

# **Behavioral Health Access Plan**

## **For the Uninsured (BHAP)**

### **Narrative Summary**

**2/28/2014**

**NORTH CAROLINA DEPARTMENT OF HEALTH  
AND HUMAN SERVICES**

**OFFICE OF RURAL HEALTH  
AND COMMUNITY CARE**

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## Table of Contents

	Page Number(s)
<b>SECTION ONE:</b> Background	5-6
<b>SECTION TWO:</b> Integrated Behavioral Health Care –The BHAP Pilot Project	7-13
A. Integrated Care Concepts	7-8
B. Conceptualization of Behavioral Health Access Plan for the Uninsured	9-11
C. The Integrated Care Experts	12-13
<b>SECTION THREE:</b> Pilot Site Profiles	14-22
Franklin County Volunteers in Medicine Care Clinic (FCVIM)	14-16
Martin-Tyrrell-Washington District Health Department (MTW)	17-18
Polk County Community Health and Wellness Center, Inc. (PWC)	19-20
Community Clinic of Rutherford County (CCRC)	21-22
<b>SECTION FOUR:</b> Overview of Technical Assistance Provided By Experts	23-29
<b>SECTION FIVE:</b> Site Process Change and Review of Performance Measures	30-43
Franklin County Volunteers in Medicine Care Clinic (FCVIM)	30-32
Martin-Tyrrell-Washington District Health Department (MTW)	33-35
Polk County Community Health and Wellness Center, Inc. (PWC)	36-38
Community Clinic of Rutherford County (CCRC)	39-42
<b>SECTION SIX:</b> Summary	43-46
<b>SECTION SEVEN:</b> References	47-49

	<b>Page Number(s)</b>
<b>APPENDICES:</b>	
<b>Appendix A:</b> Behavioral Health Access Plan (BHAP) Target Population And Site Selection Criteria	50-51
<b>Appendix B:</b> Behavioral Health Access Plan (BHAP) Integrated Care Site Self-Assessment Survey	52-57
<b>Appendix C:</b> Notification Of Funds Available For Support Services To Assist Rural Health Entities to Implement Behavioral Health Access Plan For The Uninsured (BHAP)	58-62
<b>Appendix D:</b> Standardized Care Pathways and Resources	63-67
<b>Appendix E:</b> BHAP Pre Versus Post Comparison of Self-Assessment Ratings of The Integrated Care Practice Survey	68

**North Carolina Department of Health & Human Services**  
**Office of Rural Health and Community Care**  
**Behavioral Health Access Plan for the Uninsured (BHAP)**

**SECTION ONE: Background**

North Carolina's Office of Rural Health and Community Care (ORHCC)

The mission of the N.C. Department of Health and Human Services, in collaboration with our partners, is to protect the health and safety of all North Carolinians and provide essential human services. In 1973, the Office of Rural Health Services – the first such office in the nation – was created within the North Carolina Department of Health and Human Services by Governor Jim Holshouser. The mission of ORHCC is embodied in the following statement:

“Rural Americans are older, poorer and sicker than their urban counterparts... Rural areas have higher rates of poverty, chronic disease, and uninsured and underinsured, and millions of rural Americans have limited access to a primary care provider. Disparities are compounded if you are a senior or minority in rural America. 62 million rural Americans rely on rural health providers. 20 percent of the population lives in rural America, yet they are scattered over 90% of the landmass. Extreme distances, challenging geography and weather complicate health care delivery.” (Department of Health & Human Services, 2011). (1)

At its inception, the Office was charged with assisting underserved communities by creating and supporting a network of rural health centers across the state. Since then, the Office has expanded to empower communities and populations by developing innovative strategies to improve access, quality, and cost-effectiveness of health care. Now known as The Office of Rural Health and Community Care (ORHCC), provides services in every county in North Carolina and currently supports rural health centers with funding and technical support. ORHCC also helps to place medical, psychiatric and dental providers in communities throughout the state. Rural hospitals, as well as many statewide medical facilities that treat poor and uninsured residents, may receive help through grant funds. Qualifying patients may take advantage of drug companies' free and low-cost drug programs through ORHCC's medication assistance program. (2)

U.S. DHHS Health Resources and Services Administration (HRSA) State Health Access Program (SHAP) Grant

NC ORHCC received a 5-year State Health Access Plan grant starting in FY 2009-10 that was the progenitor of the Office's integrated behavioral healthcare initiative. At the beginning of Year 3, North Carolina requested a Change in Scope for its SHAP grant funds to undertake a number of unfunded projects to bolster efforts to increase access to coverage for the uninsured in North Carolina and to help prepare the state for implementing the various preventative services to be covered by all insurance companies. One of these projects became the Behavioral Health Access Plan for the Uninsured (BHAP) pilot, designed to provide training, technical assistance, and limited reimbursement for three to six rural practices to integrate behavioral health and substance abuse treatment with primary care services using a team-based practice model. A Request for Applications for an administrative organization with expertise in behavioral health services and a Request for Applications for rural primary care practices in underserved communities that desired to become pilot sites were subsequently released in the late fall of 2012.

## **SECTION TWO: Integrated Behavioral Health Care: The BHAP Pilot Project**

### **A. Integrated Care Concepts**

### **B. Conceptualization of Behavioral Health Access Plan for The Uninsured**

### **C. The Integrated Care Experts**

#### **A. Integrated Care Concepts**

Integrated behavioral health care is an emerging field within the wider practice of high-quality, coordinated health care. In the broadest use of the term, “integrated behavioral health care” can describe any situation in which behavioral health and medical providers work together (Agency for Healthcare Research and Quality’s Academy for Integrated Care (AHRQ)).

As adapted from “AHRQ’s Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus”:

- The term “behavioral health” is used to emphasize the broad applicability of integrated health services in medical care. Behavioral health encompasses behavioral factors in chronic illness care, care of physical symptoms associated with stress rather than diseases, and health behaviors, as well as mental health and substance abuse conditions and diagnoses.
- The term “patient-centered care” reinforces that the patient is a key stakeholder in integrated care. Patient-centered care is defined as health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.
- The use of the term “systematic” indicates that integration needs to be a routine part of care. Integration should be used reliably whenever appropriate for the care of the patient.
- Integrated behavioral health care teams and services do not have to be present or delivered in the same physical location to meet the definition of integrated care. While there are advantages to bringing behavioral health services on site in primary care settings, increased integration can occur between clinicians and organizations that are physically separate but use shared care plans and workflows that achieve integration of care. Physically separate care providers are considered an acceptable variation, as long as the care team can fulfill the required functions of integrated behavioral health care from separate locations. (3) Advantages to shared locations include an increased likelihood that patients referred for services will follow through as well as an increased opportunity for medical and behavioral health providers to build their relationships and skills through informal interactions.

For the purposes of this grant, integrated care in a primary care setting was aligned with the following integrated care concepts:

- A team-based approach which implements standardized care pathways driven by evidence-based brief screening and brief treatment for mental health, substance use and health behaviors primary care settings often encounter and treat,
- Team-based care addressing health behaviors (including behavioral changes a patient needs to make in order to manage a chronic medical condition), life stressors, and patient and caregiver adjustment to chronic medical conditions and,
- Meets the physical and mental needs of patients in one location through a closely coordinated patient-centered style of practice. (3)



## B. Conceptualization of Behavioral Health Access Plan for the Uninsured

People dealing with complex and unaddressed psychosocial conditions often die decades earlier than the average person, mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease. Medical conditions are aggravated by circumstances that lead to limited physical activity, poor nutrition, smoking and/or substance misuse.

As noted in ‘Co-location Report Summary’, prepared by Chris Collins, Director of the North Carolina Office of Rural Health and Community Care, in February of 2012:

Further, the presence of one type of disorder constitutes a risk factor for developing co-morbidities. For example, while the 12-month prevalence of major depression is about 5 percent in people without chronic medical conditions, people with one medical condition have 8 percent prevalence, and those with three or more have a 12 percent chance of being diagnosed with depression during the same period of time (Druss and Walker, 2011, p.6). The 2002 National Medicaid claims data showed that more than half of disabled Medicaid recipients with psychiatric conditions also had claims for diabetes, cardiovascular disease, or pulmonary disease. Overall, these rates were substantially higher than rates for these illnesses among persons without psychiatric conditions (Druss and Walker, 2011). Psychiatric disorders were among seven of the top ten most frequent diagnostic co-morbidity triads in the most expensive 5 percent of Medicaid beneficiaries with disabilities (Druss and Walker, 2011, p5). (4)

Medical providers have become the primary resource to treat behavioral health conditions. As stated by DeGruy, writing for the Institute of Medicine, “Most people with poor mental health are cared for in primary care settings, despite many barriers. Efforts to provide everyone a medical home will require the inclusion of mental health care if it is to succeed in improving care and reducing costs.” (5) It has been reported that 83% of patients seen in primary care present with complaints that are directly related to a mental health problem. (5) Also, 85% of primary care patients report recurring or chronic depression and/or anxiety. (6) These patients’ behavioral problems are frequently not recognized and they are often treated ineffectively. This widespread lack of diagnosis and treatment contributes to over-utilization and increased health care costs.

Primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs. Depression screening and treatment rely on the chronic disease model. Over the past decade the chronic disease management model has become the most prominent and public practice model that demonstrates the effectiveness of integrated behavioral health care (Von Korff, Gruman, Schaefer, Curry & Wagner: 1997, Wagner, 1997).

Other evidence-based behavioral interventions, such as substance abuse screening and treatment (e.g., SBIRT) or counseling for smoking cessation have also gained traction within medical settings and have contributed more empirical support for integrated care (Addo, Maiden & Ethrenthal, 2011; Barbour et al., 2007; Bodenheimer, Wagner & Grumbach, 2002). (7)

Currently the focus of integrated behavioral health care is shifting from traditional models of diagnosing mental health in primary care to the role of enhancing protective factors in patient functioning, promoting healthy behavior, or preventing poor coping tendencies. The conversations about integrated behavioral health care have expanded from primary mental health to a host of behavioral health approaches such as motivational interviewing, health behavior coaching, team-based care, group visits, self-management, health literacy, and patient activation strategies for “whoever comes to see a doctor.” These developments may be forging a future pathway in integrated care. (7)

As summarized by Maruch and Bartlett,

“Safety net care systems play a large role in serving individuals who are at higher risk for behavioral, mental, and other health conditions and for those who develop chronic conditions. Integrating care effectively in safety net systems ...has the potential to positively impact the health status and life course of individuals and to alleviate the social and economic burden”. (8)

As noted earlier, HRSA SHAP grant funds became available to do an innovative project promoting integrated care in rural health clinics for January through August of 2013. The project was called Behavioral Health Access Plan for the Uninsured (BHAP) and the purpose of the Plan was to increase access to behavioral health services in a primary care setting for uninsured adults with mild to moderate behavioral health problems, and to make possible behavioral change to reduce medical health risks. The strategy was to support sustainable models of integrated care that facilitate access to empirically valid screening, brief treatment and if needed, referral to behavioral health providers or other community resources. Refer to Appendix A for the target population and pilot site selection criteria.

#### Scope of Practice for Selected BHAP Pilot Sites

- a) Utilize at least one evidence-based pathway for a selected mental health diagnosis, either depression or anxiety.
- b) Utilize at least one evidence-based pathway for a substance use issue, either alcohol misuse and/or tobacco cessation.
- c) Provide behavioral health counseling (individual and/or group) that promotes patient engagement and management of a selected medical condition such as obesity, diabetes, or cardiovascular disease.

Six applications were scored. Following written clarifications and questions from the reviewers, then review of applicant's written responses, reviewer consensus was achieved and selection recommendations based on four applications were presented to Ms. Anne Braswell, BHAP grant administrator and ORHCC Manager of the Integrated Health Care Delivery Systems Unit for approval.

The eligible applicants were also asked to complete a modified version of the Maine Health Access Foundation Integration Site Self-Assessment Survey. A review of the literature showed this tool to be capable of assessing several functional aspects of implementing integrated care. As noted by Mary Ann Scheirer, PhD, in the Maine Health Access Foundation report published in 2010:

“The evaluation plan for Maine Health Access Foundation’s (MeHAF’s) Integration Initiative is designed to use multiple data collection methods, in order to provide on-going feedback about the status of implementation, as well as to promote collaboration among the grantee projects and external independent evaluators. A key evaluation question in the plan is, Are grantees implementing the characteristics and components of patient/family-centered integrated care? In order to collect data to address this question, an operational definition of the components of patient/family-centered integrated care is needed, that is, an explicit method to assess and measure these complex components. The MeHAF’s Site Self-Assessment instrument is a method to assess sites’ progress toward implementing patient/family centered integrated care, as well as to encourage on-site staff to reflect on the changes they have made and further changes needed to deliver all components of integrated care. The MeHAF’s Site Self-Assessment instrument was based on format of the Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS) developed by the Diabetes Initiative of the Robert Wood Johnson Foundation” (Brownson, et al., 2007). (9)

Due to the brevity of time allowed for the BHAP project to occur, the MeHAF’s survey tool was modified to address 14 domains vs. 18 domains covered in the original survey. (See attached modified questionnaire as Appendix B).

### C. The Integrated Care Experts

A review of the integrated care literature revealed that implementing an integrated care approach is most successful when a team of experts works with pilot sites. As noted by Benjamin Miller and described in the Core Measures of Integrated Care as defined by the AHRQ Integrated Care Academy:

Integrated Care is administered via a population management approach involving:

- ✓ A practice team tailored to the needs of each patient and situation,
- ✓ With a shared population and mission and,
- ✓ Using a systematic clinical approach (and a system that enables the clinical approach to function).

