Torgrimson: I think my answer will be shorter than Lyn's, so I will go first. The huddle so far, no. I know as integration is supposed to go, we will need to address that at some point. I guess we have—we have made a little impact where we probably have made it a little more consistent, because our behavioral health consultants are trained to go to the medical—each medical pod and specifically request and ask, "Hey, what about your patients?" and look over your patients. But I think we have a lot more work to do there.

I will say, just even in the beginning what we were able to add was we got everyone onboard to do the anxiety screenings. Initially it was PCMH, we were just really looking at depression and had not looked at anxiety yet, but right now the clinic that has integrated services is the only clinic that is screening annually for anxiety. We also have other initiatives that we are working on.

Jeanene Smith: Because the providers feel comfortable that they will have an outlet for the patients, is that—is that a selling point?

Tori Torgrimson: I think so. That was a learning thing for me. You know, as a counselor, so the primary services I provided is counseling, you know, with anxiety it is like, "Oh yeah, that is very workable. I can totally do something with that." It was an eye-opener for me to hear from the physicians that, no, anxiety is—they do not know what to do, they do not respond to medications as well. For us it was opening that dialogue and realizing that we can definitely complement each other. Once we started having that discussion, you know, they were absolutely onboard and we did not have any resistance with that.

Jeanene Smith: Did Health West—did you guys want to add anything to that?

Doty Collins: I do meet with a couple of our providers every morning and go over their schedules as far as their patients, and then I just keep my eye on everybody's schedule throughout the day when I am at my desk, and look to see—because it changes; I can go over the schedules in the morning and by noon there can be a whole group of different patients coming in, because a bunch cancel, and new ones are scheduled. I try to keep my eye

on their schedule all day long and just see if there is anything that I think I can help them out with and then I just make sure to try to be there for them if they need me.

Jeanene Smith: Great. Other questions? As FQHCs, are any of you doing any sort of alternative payment arrangements with the state at this point that would get you more credit for BH-related—you are just on straight traditional PTS payments?

Lyn McArthur: This is Lyn. Yes, I believe it is just traditional. I am not aware of any kind of agreement with the state.

Jeanene Smith: I know in Oregon our FQHCs have gone to the alternative payment approach and then they are getting counted—they get the money upfront, and that has helped to support some of their behaviorist activities inside some of the sites and get some credit based on quality meetings, such as screening and more depression and anxiety screenings, et cetera.

Jennifer: Which CCO are you referring to?

Jeanene Smith: The state as a whole is doing that with a lot of the FQHCs, particularly in the Portland Metro Area. I can get you some more information about that if you want to look into that approach.

Jennifer: No, I am actually very familiar with it. I was just curious if you had a particular—a particular CCO you were referring to.

Jeanene Smith: Yeah, I think some of the CCOs are paying a variety of providers, not necessarily just the FQHCs, I know they pay a case management fee to Winding Rivers up in the far northeast, based on just overall PCMH work, not—and they are doing pretty aggressive BHI there too.

The contact information and the slide set will be up on the portal for those who access to the portal. Our mentors today have agreed to be available and I am sure Jen would be as well, for questions. I think everyone should've got Jen's e-mail, but we can add it to this slide so in case there are questions or inquiries to the IIBHN.

Tori Torgrimson: I will say my number on that slide is incorrect.

Jeanene Smith: Oh, okay. All right.

Tori Torgrimson: It is 1281. You have my fax number listed.
[208-734-1281]

Jeanene Smith: Okay. Oh, okay. Sorry.

Tori Torgrimson: That is all right.

Jeanene Smith: You all will be getting a survey on what you thought about how we set this up today and also to get some input on other ideas and topics. We do have another BHI focus and we actually have, from Jen's system, Saint Luke's, we have Amy Walters to talk about it in

sort of the Non-FQHC setting, for some of your colleagues. We are still working on seeing if we can get anyone else to join us for that.

We have some topics that people have sort of expressed interest in, and I am not sure of the order of these yet, possibly some sharing of how to help with the culture change, which every one of these projects has culture change in general, and how to avoid burnout, and then risk stratification I know is always a challenge You know, let your public health SHIP QI specialist know if you are interested to be a mentor or have some questions you really want to make sure we ask her.

The next slide is my contact information, if you want to also shoot me a note or Nancy Kemp, who is helping me on this project, if there is anything that you think would be really valuable or useful or deeper dives into some of these topics.

Any last words from our mentors? We really appreciate you taking the time today to all describe the great work you are doing in your sites. I would be interested to see how it progresses over time to more sites and inside your systems and hopefully across other areas of Idaho.

Jeanene Smith: All right. Laurence, do you want to take it away?

Laurence Brown: The survey that is being sent after this webinar, be on the lookout for an e-mail from GoToWebinar, that is what is going to be providing the survey for us. Other than that, thank you everybody today for your participation. I believe, Jeanene, unless you have anything further, that concludes today's webinar.

Jeanene Smith: Yes. Thank you very much, everybody.