Supported by:

- ✓ A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care,
- ✓ Practice operational systems and processes, leadership alignment, and business model and,
- ✓ Continuous quality improvement and measurement of effectiveness. (4)

ORHCC contracted with the NC Council of Community MH/DD/SA Programs to secure this expertise. The NC Council engaged three subject matter experts to provide training and technical assistance to the sites through a variety of formats. The Council maintained fiscal responsibility for the subcontracts with the experts and arranged all face-to-face meetings with the practice sites. Refer to Appendix C for integrated care experts criteria. With approval from the North Carolina Office of Rural Health and Community Care, the NC Council subcontracted with the following integrated care experts.

#### **Project Manager**

Dr. Regina Schaaf Dickens, EdD, LCSW, MSW, founder of RSD Consulting, has over 35 years of human resource practice in both the public and private business. Dr. Dickens began working in the integrated care arena in 1993, when she became the corporate manager of Champion International's Employees and Family Assistance Program. She became the Director of ICARE in 2009, an initiative of the NC Foundation for Advanced Health Programs as a collaborative of four core partners: the NC Psychiatric Association, the NC Pediatric Society, the NC Academy of Family Physicians and Southern Regional Area Health Educational Center. Integrated care models, training and technical assistance were developed. A website, [www.icarenc.org](http://www.icarenc.org), was established and public policy changes were implemented as a result of this seminal work.

## **Medical Expert**

Dr. Victoria Soltis-Jarrett, Ph.D., PMHCNS/NP-BC is a Clinical Professor and the Coordinator of the Psychiatric-Mental Health Nurse Practitioner Program at UNC-Chapel Hill School of Nursing. Dr. Soltis-Jarrett is also a Board Certified (ANCC) Family Psychiatric-Mental Health Nurse Practitioner and Clinical Nurse Specialist with over 25 years' experience as a clinician, educator and consultant with research expertise in participatory inquiry and community engagement. Dr. Soltis-Jarrett is a member of the faculty at UNC-CH School of Nursing. She teaches Diagnostic Assessment, Psychopharmacology and The Management of Complex Problems.

## **Coding and Billing Expert**

Emily Hill, PA, President of Hill and Associates, Inc., is a Coding and Billing Professional with over twenty years of experience providing consultation to a variety of medical and behavioral health practices in developing appropriate billing, coding, and documentation policies and procedures to improve their financial performance and ensure compliance with coding and billing guidelines. She provided the original ICARE Partnership and the NC Center of Excellence for Integrated Care regular updates of guides for billing and coding for all types of third party payers.

## **NC ORHCC Primary Care Behavioral Health Specialist**

In addition to the experts hired through the North Carolina Council for Community Programs, Ms. Ellen Mrha, MSW, LCSW provided consultation and technical assistance for implementing standardized care pathways based on the scope of practice each site chose. She also provided lists of resources to assist in implementing standardized care pathways. Each resource was reviewed by the team of experts and belongs to the public domain. A list of the standardized care pathways and resources is included as Appendix D.

## **SECTION THREE: Pilot Site Profiles**

The following was gathered from the information each site submitted in applying for this grant, including responses to the Integrated Care Practice Survey. Additional information was gathered from an initial site assessment completed within the first three months of the grant period.

### **Franklin County Health Department**

NC ORHCC contracted with the Franklin County Health Department to implement the BHAP project at the Franklin County Volunteers in Medicine Free Clinic (FCVIM). FCVIM had an established collaboration with the Franklin County Health Department for fiscal management and clinic space. The Director of FCVIM and the Director of the Franklin County Health Department jointly submitted the BHAP application.

#### Franklin County Volunteers in Medicine Care Clinic (FCVIM)

This site is a free clinic serving approximately 1,000 uninsured patients annually. Grant sources have included ORHCC, Cardinal Innovations Healthcare Solutions Five County Community Operations Center, Franklin County Health Department (in kind), NC Farm Bureau, NC Blue Cross/ Blue Shield, the Duke Endowment, United Way, local and Federal Faith Based funding, and other specific local grants for identified projects. They collaborate regularly with the Health Department, the Mental Health Managed Care Organization (MCO), and local dental, vision and specialty care providers for referrals.

The Clinic was using Allscripts Pro for some office functions and e-prescribing. The Clinic upgraded the electronic health record in August to a more robust reporting system. FCVIM was involved in a data project sponsored by North Carolina Blue Cross/BlueShield, and they were able to track patient specific data similar to what is expected for ‘meaningful use’ of electronic health records. The primary focus of this data project was upon COPD, diabetes and hypertension. The clinic is enrolled in ORHCC’s Medication Access and Review Program (MARF) and tracks data through that reporting system. While it is not billing for services it is able to code patient encounters.

The BHAP project involved hiring a licensed clinician who worked with the Clinic’s RN medical coordinator, certified medical assistant, physician assistant and the medical director. Of note, the medical director at this clinic treats patients with identified pain management issues using a step-wise protocol and provides Suboxone treatment.

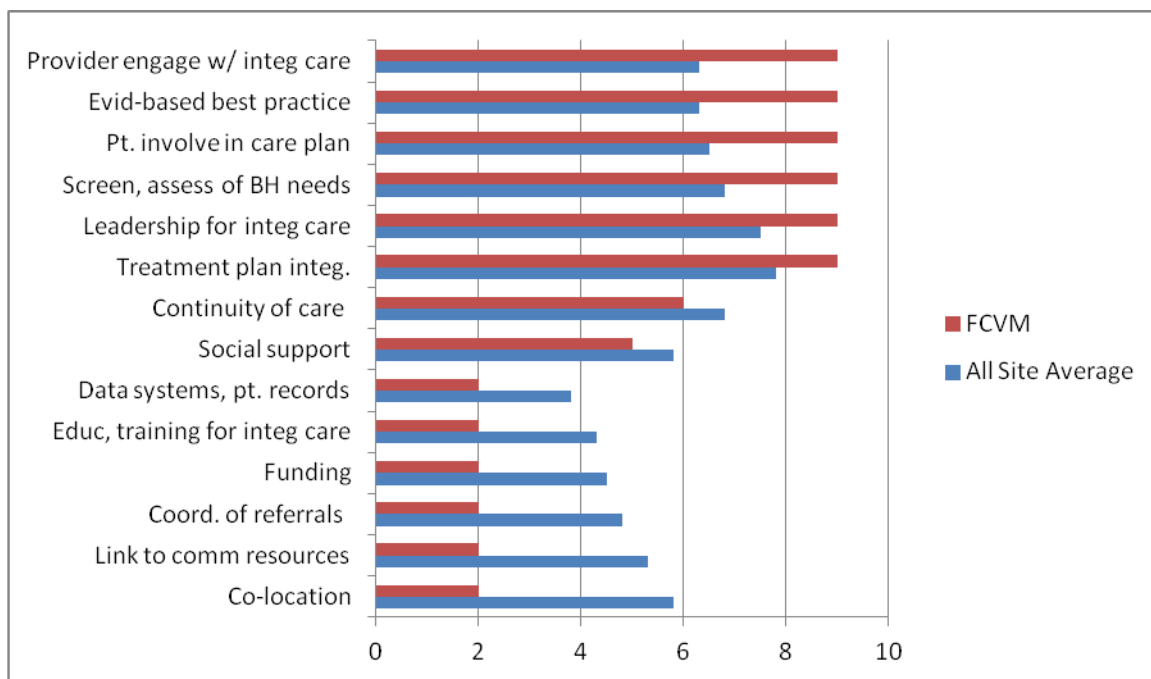
During the grant period, the state Department of Commerce reclassified Franklin County from a Tier 2 moderate economic distress county to a Tier 3 county, indicating no/mild distress, due to the effect of the growing, more affluent southern part of the county, which borders Raleigh.

However, the middle and northern sections of Franklin County remain very economically distressed with high concentrations of uninsured, indigent residents. These residents are typical of FCVIM patients, including a notable portion of the uninsured Latin American population in the region.

FCVIM Results of pre-BHAP Integrated Care Site Self-Assessment Survey

FCVIM’s Pre survey ratings are graphically presented below. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support). Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post ratings.

Figure 1. FCVIM Pre-BHAP Integrated Care Self-Assessment Ratings



There was a great deal of variance in how FCVIM staff viewed their integrated care readiness, even when their ratings are viewed *within* each of the two survey dimensions. Their ratings were significantly higher or lower than the all-site averages. This variance is reflective in part of the funding and staffing instability that plagues free clinics. FCVIM did have a Behaviorist prior to BHAP but only for about four hours one day a week. Thus, there was minimal co-location. The relative absence of a behavioral health provider in the day-to-day operations of the clinic was somewhat compensated by the Clinic’s director whose social work background included behavioral health experience and skills. She has an established history of promoting integrated care and collaborating with local and state partners. In addition, the medical director had already

implemented standardized care pathways to promote patient’s psychological and physical health while treating a variety of health conditions. The leadership at this clinic is reflected in the leadership rating of 9. It is interesting to note that despite their perception of a minimal level of co-location, FCVIM staff rated the standardization of screening and assessment protocols, treatment plan(s) integration, and the integration of evidence-based guidelines into practice so highly. These items were rated one or two points lower in the Post-BHAP survey, suggesting the staff acquired a more expanded view of the domains integrated care involves. The high rating for patient/family involvement in care plans is more readily understandable; Collaborating with patients and family members on what they can do to help themselves given their strengths, resources and barriers is an integral value and practice at FCVIM.

Linkage to community resources was rated in the middle of the scale; the impression of some of the BHAP TA Team was that linkage occurred on a crisis basis but frequent staffing shortages and turnover meant referral and linkage was neither organized nor routine. Staff portrayed case management as spotty and post-referral follow-up as minimal.

The medical director and other staff frequently attempted to engage the local behavioral health publically funded system with unsatisfactory results, which likely fueled the FCVIM rating of coordination of referrals for behavioral health as a 2.



## **Martin-Tyrrell-Washington District Health Department (MTW)**

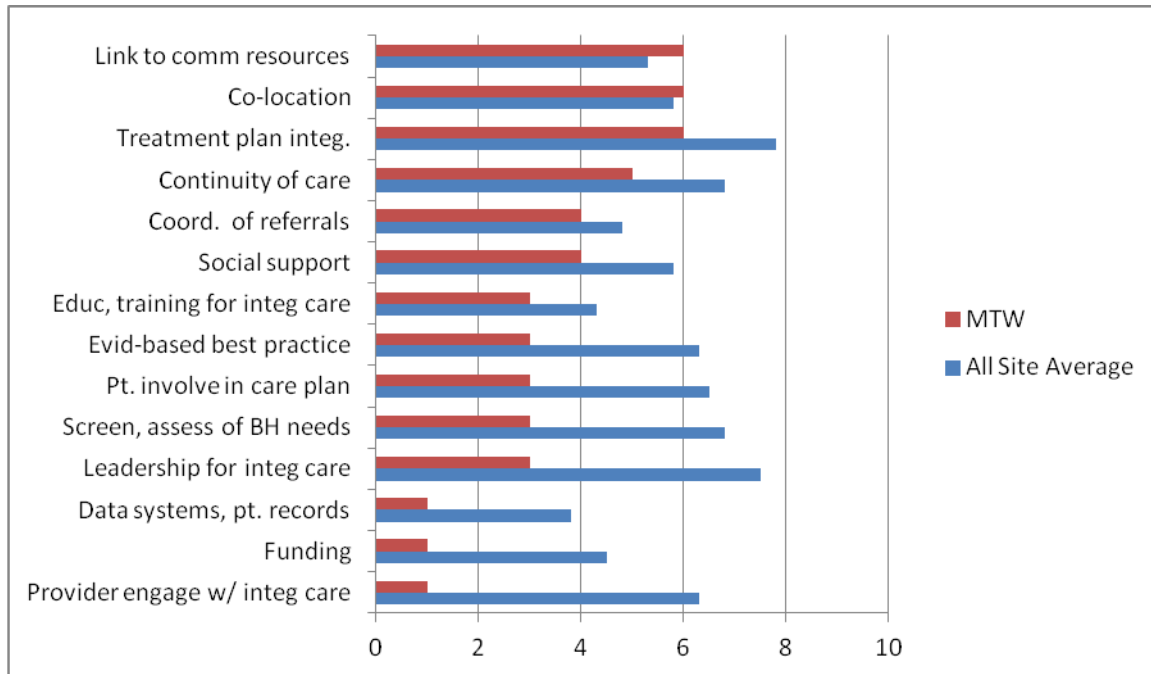
This site is a multi-county health department with the central office in Plymouth. They serve over 2,100 patients annually in the three counties. Funding is provided through state and county dollars, grants from ORHCC, Kate B. Reynolds and contracting with East Carolina Behavioral Health. The clinics bill Medicaid, Medicare, private insurance and patient self-pay. They are co-located with the local mental health provider who offers emergency crisis services on site in the Martin County clinic. The behavioral health provider offers services on a rotating basis at all sites. The Health Department is a Community Care of North Carolina (CCNC) provider and offers Pregnancy Home Care and Care Coordination for Children (CC4C) services to young children and families. They also participate in the Medication Access and Review Program (MARF). They do not have electronic health records currently, so all tracking is done manually. They are using eScripts for electronic prescribing.

The BHAP project partially funded three Nurse Practitioners, one of whom was the identified lead integrated care champion. The clinic's RN was the primary liaison for reporting data to NC ORHCC and coordinating tasks required to complete the project. The clinics' coding and billing contract person also participated in full day training and received individualized consultation with BHAP's coding and billing expert. The behavioral health provider is supported in part by a Kate B. Reynolds' grant, which is a collaborative effort between the health department and the local Managed Care Organization (MCO). She provides individual and group counseling, coordinates and supervises peer support services. In addition, this health department has a bi-lingual, licensed clinical social worker who serves patients in the obstetrics and gynecological clinic. Her position is supported by the local Community Care of North Carolina Child Care for Children (CC4C) program.

### MTW Results of pre-BHAP Integrated Care Site Self-Assessment Survey

MTW's Pre survey ratings are graphically presented below as Figure 2. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post ratings.

Figure 2. MTW Pre-BHAP Integrated Care Self-Assessment Ratings



MTW perceived their agency as having non-existent or minimal resources or capabilities on nearly every one of the 14 survey items, despite being co-located with the local mental health provider agency. They assigned the lowest or second-lowest level rating to every item compared to the other three pilot sites. MTW accounted for 8 of the Pre-survey total of ratings in the 1-3 range (57%). The starkest difference in ratings between MTW and the other sites is evident in the areas of screening/assessment, evidence-based practice, and patient/family involvement in care plans and particularly in 5 of the 7 items comprising the Organizational Supports for Practice Change toward Integrated Services dimension.

MTW represents three fairly disbursed and distinct service sites. Cross-staff interaction is very difficult and thus infrequent. It is difficult to ascertain the degree to which the resultant lack in centralized, standardized clinical protocols and practice management across MTW influenced their Pre-BHAP perspectives of their lack of integrated care readiness. When the Post-BHAP survey results are presented, the reader will learn, however, that the BHAP TA Team interventions facilitated a notable amount of MTW staff dialogue, coordination and cross-fertilization of screening and treatment protocols. The grand average of MTW’s ratings increased 57%, from 3.50 to 5.50.

## **Polk County Community Health and Wellness Center, Inc. (PWC)**

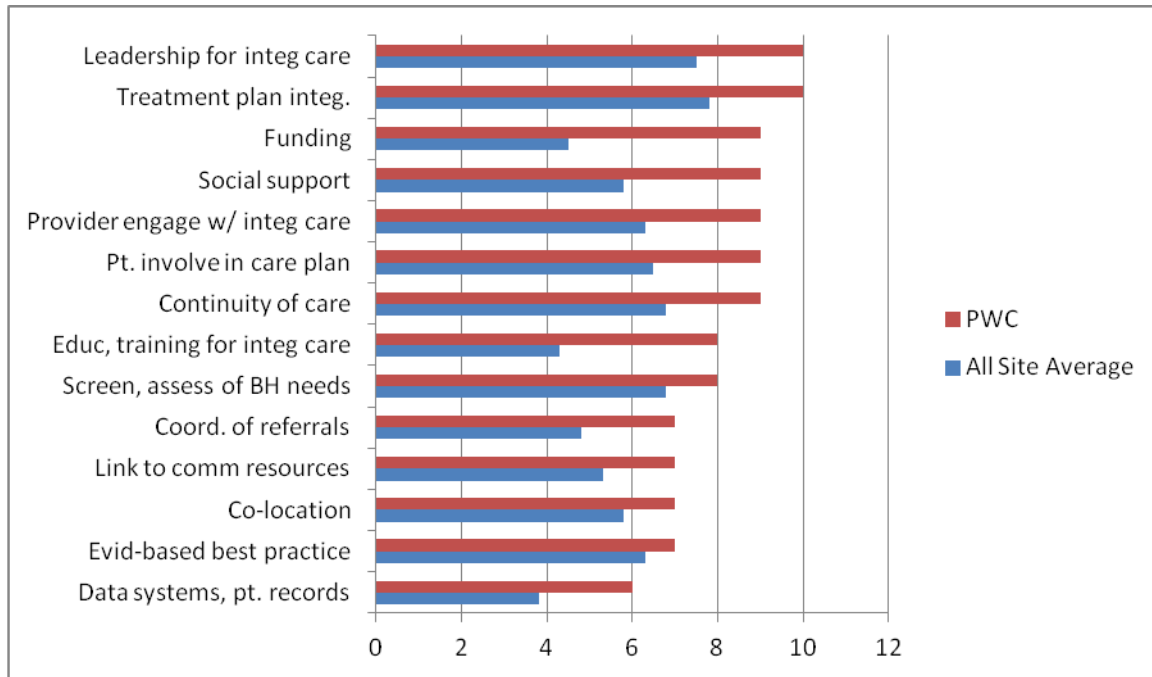
This site began as a behavioral health provider and added medical services in a co-located facility in Columbus. They serve approximately 500 adults and 100 children annually. PWC has a variety of funding sources including contracts with the local behavioral health MCO (changed mid-project from Western Highlands to Smoky Mountain) to provide facility-based crisis services and other outpatient care for psychiatric patients in the region, local and state grants. They bill Medicaid, Medicare, private insurance and patient self-pay. They also bill the MCO for qualified indigent behavioral health consumers. The site already used an electronic health record and was in the process of moving to another product during the time of the project. Allscripts was in place. They have a data tracking system and are able to extract monthly reports. PWC is a contracted CCNC provider. They work closely with other community health care and support organizations for health promotion and have an active referral network. The Center provides Employee Assistance Program services to some employers in the county.

The Polk Center Director and integrated clinical coordinator, both licensed mental health clinicians, served as project managers for the grant. The clinic has a Physician Assistant providing the medical leadership and direct patient care. The clinic has a total of five licensed behavioral health practitioners, a certified coding and billing specialist and they recently added a certified diabetes specialist to their team.

### PWC Results of pre-BHAP Integrated Care Site Self-Assessment Survey

PWC's Pre survey ratings are graphically presented below as Figure 3. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support). Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post ratings.

Figure 3. PWC Pre-BHAP Integrated Care Self-Assessment Ratings



PWC, having started as a behavioral health provider and being ideologically committed to integrated care, had the highest pre-BHAP self-ratings of the four pilot sites by a significant margin. Polk accounted for 53% (9 of 17) of the 8-9-10 range of scores. Uncharacteristic of the other sites, PWC staff rated their funding resources and billing very highly. This can probably be attributed in part to a strong relationship with their regional behavioral health MCO, who provides funding to PWC for indigent patients needing behavioral health services. PWC staff also perceived themselves as actively supporting staff education and training about integrated care and evidence-based practices.

## **Community Clinic of Rutherford County (CCRC)**

CCRC is a Federally Qualified Health Center “look-alike” Rural Health Center. Historically their mission has been to provide services to underinsured populations in the county. They began as a free clinic and began billing in 2012 and tracking data as required of FQHC sites. They work closely with a local substance abuse provider in a co-located facility. The clinic serves approximately 2,500 patients annually. Funding comes from ORHCC grants such as MARP, contracts with the regional behavioral health Managed Care Entity (MCO) (Western Highlands became Smoky Mountain mid-project), and direct billing to Medicaid, Medicare, private insurance and patient self-pay. Their electronic health record is Centricity and they were in the middle of an upgrade during the project. Behavioral health records are not integrated into the system and tracking had to be done manually. Tracking of medical data was available via Crystal Reports.

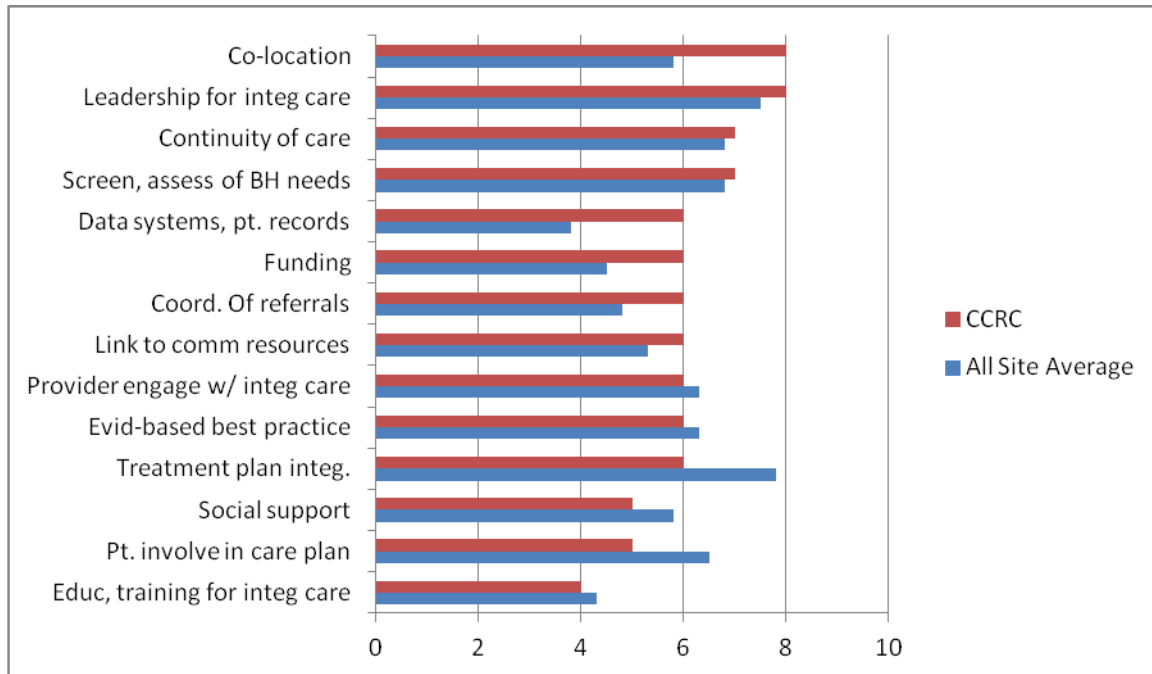
The Development Manager wrote the proposal for the site and served as contact in collaboration with the lead RN who was also the quality assurance contact. The grant supported funding for two licensed behavioral health clinicians to provide integrated care and behavioral services. The clinic also has a Physician Assistant who served as medical champion for the project. During the project, the clinic moved to an expanded facility with nine clinic rooms staffed by thirteen primary care providers. A Registered Dietician was hired near the end of the project. The clinic staff has been successful in developing a network of specialists who offer on-site services as volunteer providers.

The community as a whole has supported the concept of integrated care in the past. CCNC case managers are housed in the clinic as well as a Family Preservation Service and a behavioral health peer support program. Much emphasis has been placed upon the site to become a Patient Centered Medical Home and a full FQHC. Tele-psychiatry is beginning and CCRC is a partner with CCNC in a communication pilot project.

### CCRC Results of pre-BHAP Integrated Care Site Self-Assessment Survey

CCRC’s Pre survey ratings are graphically presented below as Figure 4. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support). Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post ratings.

Figure 4. CCRC Pre-BHAP Integrated Care Self-Assessment Ratings



CCRC had an independent co-located behavioral health provider before BHAP, which is reflected in the highest rating for that survey item. Although most of their ratings were in the middle of the scale, overall, their total score and average was second highest. CCRC staff rated their data system as a bit above average but the CCRC behavioral health staff did not have computer access until after the BHAP midway point. Gathering BHAP encounter data was very time consuming and labor intensive. Although CCRC leadership were rated as significantly supportive of integrated care, behavioral health staff were accustomed to a traditional practice style of delivery (e.g., psychodynamic therapy, 50-minute hour) which is reflected in the rating of 6 for Provider’s engagement with integrated care.

## **SECTION FOUR: Overview of Technical Assistance Provided By Experts**

**Project Manager Accomplishments:** Dr. Dickens fulfilled the following contract deliverables:

She developed a project management plan within the first 45 days with target dates/timelines for the completion of each segment of the project. These segments included completing initial individual site analysis of staff training and technical assistance needs, providing a sequential approach to training for the four sites as learning collaborative. The segments also tracked the work with each site to develop a specific coaching/TA plan, onsite assessment of policies and medical records, and designed a report format that tracked project progress and met the expectations of the funder. Dr. Dickens worked with other BHAP TA Team members to assign roles and responsibilities for each segment of the project.

Dr. Dickens established a training/consultation schedule in collaboration with BHAP TA Team members and pilot sites. After initial site visits/phone conferences it was determined that training would best be delivered to two eastern and two western cohort sites. Budgets and staff resource constraints at the sites did not allow for extensive travel and time away from the clinics. The BHAP TA team negotiated:

- a. Four full day formal trainings for the site learning cohort groups. The content included basic screening, brief intervention, medication management, and referral to treatment models for the clinical practitioners, and coding and billing for all staff and quality improvement techniques. Content will be further described below.
- b. The pilot site staff determined the best format and frequency for follow-up training/ mutual learning through conference calls, site visits and webinars.
- c. Each site developed a coaching/ TA plan for ongoing consultation with the project manager and content experts. Staffing turnover and role redefinitions occurred at all sites as the project moved from inception to implementation. The process was fluid and change in the processes was unique to each site. These experiences will be more fully described in following sections from the perspective of clinical, coding and process change.

Dr. Dickens developed agendas for the BHAP TA Team to track and evaluate progress. These meetings occurred more frequently in the beginning of the project using a PDSA approach to identify and manage barriers to implementation of integrated care process change. ORHCC staff worked directly with the project sites to define, capture and report monthly behavioral health encounter data.

Dr. Dickens developed a plan for ongoing process evaluation for the pilot sites, including a combination of needs assessment tools, verbal and written responses to training and technical assistance events.

She provided direct linkages to the Managed Care Organizations (MCOs) responsible for Medicaid and indigent mental health care for each project site. A representative from each MCO

was invited to participate in initial formal training and one MCO attended the final wrap-up session. It must be noted that during the course of the project significant changes were occurring with the MCOs across the state. Individual sites had varying levels of direct contracting with the MCOs in their region. In one case, the behavioral health MCO managing the area covered in the Western cohort was taken over by another MCO.

### **Medical Expert Accomplishments**

Dr. Soltis-Jarrett provided training, consultation, and TA to pilot sites on screening, treatment, and clinical practices in integrated care. The services were provided through formal training, a series of learning collaborative conference calls/webinars, telephonic lunch and learn sessions and individualized TA by telephone/email as needed. She worked directly with the Project Manager, ORHCC staff and other consultants to coordinate a single, sequentially designed training/TA plan.

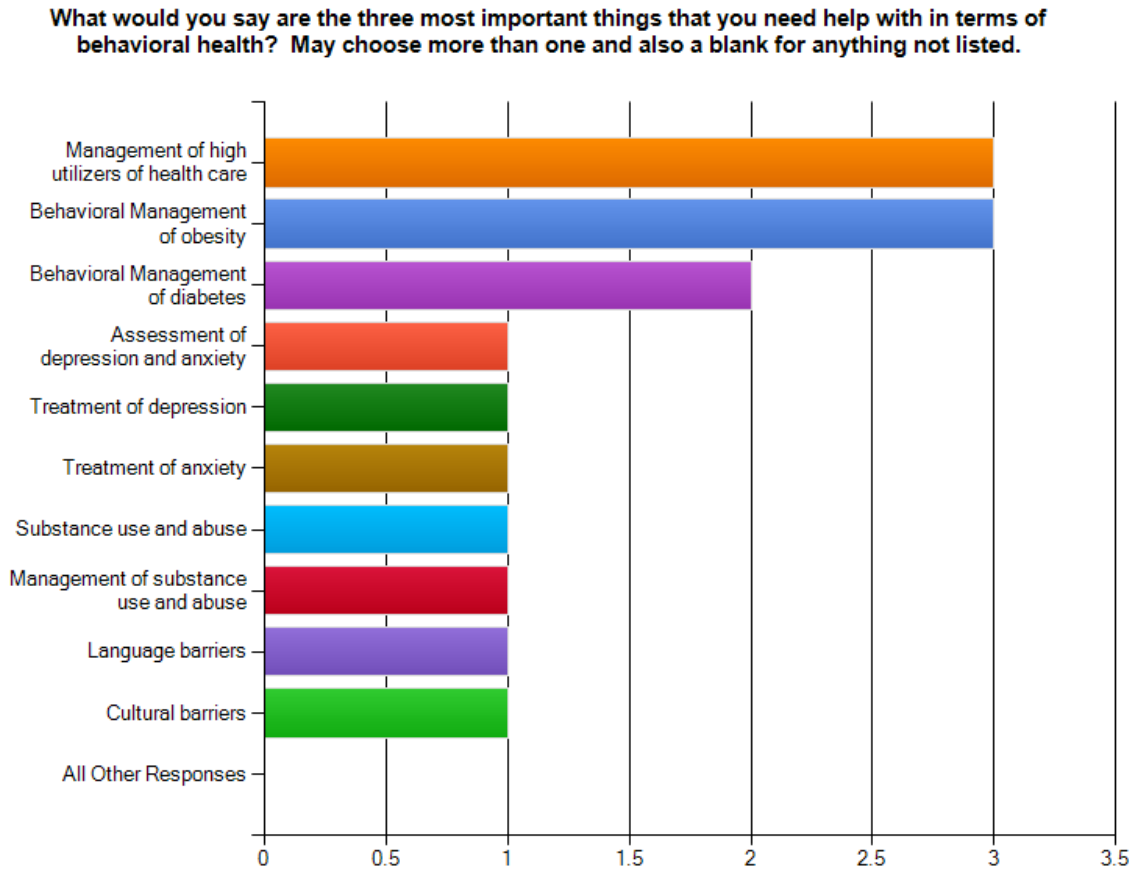
The delivery of clinical information occurred in two waves of workshops in each region as well as a series of teleconference peer-to-peer sessions throughout the project course. The first wave was a general workshop held in the beginning of the project and then a follow-up workshop was held 4 to 6 weeks later. It was important to ensure that the sites had enough clinical information and guidance to be able to initiate and sustain their integrated care pathways. Concepts of integrated care were articulated during the two workshops and then the participants were assessed for their ability to understand and integrate the knowledge into their practices. Specific clinical concepts were addressed both in the second workshops and during the peer-to-peer teleconferences. The process of assessment, planning and implementing the clinical portion of the BHAP are briefly described below.

#### **Step One: Needs Assessment**

In order to determine the learning needs of the BHAP sites, Dr. Soltis-Jarrett designed and implemented a needs assessment questionnaire. This assessment was sent via Survey Monkey (email) and disseminated in hard copy form to each of the identified "champions" at each site at the beginning of the project. All champions responded from each site. An example of a question was: "*What would you say are the three most important things that you need help with in terms of behavioral health?*" The champions identified management of: (a) high utilizers, (b) obesity and (c) diabetes as the top three learning needs followed by the assessment and treatment of depression and anxiety. The majority of the respondents (60%) reported that they had familiarized themselves with some clinical pathways in the past, but agreed that they were in need of additional assistance with implementing.



Figure 5.



### Step Two: Addressing the individual needs of the prescribers

Each BHAP site had a different prescriber and level of experience working with behavioral health diagnoses and management of psychotropic medication. The eastern region had three Family Nurse Practitioners (and one Midwife) and the western region had one Physician's Assistant who had no experience in psychiatric-mental health. During the time of this project, the prescribers also varied in their attendance at the teleconferences and at one site (east), the FNP resigned, leaving the Family Practice Physician as the sole prescriber. Peer- to- peer teleconference sessions were planned at the discretion and need of the sites. Initially the eastern region sites requested biweekly sessions of one hour each whereby a case was presented and discussed. Staff members at each BHAP pilot site were invited and some non-prescribers did attend and participate. Seven peer- to- peer teleconference sessions were scheduled and only one was cancelled.

### Step Three: Evaluation

Evaluation of the material covered and whether it was integrated was ascertained through online Survey Monkey questions and hard copy evaluation forms after the workshops. Both the east and west regions (all sites) completed evaluations for the clinical portion of the workshops. The surveys were designed to assess knowledge and application using a 4-point Likert scale (completely understood to not at all) and sought to measure the participant's perceptions of the eight broad clinical areas presented during the workshops.

#### Eastern Region

Overall, the participants (n=6) who attended the workshops from the eastern region (MTW & Franklin) reported that they were 'mostly' able to: *completely* describe and understand the concept of a clinical pathway (50%); yet were less confident (*somewhat*) about being able to identify the steps to implement a clinical pathway at their individual site (50%) and/or have a working knowledge of the screening tools to be used in primary care (33%). The majority of the participants were able to: *mostly* identify the three phases of assessment and treatment of depression/anxiety in primary care (50%); the different types of antidepressants (50%) and the adverse effects (66%), which they acknowledged is essential information for everyone on the treatment team. In addition, a follow up needs assessment question asked what, if any, clinical information would be useful for them. The majority of the respondents reported that they wanted more psychopharmacology (80%) and diagnostic reasoning (50%).

#### Western Region

Overall, the participants (n=10) who attended the workshops from the western region (Rutherford and Polk) reported that they were able to: *completely* describe and understand the concept of a clinical pathway (80%); identify the steps to implement a clinical pathway at their individual site (50%) and *mostly* have a working knowledge of the screening tools to be used in primary care (60%). The majority of the participants were able to *completely* identify the three phases of assessment and treatment of depression/anxiety in primary care (70%); the different types of antidepressants (50% *mostly*) and the adverse effects (50%), which they acknowledged is essential information for everyone on the treatment team. The participants reported a split view of whether the information that they gleaned from the workshop "will assist me in my work" with 50% acknowledging that they were *completely sure* and 50% reporting that they were *somewhat* sure. In addition, a follow up needs assessment question asked what, if any, clinical information would be useful for them. The majority of the respondents reported that they wanted more information on the management of somatic symptoms (75%), psychopharmacology (50%) and malingering (50%).

## **Coding and Billing Expert Accomplishments**

Ms. Hill provided training and TA regarding the use of CPT codes, bundled and fee-for-service billing approaches. She also offered on-site record review and feedback. She worked with the Project Manager and ORHCC staff to develop a feasibility plan for group visits and for the expansion of preventative screening services. The services were provided through formal training, a webinar, and on-site sessions and individualized TA by telephone/email as needed. She worked directly with the Project Manager, ORHCC staff and other consultants to coordinate a single, sequentially designed training/TA plan.

As a first step, Ms. Hill presented an overview of the coding and billing issues affecting integrated care practices during the initial meetings with the grant sites. The behavioral health screening codes recognized by Medicaid and Medicare were emphasized as a means to track screening efforts and identify those individuals who may benefit from behavioral health services. A handout was provided that identified the screening codes, reimbursements, eligible providers, and any special provisions for both Medicaid and Medicare reporting. This handout was updated toward the end of the grant period to incorporate new information and an increased focus on RHC and FQHC settings.

Sites were encouraged to incorporate the available screening codes into services provided to all patient populations. However, the BHAP TA Team recognized that each site needed to define its goals and approaches before fully utilizing the coding and billing expertise offered by Ms. Hill.

Ms. Hill requested coding and billing data from each site and phone conferences with billing and coding personnel. The purpose of the data was to provide a mechanism to compare current coding activities to expected coding patterns for primary care and behavioral health practices and thereby identify potential billing opportunities. The data also could be tracked to assess screening practices and incorporate coding into the clinical plan for each site. The requested data was not received from any site. Further, the sites' utilization of technical assistance for coding and billing issues was more limited than the BHAP TA Team expected and desired. There are several potential reasons for this including the limited involvement of the identified coding and billing staff in the overall project, limitations of the sites' practice management systems, and internal practice issues. The focus of the grant on the uninsured may have caused sites to minimize the importance of the coding and billing aspects of integrated care. In addition, the project duration may not have provided ample time for sites to translate the clinical goals and activities into the practice management aspect of the operations.

The BHAP TA Team determined that a coding and billing webinar that could be archived for future reference was an important practice tool. A webinar was presented in early August.

Following the webinar, a Frequently Asked Questions document was created based on questions from the live webinar and Ms. Hill's experiences with coding in integrated practices.

#### Coding and Billing: Polk Wellness Center

As a mental health organization incorporating medical services, the coding and billing challenges at Polk primarily involved medical services. The group was familiar with reporting mental health assessment and therapy codes for behavioral health providers but the incorporation of medical services into a behavioral health model was more challenging.

A conference call was held in late June with the clinical coordinator and the coding specialist for the clinic. The majority of questions and concerns were centered on the reporting of physical and behavioral health services on the same day. In most instances, the site was having patients return on different days for their medical and behavioral health care to ensure reimbursement of both services. This limited the number and types of screening services the practice was reporting and/or accounting for within its billing practices. As part of this concern, the practice was under the impression that Physician Assistants could not be enrolled with Medicare and bill services directly. Ms. Hill provided information on Medicare enrollment for Physician Assistants and addressed the importance of billing under each provider's individual provider numbers to facilitate payment of multiple services on the same day. The practice was encouraged to contact Ms. Hill once clinical and billing processes were revised.

#### Coding and Billing: Franklin County Volunteers in Medicine Care Clinic (FCVIM)

FCVIM expressed an interest in early summer for a face-to-face meeting to discuss coding and billing questions and discuss potential coding options for various models of care and provider types. Several dates were offered in June and July but due to internal practice issues, the meeting was not held until the end of August.

Clinic administration, members of the clinical and coding staff, and the medical director, met with Ms. Hill at the FCVIM location. At the meeting, approaches to coding and reimbursement for diabetes group sessions implemented as part of the grant process were discussed. The opportunities for clinical staff to facilitate the implementation and billing of screening services as well as other billing opportunities for nursing and pharmacy staff were also discussed. Follow-up information was sent to the practice on coding and documentation requirements for Evaluation and Management Services reported by the medical director and the 2013 CPT changes for psychiatric services.

#### Coding and Billing: Martin-Tyrrell-Washington Health District (MTW)

Ms. Hill made multiple direct contacts with MTW billing staff offering assistance. All offers were declined until receipt of a billing number from Medicaid for the LCSW. At the request of MTW administration, Ms. Hill met with coding and billing staff at its location in Plymouth at the end of August. Coding personnel stated they were not aware of screening services implemented by clinical staff and further indicated they had limited contact with clinical staff at other practice locations. Coding opportunities for reporting screening services were reviewed with an emphasis on the clinical goals set for this project. Coding personnel indicated they were unaware of available screening codes, Medicaid, and Medicare coverage policies. A clinical staff member joined the discussion to discuss current screening activities and approaches for capturing applicable billing codes. Following the on-site meeting, Ms. Hill emailed copies of all coding and billing information that had previously been sent to all pilot sites.

#### Coding and Billing: Community Clinic of Rutherford County (CCRC)

Direct contact with CCRC was limited to the initial group meeting in the western region and subsequent email communications. Although CCRC staff did not respond to the offer for conference calls or on-site meetings, they reported incorporation of the coding and billing information into the practice.

#### Coding and Billing Summary

In retrospect, strengthening the role and responsibilities of the coding and billing staff in the implementation process would have been advisable. The attachment of specific coding and billing activities to each proposed clinical goal would have been beneficial and encouraged a team approach to integrated care.

## **SECTION FIVE: Site Process Change and Review of Performance Measures**

### **FRANKLIN COUNTY VOLUNTEERS IN MEDICINE (FCVIM)**

#### **Analysis of FCVIM BHAP Patient Encounters**

FCVIM saw 21 BHAP patients, all of which received at least one type of screening at their first visit along with medication management and care coordination. One-third received behavioral health counseling at the first visit. The average number of visits during the grant period per BHAP patient was 2.5

#### **FCVIM Performance Measures**

**Track uninsured patients served.** All patients served met the BHAP Project criteria. Staff tracked the number of patient visits. The data was captured through use of the Allscripts EHR. An upgrade to the system was completed at the end of August.

**Hire .5 FTE for project.** The Behaviorist provided hours representing 0.55 FTE.

**Increase screening and treatment for tobacco use.** All patients are being screened and positive screens added to Patient Problem List in medical records. In addition, front desk staff and the Medical Assistant now administer the screening at intake. Pharmacy is stocking patches currently.

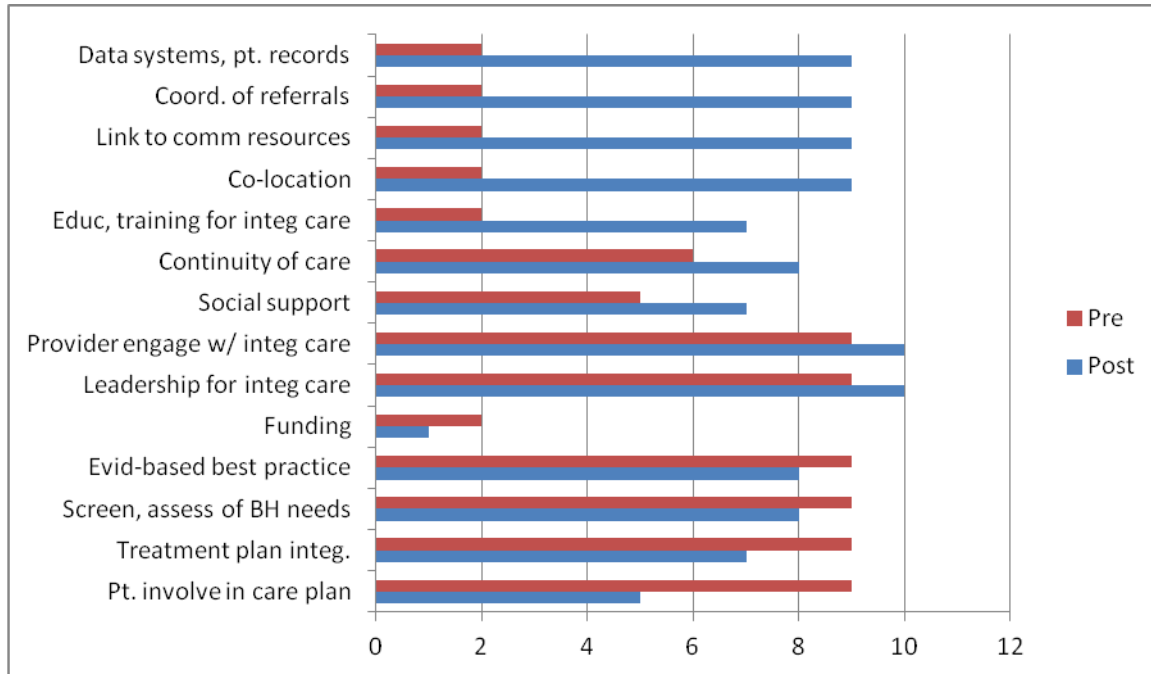
**Improve screening and treatment for depression.** 100% of patients in the Diabetes Project are being screened with the PHQ 9 depression inventory. An anxiety inventory was administered as part of the patient intake process. The clinic expanded the use of screening tools to all patients with clinical staff administering the screens prior to the PCP encounter.

**Increase patient education and self-management of diabetes.** FCVIM staff created three study groups; two were initially scheduled to meet monthly from April through August and one control group of patients with diabetes who would not receive specialized interventions beyond regular individual medical visits. There will be a hemoglobin A1C follow-up in 3 months to determine outcomes of the group interventions. Groups were late starting due to staff turnover and issues with the meeting site. Patients expressed a strong desire to continue the group visits after the project and this will occur. Patients and staff see the need to include a caregiver component within the education/support groups in the future. BMIs are now being tracked for all patients.

## FCVIM Changes in the Integrated Care Site Self-Assessment Survey

FCVIM’s Pre- versus Post-BHAP survey ratings are graphically presented below. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support). Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post ratings.

Figure 6. FCVIM Pre- versus Post-BHAP Integrated Care Site Self-Assessment



FCVIM experienced the largest change in ratings of the four pilot sites – a 30-point improvement. The grand average of their ratings increased 2.14 points, from 5.50 to 7.64. A cluster of perceptions that are part of the Organizational Supports for Practice Change Toward Integrated Services dimension showed the greatest improvement; these included data systems and education and training. The third element, coordination of referrals for behavioral health care, was accompanied by an equally dramatic change in a thematically related perception, linking to community resources. The big changes in these last two items are likely best explained by another dramatic improvement in co-location. With BHAP financial assistance, the behaviorist significantly increased his hours and collaborated with Clinic leadership to effect operational and clinical service improvements within the emerging integrated care model. A modest but meaningful gain in continuity of care between primary care and behavioral health provision was subsequently noted. The renewed synergy amongst Clinic staff led to the start of weekly team meetings about integrating care. These meetings, several of which were attended by a BHAP TA

Team member, coupled with TA Team interventions, resulted in a re-assessment by FCVIM staff about their pre-BHAP ratings for integration of treatment plans, screening and assessment of behavioral health needs, and integration of evidence-based practice. These three elements were rated lower at Post time, but the most dramatic “recalibration” occurred for patient/family involvement in care planning. The Director explained that once the staff consistently met, they focused on building operational consistency. As a result, they did more work to address the elements rated lower on the post survey.

### **FCVIM Future Vision**

FCVIM submitted a grant proposal to Kate B. Reynolds to expand and refine their diabetes self-management and shared medical visits initiative. A challenge they face is the fact that Franklin County had been moved into the Tier 3 (low-need) state economic distress category due to the close proximity to the Raleigh/ Wake County area. However, for 2014, Franklin has been reclassified as a moderate level Tier 2 county. This will again make county providers like FCVIM eligible for many more grant opportunities. The population served by the Clinic is much more reflective of Tier 1 counties with regard to the rural distribution of households, the low-income levels of patients, and the number of Hispanic families who seek treatment. Therefore, this re-designation, while helpful, may still put them at a disadvantage for receiving foundation and other grant funding.

In the interest of rebranding FCVIM and through the support of their BC/BS grant, FCVIM has a commitment from a professional marketing company to help develop a marketing plan. The Catch a Fire project will offer 50 hours of on-site consultation to develop a multi-media approach. The staff has begun spending time identifying their target groups and designing the unique messages for each. They have identified the local hospital as the first strategic partner.



## **MARTIN-TYRELL-WASHINGTON HEALTH DISTRICT (MTW)**

The three clinics (plus one limited hour satellite) are unique in the services and supports available in each county. The teams worked fairly independently regarding the roll out of screening tools and practice change. They quickly agreed that any screening and intervention protocols would be made available to all patients, not just those who fit the BHAP criteria. This level of practice change had an immediate buy-in and there was widespread adoption.

### **Analysis of MTW BHAP Patient Encounters**

MTW saw 232 BHAP patients. The Washington clinic staff saw 131 of them and provided at least one type of behavioral health screening to 45%. Approximately 20% received behavioral health counseling and medication management at the first visits, as did the 46 patients at the Tyrrell clinic. Of the 55 BHAP patients attending the Martin clinic, 46 of them received at least one type of behavioral health screening and about the same number received counseling, medication management and patient education at their first visits.

### **MTW Performance Measures**

**Track uninsured patients served.** Because there is not an EHR system to collect data consistently, each site developed a process for reporting and collated the data. They worked closely with ORHCC and successfully transmitted data.

**Hire .35 FTE for project.** The team made necessary changes in timesheets for tracking purposes. Their commitment to the project grew to include a portion of five staffs' time on a regular basis – above .35 FTE. Most of the screening tools and process changes have occurred with all patients across MTW panels.

**Track number of diabetes management sessions held.** The Diabetes Educator became actively involved in the project. The teams are now providing more referrals to her service as a result of facilitation provided by the BHAP TA Team. She has held both individual and group sessions with identified patients. She and the behavioral health specialist have held four joint sessions. Patients are having hemoglobin A1C draws done in-house and medication changes are done at the time of their visits. Incentives for patient engagement are available through other grant money and include gas cards and arrangement of public transportation as needed. Those funds will end with the grant. The lead Nurse Practitioner attempted to develop a group in Oak City and met several barriers. She has gone forward with her project by identifying patients with high hemoglobin A1Cs and provides counseling on diet, exercise and lifestyle change. She makes telephone contact to recruit and to follow-up. Letters are sent to patients regarding follow-up concerns. Patient fees increased in July making extra visits less appealing.

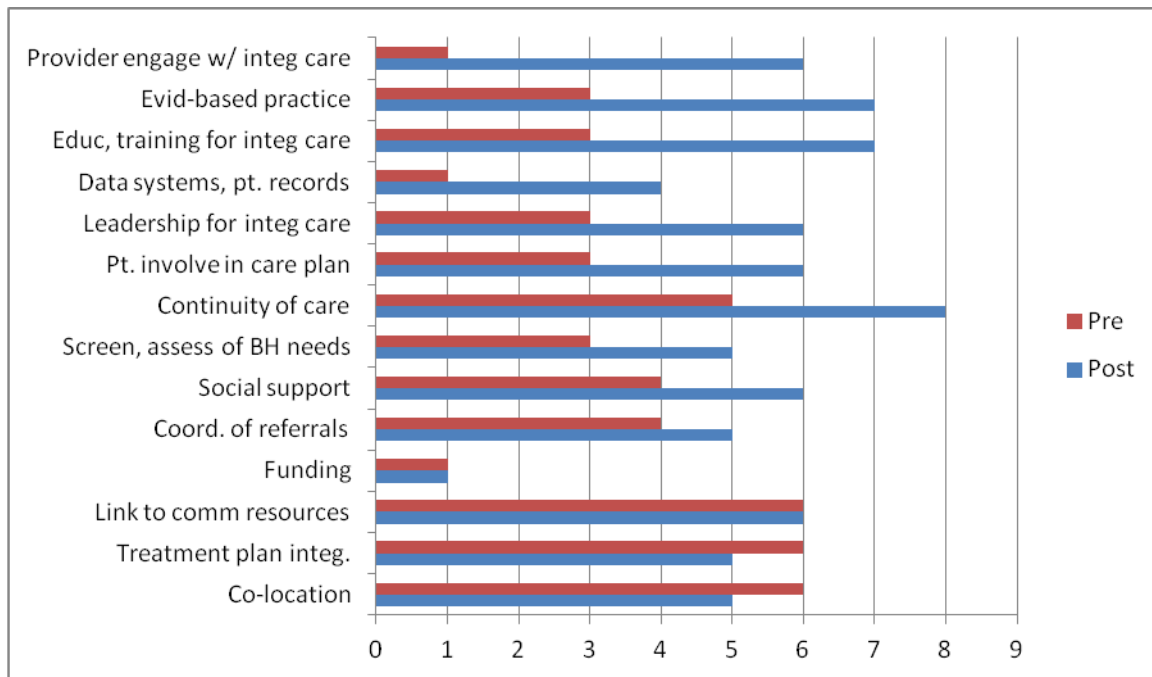
**Increase screening and treatment process for tobacco use.** All MTW patients reporting tobacco use are now given information regarding the NC Quit Line. Clinical staff is documenting these encounters in patient medical records. Nurses report beginning to see an increase in the numbers of patients who have stopped or reduced tobacco use. Written and verbal congratulations are given to patients who have made a behavioral change.

**Improve the screening process and treatment for depression and anxiety.** Depression screens are now offered to 100% of MTW patients; the PHQ 2 depression inventory is used in Tyrrell and Washington and the PHQ 4 is used in Martin. The full PHQ 9 is administered if there are positive scores to the briefer versions. Patients are given the screening tool to complete at check-in and the results are reviewed with the patients by clinical staff. Screens are then filed in the patient’s medical record. Medication prescribing has increased as a result. A significant number of patients refused further referral for treatment. The team is planning to use the PHQ 9 for follow-up to document patient progress.

**MTW Changes in the Integrated Care Site Self-Assessment Survey**

MTW’s Pre- versus Post-BHAP survey ratings are graphically presented below. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support). Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post ratings.

Figure 7. MTW Pre- versus Post-BHAP Integrated Care Site Self-Assessment Ratings



MTW experienced large improvements in their perceptions of integrated care readiness. The sum of their ratings increased 28 points. Their average rating increased a full 2 points, from 3.5 to 5.5. Improvements in MTW staff perceptions were fairly widespread; 10 of the 14 items were viewed more positively at Post time. The largest gains occurred in 5 of the 7 items that comprise the Organizational Supports for Practice Change Toward Integrated Services dimension. By far the largest gain was in provider's engagement with integrated care ("buy-in"), a 5-point increase from the lowest possible rating (1, minimal) to a 6 (moderately consistent). This dramatic increase is exemplified by the quick adoption of behavioral health screening tools with all patients, and implementation of evidence-based practices for diabetes, motivational interviewing and psychopharmacologic management of depression and anxiety. These improvements are bolstered by staff's perception that MTW leadership's attitude has improved from one of perceiving integrated care as a special project to one of an ongoing quality improvement initiative. MTW experienced some small regression in ratings (co-location and treatment plan integration). The consensual interpretation of small, negative changes in staff perceptions of integrated care readiness is that once staff learned more about what integrated care requires, they adjusted their expectations around steps to take to implementing a robust integrated care model.

### **MTW Future Vision**

The changes that have occurred in the past few months have been institutionalized throughout all of the clinics. Tracking outcomes for patient populations has been assigned to specific staff. Transportation is a major barrier for provision of patient care. Opportunities for funding for integrated care will be pursued.

## **POLK COUNTY COMMUNITY HEALTH AND WELLNESS CENTER, INC (PWC)**

Polk developed a different vision as they moved from a specialty mental health to a medical model of integrated care. Brief intervention in the medical clinic has increased significantly. The Integrated Care team meets twice monthly to assure that the internal referral process is understood and is working well. Forty percent of the behavioral health consumers are now referred for a primary care visit. A change in the BHAP funding was instituted in June, which allowed the integrated clinical care coordinator to increase in her in time allocation to the project. Eight behavioral health providers share a very complex billing system, but they are beginning to use health behavioral intervention codes for Medicaid patients.

The PA has increased medical presence from three to five days. There has been success in extending the use of the PA for medication management for behavioral health consumers as well as increasing prescribing for primary care patients with depression and anxiety.

This project has worked well for Polk staff as they have folded it into their Community Health Improvement Plan. The clinic is preparing to become the certified Diabetic Education Resource for the entire county.

### **Analysis of PWC BHAP Patient Encounters**

PWC saw 35 BHAP patients, all of which received at least one type of screening at their first visit along with counseling, patient education and care coordination. Nearly all BHAP patients received medication management at their first visit. The average number of visits during the grant period per BHAP patient was 2.7, the highest ratio of the four pilot sites.

### **PWC Performance Measures**

**Increase access to integrated services for 100 uninsured adults (added: diabetes education/peer support to patients with hemoglobin A1Cs of 8 or above).** Since January, PWC served 133 uninsured patients in the BHAP project. Three diabetes groups have served 11 patients, 5 of whom are uninsured. Many persons with severe and persistent mental illness have been identified as also having developed diabetes. There will be a hemoglobin A1C follow-up in 3 months to determine outcomes of the group interventions.

Polk staff began integrated care team meetings to plan for uninsured adults (pre-visit planning; contractors report improved communication around shared patients). The team is now offering brief interventions and instituted education/peer support groups. They recently began billing new codes and are requiring patients to apply for Medicaid when eligible. PWC is in the process of implementing the SBIRT alcohol and substance abuse screening, treatment and referral protocol.

**Increase symptom improvement in 80% patients with hypertension and depression or anxiety.** A recent medical record review result verified that 80% of these patients have shown an improvement in symptom reduction.

PWC is completing routine screens for hypertension, depression, anxiety and diabetes. They plan to expand these screens to all patients. They are using standard treatment protocols for anxiety in medical clinic settings. They are developing policies to support that plan. The PA reports an increased confidence in prescribing antidepressant medications for depression and anxiety.

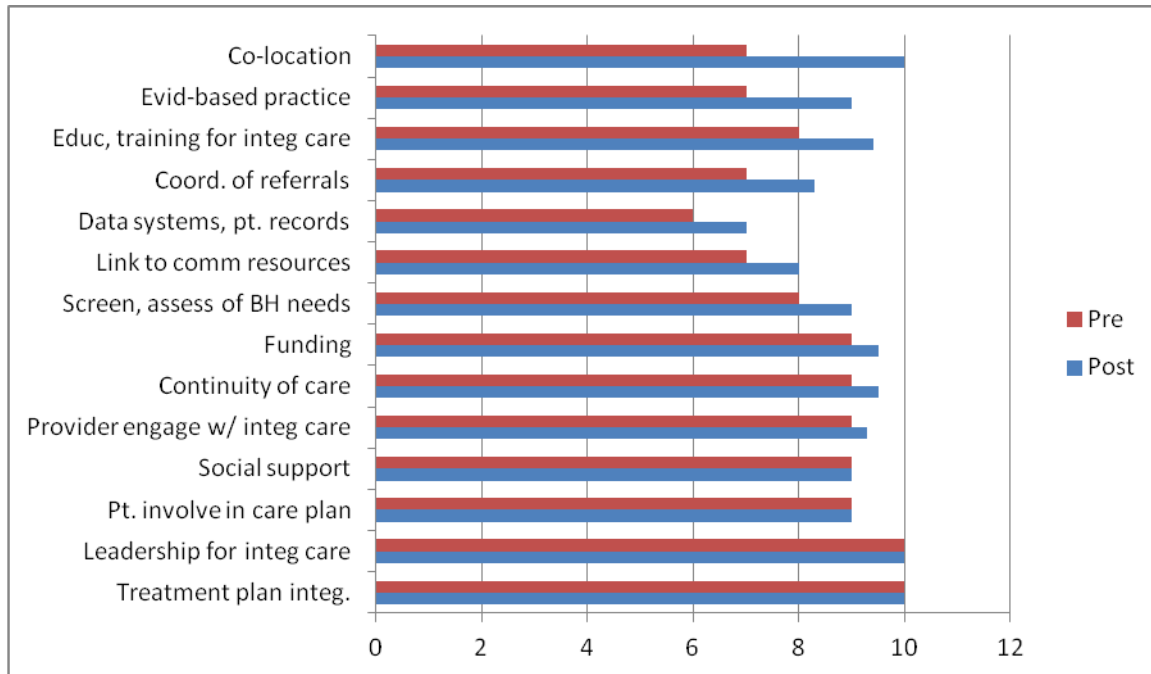
**Improve the screening process and treatment for depression and alcohol misuse.** The Medical Assistant is offering screenings and patient education using the PQH 2 depression inventory. The team has enhanced alcohol screens and diabetes education. They are developing internal protocols for routine SBIRT, depression, and anxiety screening. PWC has implemented new strategies to continue employee education and communication updates (weekly newsletter) that will support their integrated care efforts.

**Increase patient satisfaction to 85% of patients served.** A Satisfaction Survey was developed near the end of the project. Five have been completed to date indicating a 90% rating of “very good” regarding satisfaction with services received.

### **PWC Changes in the Integrated Care Site Self-Assessment Survey**

PWC’s Pre- versus Post-BHAP survey ratings are graphically presented below as Figure 8. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support). Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post Ratings.

Figure 8. PWC Pre- versus Post-BHAP Integrated Care Site Self-Assessment Ratings



As with the Pre-BHAP ratings, PWC staff rated their Post-BHAP integrated care readiness higher in nearly every aspect as compared to the other three pilot sites. Their range of ratings was also much tighter, with 11 of the 14 items being rated between 9 and 10 at Post time. Their grand average of ratings increased from 8.21 to 9.07. The standout perception was co-location, which moved from a 7 (some coordination of appointments and services for primary care and behavioral health care) to the highest rating, a 10 (appointments jointly scheduled; one visit can address multiple needs). The lowest-rated item at Pre time was also their lowest at Post time; data systems, patient records.

### PWC Future Vision

The team has submitted a proposal to Kate B. Reynolds for a technical assistance grant to be used for further developing integrated care in the clinics. They plan to continue the diabetes self-management groups. They foresee increasing the number of warm hand-offs between the primary care provider and the behavioral health staff. The team sees the need to hire a full-time Integrated Care Coordinator in order to maintain the momentum of what has begun to be a powerful culture change for improved patient care.

## **COMMUNITY CLINIC OF RUTHERFORD COUNTY (CCRC)**

During the course of the project, CCRC moved into a new clinic space and successfully completed a Medicaid audit with a very positive preliminary report. The clinic continues a computer software upgrade and testing a new interface that has had some challenges. The behavioral health care staff did not have access to the EHR, so all data for this project was manually distilled by record review of all uninsured patients. The behavioral health care staff experienced a significant learning curve in transitioning from a traditional substance abuse treatment approach to an integrated care model. Behavioral health care consumers have a very high no show rate. The integrated screening and brief intervention approach as part of the medical visit has recently begun to show some success in increasing behavioral health treatment encounters. The therapist is only available two half days per week currently.

The current Medical Director has a substance abuse treatment background and is beginning staff training around Patient Centered Medical Home and integrated care. He is scheduling regular staff meetings/ lunch and learns sessions. They will be focusing on establishing pain contracts in the future. A Nurse Practitioner in the area has recently stopped practice and CCRC has experienced an increase in the number of patients now seeking prescriptions for benzodiazepines; Dr. Victoria Soltis-Jarrett provided consultation.

### **Analysis of CCRC BHAP Patient Encounters**

CCRC saw 37 BHAP patients, all of which received at least one type of screening at their first visit along with patient education and care coordination. Nearly all also received behavioral health counseling, and 29 of the 37 received medication management. The average number of visits during the grant period per BHAP patient was 1.0.

### **CCRC Performance Measures**

**Track numbers of uninsured patients served by the contractor.** Upgrade of the EHR will allow report writing which will reduce the labor intensity of this element. The behavioral health providers began tracking their uninsured clients in June. The tracking report was adjusted to meet their needs.

**Hire .45 FTE for project:** The Behavioral Health Director has .15 of his FTE assigned to BHAP and the other licensed clinician was hired for .30 FTE for BHAP-related duties.

**Increase patient screening and treatment for alcohol misuse from 0% to 5%.** All nurses are using the SBIRT protocol for alcohol and substance abuse screening of 100% of CCRC patients. Their new Electronic Health Record has the CAGE brief substance abuse assessment built in and a

Risk Factor Template is in the record. All patients are screened at intake. Training in a variety of mental illness issues for all staff is planned.

**Increase patients receiving self-management and education about obesity from 0% to 5%.**

Implementation and thus measurement of this performance measure was delayed until a Registered Dietician could be hired. The RD has begun classes and groups for diabetes, which encompasses many people with high BMIs. The Behavioral Health Team and the RD are planning regularly scheduled joint patient education activities and group interventions for patients with multiple issues including obesity. Patients with diabetes are receiving educational materials regarding weight/blood sugar control and healthy life styles. The medical director instituted standing orders for complete work-ups for patients with chronic diseases for nursing staff to complete before being seen by PCPs. An exit nurse does the patient education at each visit reviewing carbohydrate counting and potential referral to group. The nurses are using evidence-based diabetes self-management tools with all patients. The lead nurse is seeking help from a local podiatrist to provide foot exams for uninsured patients.

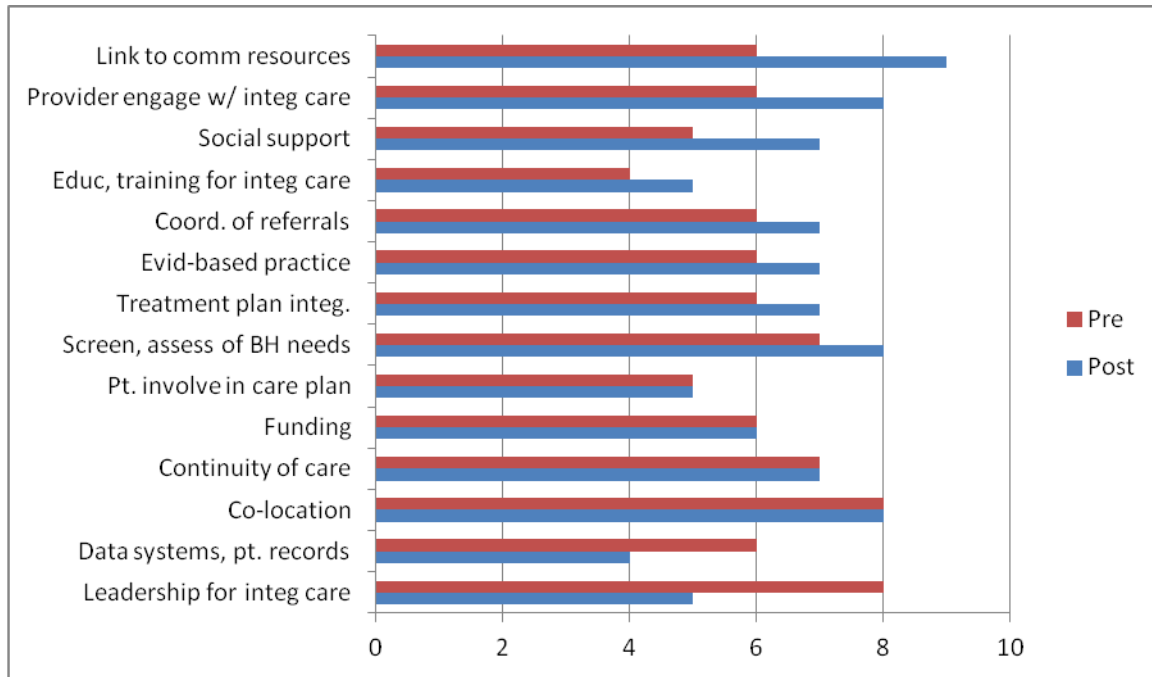
**Increase number of patients receiving behavioral health services after depression diagnosis from a primary care practitioner from 8% to 16%.** The PHQ-9 depression inventory is being completed regularly and re-administered in 6 weeks if medical treatment is provided for positive depression screens. The PCPs have begun prescribing more antidepressants since the training.

**CCRC Changes in the Integrated Care Site Self-Assessment Survey**

CCRC's Pre- versus Post-BHAP survey ratings are graphically presented below as Figure 9. The rating scale ranged from 1 (does not exist or occur) to 10 (complete integration, access, support). Refer to Appendix B for the actual questionnaire and Appendix E for a numerical table comparing all of the Pre and Post ratings.



Figure 9. CCRC Pre- versus Post-BHAP Integrated Care Site Self-Assessment Ratings



With the exception of notably improved linkage, coordination and follow-up with community resources, CCRC experienced very modest improvements in about half of their perceptions, spread across dimensions. This may be explained in part to changes in medical and behavioral staff leadership during the project, an ambitious agenda concerning PCMH readiness, a Medicaid audit and trying to implement a new EHR.

Some of the gains made in the dimension of Organizational Support for Practice Change Toward Integrated Services were offset by regression in two items. Organizational leadership for providing behavioral health care was perceived as an 8 at Pre-BHAP time and a 5 at Post time. The access to and integration of data systems and patient records was downgraded from a 6 to a 4 as the behavioral health care staff not having PCs until well after the midpoint of the project resulted in a very time- and labor-intensive ordeal to collate BHAP encounter data and fulfill a growing number of other data needs. Staff stated that the new EHR had report generation shortcomings and it is plausible that the staff had not completed enough training on the new system to become proficient with extracting data from it and transforming it to decision-supportive information.

CCRC staff remained very positive about their perceived level of co-location of treatment for primary care and behavioral health care, despite clinical staff changes. A related perception,

provider engagement with integrated care, (“buy-in”) moved from being seen as moderately consistent but with some concerns to all or nearly all providers becoming enthusiastic about implementing integrated care.

### **CCRC Future Vision**

The clinic would like to hire a fulltime behavioral health provider to be assigned to the primary care clinic. They are beginning to consider developing a medical approach to chronic pain management and a behavioral health therapist would be invaluable in this effort.

## **SECTION SIX: Summary**

### **Why integrate behavioral health into primary care?**

The genesis of this project is a simple fact: Most of the time, the majority of people with emotional, mental or substance abuse problems cannot get the treatment they need. This reality is the result of several interlocking factors:

- Continued stigma, myriad difficulties in accessing behavioral health services and concerns about affordability deter most people and their families from seeking services,
- 67% of people with a behavioral health disorder do not get behavioral health treatment, (13)
- 30-50% of patients referred from primary care to an outpatient behavioral health clinic do not make the first appointment, (14)
- Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by primary care providers as critical barriers to mental healthcare access (15) and,
- Improving billing, coding and reimbursement for behavioral care remains a frequently changing patchwork of credentials, supervision, same-day limits and maximum benefit amounts.

Following decades of the public mental health system being severely under-resourced, primary care has become the defacto source of treatment for the vast majority of people with behavioral problems. Consider:

- 80% of people with a behavioral health disorder will visit a primary care provider at least once a year, (10)
- 50% of all behavioral health disorders are treated in primary care, (11)
- 48% of appointments for all psychotropic agents are with a non-psychiatric primary care provider (12) and,
- Two-thirds of primary care physicians report not being able to access outpatient behavioral health for their patients. (15)

The economic and public health costs of this dilemma are staggering, but integrated care offers an effective solution. As stated by Dr. Marci Nielsen, CEO of the Patient-Centered Primary Care Collaborative:

“The Centers for Disease Control and Prevention (CDC) estimates that one in four Americans reported a mental health issue in the previous year, at a cost of more than \$300 billion, including the cost of care and productivity loss. Further, over a lifetime, half of all Americans are expected to experience a mental health disorder.

Research demonstrates that integrated models of primary care and mental health improve access to mental health services and treatment, increase adherence to treatment and medication and result in better health outcomes. When offered in a primary care setting, researchers of a multi-site and multi-state study found that patients had 50% better access to mental health care services.” (16)

### **Overall Accomplishments During the Behavioral Health Access Plan Pilot Project**

All four rural sites engaged in at least two full day team based trainings about standardized care pathways to treat depression/anxiety, tobacco dependence or risky drinking and psychosocial aspects of a chronic condition (diabetes).

All four sites implemented evidence-based screening and brief treatment for each condition.

All four sites made significant movement in expanding the concept of integrated care to address chronic health conditions, screen for preventative purposes and experienced increased team cohesiveness and communication.

All four sites made a connection between this pilot project, the need to start quality improvement processes and the benefits of pursuing further integration of behavioral health within the patient centered medical home model.

One of the premier strengths of this pilot project was the understanding that to increase team cohesiveness and functioning, a team based approach needed to be role modeled by engaging experts in community resources, standardized care pathways, quality improvement and coding and billing. Although each pilot site had limited time to utilize these experts, it appears each one made significant cultural shifts in how they practiced by utilizing each other’s expertise and increasing real-time communication around patient care.

Several sites decided to implement group visits to manage diabetes in which all care team members were present (medical, behavioral, nutritionist, etc.). Although there are no current payment models that reimburse this concept of ‘shared medical visits’, it was driven by the team members determining this was a highly beneficial service to offer to patients. The majority of participants expressed a desire to continue the groups beyond the pilot period, and endorsed the idea of family members joining the group and/or having their own group. It was reported that many participants learned to embrace self-management of their diabetes. Implementing group medical visits is a strong indicator of adoption of a multi-disciplinary approach to patient care, which the field reports and research indicates meets the Triple AIM standard.

## **Major Challenges During the Behavioral Health Access Plan Pilot Project**

There was a lack of sufficient time for continued technical assistance needed to assist in sustaining the many gains that were made. Some of these TA needs included specific training around enhancing patient engagement, on-going quality improvement processes to demonstrate disease management, ensure health and behavior codes were being utilized and the time needed to capture data that would demonstrate outcomes achieved. Although the project began in January of 2013, the key staff at all four sites were not available to receive full day trainings until mid-March. Thus, it was not until about May that the impact of the training, consultation, technical assistance and resource sharing on changing expectations of co-workers and patients, care coordination, team-based practice, medication prescribing and monitoring, measuring change and coding and billing began to emerge. Therefore, the actual time that the “intervention” was operative was a mere three to four months.

In particular, sites struggled with adopting an electronic health care record or utilizing their current health care record to relay patient data that documented patients received an integrated care visit (i.e. saw more than one provider in a day and received more than one intervention). This strongly speaks to the need for an electronic health care record system that would include screening tools and results, evidence-based algorithms and culturally competent patient education materials for behavioral health services provided in a primary care setting.

## **Lessons Learned During the Behavioral Health Access Plan Pilot Project**

Changes in clinic culture and clinician behavior that are essential to adoption of healthcare service delivery improvements have lagged far behind technological changes such as rapid HIV testing in health departments, or even the growing use of point-of-care devices for clinical decision support. Many healthcare delivery innovations like integrated team-based care hold the promise of improved quality of care, better outcomes and lower costs but are not adopted if the staff perceives the costs to be greater than the benefits. (17)

The rapid adoption of the BHAP project site staff, however, could more accurately be considered a rapid cycle improvement than what has been termed the ‘natural rate of diffusion’ in healthcare delivery. (18) Rapid acceptance, implementation and diffusion of the practices and methods promoted by the BHAP TA team is all the more remarkable in that there was no site strategy period nor early and clearly defined champions or change agents, which defies current thinking about rapid adoption.

We are compelled to ask, then, how did it happen, and can it be replicated? The following drivers may offer some answers:

The TA Team provided evidence-based care pathways and education on coding and billing. The Team used a problem-solution paradigm and encouraged each team to utilize identified strengths in how they chose to implement this information into their daily workflow. This led to site staff perceiving Team members as helpful, and lowered their resistance to and anxiety about having to change things they would rather not.

At every juncture, TA Team members modeled what it is like to act like a team by openly sharing ideas and asking questions of one another. Also, updates from when the TA team members met or communicated amongst each other was relayed to the sites.

The early attempts to solve the site staff's problems, such as the presentations, lunch-and-learns and individual consultation provided by Dr. Soltis-Jarrett on prescribing and dosing with complex cases, made the possibility of the BHAP message more compelling to the site staff. As requested, on site, phone consultation and email response provided by Dr. Regina Dickens, coached staff through processes of change and utilized a quality improvement process throughout the project. Ms. Hill also was available for each site at the medical team's request as the clinic started connecting the standardized care pathways to coding and billing.

This accessible team approach offered to the clinics facilitated Gladwell's 'tipping point' amongst the site staff. (19) Presenting new, possibly disruptive innovations by individuals that were seen as 'peer leaders' like the TA team members is considered essential to establishing the value of the innovation for creating a better situation for the adopter. (20)

Team-based care appealed to the site staff because it produces its greatest benefit with complicated and chronic conditions.

In closing, the summary statement from the landmark study, 'Crossing the Quality Chasm: A New Health System for the 21st Century', is a fitting synopsis of the value of team based, patient centered care that each BHAP pilot site diligently worked to strengthen:

“Carefully designed, evidence-based care processes, supported by automated clinical information and decision support systems, offers the greatest promise of achieving the best outcomes from care for chronic conditions...Moreover, such efforts to improve quality must be supported by payment methods that remove barriers to integrated care and provide strong incentives and rewards for improvement.” (21)

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## Appendix A

### Behavioral Health Access Plan (BHAP) Target Population and Site Selection Criteria

#### Target Population

The target population to be served under BHAP is uninsured adult patients of the rural health entity who:

- Are aged 18-64 years old;
- Are not eligible for Medicaid or enrolled in other comprehensive health insurance;
- Would benefit from a brief, evidence-based behavioral intervention; and
- Have significant medical needs that require a medical home, case management, and care coordination.

#### Selection Eligibility Criteria

- A. Applicant must be a rural primary care entity providing primary care in rural community. Rural Health Entities are Rural Health Centers currently or previously supported by the ORHCC, as well as federally designated Rural Health Clinics and local Public Health Departments.
- B. Applicant must be located in either a Tier 1 or Tier 2 County. For a current listing of these counties, refer to:
  1. <http://www.nccommerce.com/research-publications/incentive-reports/county-tier-designations>
- C. Applicant must currently offer services to the uninsured and underinsured, preferably utilizing a sliding fee scale based on income.
- D. Applicant must demonstrate willingness to implement behavioral health services that are integrated with primary care including medical team support.
- E. Applicant must identify a champion that will be committed to the project goals and will identify key staff to be part of an integrated care team. This individual will also coordinate trainings and consultations provided by technical assistance consultants.
- F. Applicant's champion must commit time and resources to developing a training plan, attending at least two days of training, and weekly contacts and other activities.

## Items of Preference

- A. Applicant currently provides a substantial amount of services for the uninsured. Provide documentation of total number of uninsured patients and number of uninsured patient encounters relative to practice's patient mix totals.
- B. Applicant currently provides care coordination function, which can include case management of other chronic conditions and may be in conjunction with CCNC and/or Health Net.
- C. Applicant currently utilizes the Medication Access and Review Program (MARP) software or is willing to become a participant in MARP. Any other medication assistance for the uninsured through other venues will also be considered.
- D. Applicant has or is willing to develop a collaborative relationship with the behavioral Managed Care Organization (MCO) in its region. This may also include referral relationships with local behavioral health providers.
- E. Applicant is either a CCNC participating practice or has a strong collaborative relationship with its CCNC network, and can demonstrate resources (i.e. network staff) the local CCNC network is willing to offer to support this project.

## Appendix B

### Behavioral Health Access Plan (BHAP) Integrated Care Site Self-Assessment Survey

This Survey was adapted from similar formats used to assess primary care for chronic diseases. We would like you to focus on your site's *current* extent of integration for patient and family-centered primary care, behavioral and mental health care. The purpose of this assessment is to gather information on current status along several dimensions of providing behavioral care. Future repeat administrations of the Survey will help to show changes your site is making over time.

It is desirable to obtain input from your team to complete this Survey, for example, by asking each team members to score it, then discussing the scores in a team meeting, and reaching consensus. If that is not feasible, then the site manager may complete it individually. Please rate your patient care team(s) on the extent to which they currently do each activity for the patients/clients.

The term "patient care team" is meant to describe the staff members who work together to provide and coordinate care for patients and identified caregiver(s). This often, but not always, involves health care providers, behavioral health specialists and possibly case managers or health educators and front office staff.

Using the 1-10 scale in each row, circle one numeric rating for each of the 14 characteristics.

If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: *There are no right or wrong answers.*

#### Identifying Information:

Name of your site: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person completing the SSA form: \_\_\_\_\_ Your job role: \_\_\_\_\_

Did you discuss these ratings with other members of your team? Yes \_\_\_\_\_ No \_\_\_\_\_

<p>1. Co-location of treatment for primary care and mental/behavioral health care</p>	<p>... does not exist; consumers go to separate sites for services</p> <p style="text-align: center;"><b>1</b></p>	<p>... is minimal; but some conversations occur among types of providers; established referral partners exist</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>... is partially provided; multiple services are available at same site; some coordination of appointments and services</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... exists, with one reception area; appointments jointly scheduled; one visit can address multiple needs</p> <p style="text-align: center;"><b>8            9            10</b></p>
<p>2. Emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)</p>	<p>... are not assessed (in this site)</p> <p style="text-align: center;"><b>1</b></p>	<p>...are occasionally assessed; screening/assessment protocols are not standardized or are nonexistent</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>...screening/assessment is integrated into care on a pilot basis; assessment results are documented prior to treatment</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... screening/assessment tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented.</p> <p style="text-align: center;"><b>8            9            10</b></p>
<p>3. Treatment plan(s) for primary care <i>and</i> behavioral/mental health care</p>	<p>... do not exist</p> <p style="text-align: center;"><b>1</b></p>	<p>... exist, but are separate and uncoordinated among providers; occasional sharing of information occurs</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>...Providers have separate plans, but work in consultation; needs for specialty care are served separately</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... are integrated and accessible to all providers and care manager; patients with high behavioral health needs have specialty services that are coordinated with primary care</p> <p style="text-align: center;"><b>8            9            10</b></p>

<p>4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care</p>	<p>... does not exist in a systematic way</p> <p style="text-align: center;"><b>1</b></p>	<p>... depends on each Provider's own use of the evidence; some shared evidence-based approaches occur in individual cases</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently</p> <p style="text-align: center;"><b>8            9            10</b></p>
<p>5. Patient/family involvement in care plan</p>	<p>... does not occur</p> <p style="text-align: center;"><b>1</b></p>	<p>... is passive; clinician or educator directs care with occasional patient/family input</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>... is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with <i>some</i> patients/families and their provider(s)</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources</p> <p style="text-align: center;"><b>8            9            10</b></p>
<p>6. Social support (for patients to implement recommended treatment)</p>	<p>... is not addressed</p> <p style="text-align: center;"><b>1</b></p>	<p>... is discussed in general terms, not based on an assessment of patient's individual needs or resources</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>... is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources</p> <p style="text-align: center;"><b>8            9            10</b></p>

7. Linking to Community Resources	... does not occur	... is limited to a list or pamphlet of contact information for relevant resources	... occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral	... is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients
	1	2      3      4	5      6      7	8      9      10

II. Practice/Organization (Circle one NUMBER for each characteristic)				
Characteristic	Levels			
1. Organizational leadership for providing behavioral health care	... does not exist or shows little interest	... is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care	... is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)	... strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models
	1	2      3      4	5      6      7	8      9      10
2. Providers' engagement with integrated care ("buy-in")	... is minimal	... engaged some of the time, but some providers not enthusiastic about integrated care	... is moderately consistent, but with some concerns; some providers not fully implementing intended integration components	... all or nearly all providers are enthusiastically implementing all components of your site's integrated care
	1	2      3      4	5      6      7	8      9      10

<p>3. Continuity of care between primary care and behavioral/mental health</p>	<p>... does not exist</p> <p style="text-align: center;"><b>1</b></p>	<p>... is not always assured; patients with multiple needs are responsible for their own coordination and follow-up</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>... is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained</p> <p style="text-align: center;"><b>8            9            10</b></p>
<p>4. Coordination of referrals and specialists related to behavioral health issues</p>	<p>... does not exist</p> <p style="text-align: center;"><b>1</b></p>	<p>... is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>... occurs through teamwork &amp; care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>... is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement</p> <p style="text-align: center;"><b>8            9            10</b></p>
<p>5. Data systems/patient records</p>	<p>... are based on paper records only; separate records used by each provider</p> <p style="text-align: center;"><b>1</b></p>	<p>... are shared among providers on an <i>ad hoc</i> basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps</p> <p style="text-align: center;"><b>2            3            4</b></p>	<p>... use a data system (paper or EHR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals</p> <p style="text-align: center;"><b>5            6            7</b></p>	<p>...has a full EHR accessible to all providers; team uses a registry or EHR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process</p> <p style="text-align: center;"><b>8            9            10</b></p>



<p>6. Physician, team and staff education and training for integrated care</p>	<p>... does not occur</p> <p style="text-align: center;"><b>1</b></p>	<p>... occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic</p> <p style="text-align: center;"><b>2      3      4</b></p>	<p>... is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation</p> <p style="text-align: center;"><b>5      6      7</b></p>	<p>... is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration</p> <p style="text-align: center;"><b>8      9      10</b></p>
<p>7. Funding sources/resources</p>	<p>... are only from grants; no shared resource streams</p> <p style="text-align: center;"><b>1</b></p>	<p>... separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies</p> <p style="text-align: center;"><b>2      3      4</b></p>	<p>... separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training</p> <p style="text-align: center;"><b>5      6      7</b></p>	<p>... have fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly</p> <p style="text-align: center;"><b>8      9      10</b></p>

## Appendix C

### **NOTIFICATION OF FUNDS AVAILABLE FOR SUPPORT SERVICES TO ASSIST RURAL HEALTH ENTITIES IMPLEMENT A BEHAVIORAL HEALTH ACCESS PLAN FOR THE UNINSURED (BHAP)**

ORHCC will award up to \$100,000 for the contract period which is anticipated to begin on November 15, 2012 and will conclude August 31, 2013. Funding will be awarded to the organization that best demonstrates its ability to provide project management, as well as clinical and coding expertise, to rural health entities that are selected to participate in the BHAP project. Specifically, the successful bidder will be the organization that meets the identified credentials, and most convincingly demonstrates an ability to meet or exceed the primary responsibilities described in the nine BHAP project objectives described below.

#### **Target Population**

Uninsured adult patients of selected rural health entities aged 18-64 and not currently enrolled in Medicaid, who would benefit from a brief, evidence-based behavioral intervention. Research indicates that these individuals have or will have significant medical needs that require a medical home, case management and care coordination.

#### **Project Manager Credentials**

##### Knowledge, skills and abilities:

Please identify relevant experiences with integrated care related to any of the bulleted items below as part of your response. Integrated care experience preferred. Work samples welcomed.

- Project management skills: task prioritization, obtaining buy-in, delegation, evaluating barriers, threats, weaknesses, devising solutions, monitoring status,
- Excellent oral and written skills, facilitation skills in multiple contexts, i.e., in-person individually and with small and large groups, webinars and conference calls,
- Proven experience in team development, collaboration involving various organizational levels including support staff, clinicians, senior leadership,
- Ability to assess training and professional development needs, develop training plans for knowledge and skill-building and most effective methods for delivery,
- Data capture and data management, analysis and interpretation skills,
- Program evaluation experience and,
- Intermediate-level Microsoft Word and Excel skills: formatting information for presentations, spreadsheet development.

### Required Education, Training, Experience:

- Master's Level degree in a relevant discipline including Human Services, Business, Communications, Organizational Development, Organizational Effectiveness, or other related field or equivalent work experience, with a strong emphasis on program management and process improvement in nonprofits,
- Five or more years of experience in a leadership and project management role, focused on delivering team based services, performance management, fiscal management, organizational design, organizational effectiveness and,
- Five years of professional experience with demonstrable track record in improving systems, processes, services.

### **Primary Responsibilities of Project Manager**

**PROJECT OBJECTIVE 1:** Develop a project management plan within the first 45 days of the contract award date that will address concurrent and sequential tasks with responsible parties and target completion dates covering, at minimum, the following:

SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats) related to implementing BHAP project in each of the pilot sites: Time, resources and expenses to provide remedial training, TA and consultation to address site weaknesses, threats, including but not limited to:

- a. Assessment of pilot site staff motivational readiness to adopt a fully-integrated care model, including identification of attitudinal barriers, fears, concerns,
- b. Assessment of staff capacity relative to estimated demand for behavioral intervention and ability to implement screenings,
- c. Evaluation of the adequacy of pilot site policies, procedures and practices to support BHAP project,
- d. Integrated /parallel behavioral health and primary care sections of the medical record,
- e. Assuring confidentiality of substance abuse information commensurate with 42CFR and related state and federal regulations,
- f. Effectiveness and efficiency of making and tracking referrals to behavioral health providers.

**PROJECT OBJECTIVE 2:** Assign or subcontract for a Medical Expert with demonstrable knowledge of integrated care and competency to train others. Preference given to integrated care experience with target population.

### Medical Expert Credentials:

- Valid license in North Carolina as a Nurse Practitioner, Physician Assistant or Medical Doctor and licensure to prescribe medications,
- Demonstrable knowledge and competence in training medical providers and their team members in how to treat patients with multiple medical conditions who also have behavioral health symptoms or diagnoses (i.e. mental illness, substance use disorders and intellectual or developmental disabilities),
- Demonstrable competence and experience in training medical providers and members of medical team in clinical pathways to treat depression, anxiety, alcohol misuse and tobacco cessation (including psychopharmacological treatment),
- Demonstrable knowledge and competence in training medical providers on best practice clinical pathways chosen by selected BHAP pilot sites. Pathways to be selected from nationally recognized sources (HEDIS, NCQA, ICSI, etc.),
- Experience with practice management changes to improve quality of care and/or meet clinical outcome metrics/measures,
- Familiarity with the needs of the uninsured in rural areas,
- Demonstrable experience providing training that incorporates awareness of cultural mores, and awareness of health literacy issues and,
- Demonstrable knowledge and ability to train medical providers on patient/caregiver engagement in co-managing health.

### Primary Responsibilities of Medical Expert:

- In coordination with ORHCC Behavioral Primary Care Systems Associate, provide training, consultation and technical assistance to designated BHAP pilot sites on screening, treatment and clinical practices aspects of integrated care,
- Travel as needed to provide on- site training, TA and consultation to sites,
- Attend meetings and communicate in a timely manner with project team members and others as identified by the Project Manager, as needed to fulfill tasks identified in the project management plan.

### **PROJECT OBJECTIVE 3:** Facilitate financial sustainability

- a. Assign or subcontract with a Certified Billing And Coding Expert who is familiar with billing and coding behavioral health care screenings and treatments in primary care settings. Preference shown for experts with experience in integrated care practices. .

Certified Billing And Coding Expert Credentials:

- Experience in providing training, technical assistance and consultation to rural health clinics regarding guidelines for utilizing CPT codes to promote integrated care,
- Must demonstrate knowledge of, and remain up to date, with state guidelines for coding pertaining to designated BHAP pilots,
- Must demonstrate knowledge of, and remain up to date, with federal CMS guidelines for billing and coding for Medicaid, Medicare and TriCare,
- Knowledge of CPT codes used by other payers (i.e. NC State Blue Cross Blue Shield) that promote identified best practice clinical pathways,
- Must demonstrate knowledge of bundled payment systems either in North Carolina or other states that promote integrated care.

Primary Responsibilities of Certified Billing And Coding Expert:

- Offer technical assistance regarding bundled payments or other payment options to ORHCC staff.
  - In coordination with ORHCC Behavioral Primary Care Systems Associate and Medical Expert, provide on-site training, consultation and technical assistance to designated BHAP pilot sites,
  - Develop billing and coding guidelines for BHAP pilot sites and,
  - Attend meetings and communicate in a timely manner with project team members and others as identified by the Project Manager, as needed to fulfill tasks identified in the project management plan.
- b. Analyze a representative sample of medical procedures and claims for each BHAP pilot site sufficient to project additional revenue from upgraded coding and billing practices.
- c. Feasibility plan to establish group visits.
- d. Plan to implement expanded preventative screenings ratified under the ACA.

**PROJECT OBJECTIVE 4:** Schedule and coordinate training, technical assistance and consultation sessions provided to BHAP pilot sites.

**PROJECT OBJECTIVE 5:** Maintain complete and up to date documentation to support all project expenses.

**PROJECT OBJECTIVE 6:** Schedule and preside at team meetings that involve ORHCC Behavioral Primary Care Systems Associate, Billing And Coding Expert and Medical Expert.

Provide agendas beforehand to include status of project management plan tasks as a standing item. Document assigned action items and decisions and track progress using Quality Improvement and PDSA tools.

**PROJECT OBJECTIVE 7:** With input from team members and subject matter expert(s), review, revise, and implement questionnaires and analyze responses to assess value of trainings and technical assistance, consultation provided.

**PROJECT OBJECTIVE 8:** Develop a process to capture and maintain relevant data from each BHAP pilot site including but not limited to: BHAP service invoices with relevant codes, Medicaid claims for CPT codes utilized and data obtained from Care Management Information System.

**PROJECT OBJECTIVE 9:** Utilize quantitative and qualitative data (i.e., criteria 7 and 8) to write a project evaluation report of the status of each BHAP objective. Emphasis should be placed on detailed descriptions of barriers and problems encountered, their known or speculative causes, strategies and solutions employed to address them, and results. The report should also include recommendations for future ORHCC efforts to promote integrated care in rural clinics.

## Appendix D

### Standardized Care Pathways and Resources

#### Depression/Anxiety Pathways and Resources

- 1) Community Care of North Carolina Toolkit for Treating Adult Depression in Primary Care:

<https://www.communitycarenc.org/media/related-downloads/depression-toolkit.pdf>

- 2) Community Care of North Carolina, in partnership with other stakeholders, has developed a set of three referral forms for primary care and behavioral health providers to facilitate easier consultation and communication. Initially released in Spring 2012, the forms have been updated based on feedback received from our partners. A summary of revisions to the forms is available [here](#) and instructions for using the forms are available [here](#).

Form #1 – [Behavioral Health Request for Information](#) – this form is for behavioral health providers who begin working with a new consumer or identify a potential medical need, and wish to make contact with the PCP.

Form #2 – [Referral to Behavioral Health Services Section I](#) – this form is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.

Form #3 – [Behavioral Health Feedback to Primary Care Section II](#) – this form is to be used in conjunction with the 2nd form listed above. It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

For your convenience, these forms are downloadable at right as either PDFs (fillable form fields) or MS-Word documents. \*\*\*Providers are encouraged to obtain consent for release of information, as is necessary in the sharing of substance abuse information.

- 3) Improving Mood –Promoting Access to Collaborative Treatment (IMPACT) free on line training:

IMPACT is a program of the University of Washington, Department of Psychiatry & Behavioral Sciences.

It is a 13 module online training program in IMPACT care adapted from a three-day in-person training offered in September, 2010. In total, it includes approximately 17 hours of content; however, you can choose to complete as many modules as you like. Viewing the training modules is FREE. A certificate for continuing education contact hours requires a recordkeeping fee of \$50.

This training introduces you to IMPACT, an evidence-based model of collaborative care management for depression. A nationwide study demonstrated that this integrated team approach more than doubles the effectiveness of depression treatment and that the effects of the program are sustained even one year after it ends.

IMPACT is associated with significantly greater improvement in depression, functioning, and quality of life over a 2-year follow-up period compared with usual care. Reports also show a reduction of more than \$3,000 in total healthcare costs over a four year period.

<http://impact-uw.org/training/onlinetraining.html>

### **Tobacco Dependence Pathways and Resources**

- 1) Tobacco Use Cessation: A Brief Primary Care Intervention: Presented by Peg Dundon, PhD and Katherine M. Dollar, PhD: VISN 2 Center for Integrated Healthcare:

A Training Manual for Integrated Primary Care Behavioral Health Providers and other Tobacco Cessation Providers:

[http://www.mentalhealth.va.gov/coe/cihsn2/Documents/Clinical/Tobacco\\_Use\\_Cessation/TUC\\_Manual\\_August\\_2010.pdf](http://www.mentalhealth.va.gov/coe/cihsn2/Documents/Clinical/Tobacco_Use_Cessation/TUC_Manual_August_2010.pdf)



- 2) Patient referral forms to North Carolina Quit Line:

<https://www.communitycarenc.org/media/tool-resource-files/tobacco-cessation-quitline-fax-referral-form-nc-dh.pdf>

<https://www.communitycarenc.org/media/tool-resource-files/tobacco-cessation-quitline-fax-referral-form-spani.pdf>

- 3) Association for Clinicians for the Uninsured: Link to web page with several tools, including how to implement, quality improvement process, etc.,

<http://www.clinicians.org/tobaccofree/index.html>

- 4) Smoking Cessation Leadership Home

<http://smokingcessationleadership.ucsf.edu/index.htm>

### **Addressing Risky Drinking Pathways and Resources**

- 1) Rethinking Drinking: You can easily order multiple copies of the patient and clinician material from the web page.

<http://rethinkingdrinking.niaaa.nih.gov/>

<http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf>

- 2) North Carolina's SBIRT web page via North Carolina Governor's Institute for Drug and Alcohol Policy

<http://www.sbirdnc.org/>

- 3) SBIRT implementation guide:

<http://www.casacolumbia.org/upload/2012/20121003SBIRT.pdf>

## Diabetes Care and Self-Management

- 1) Diabetes Care: Patient Activation Pathways can be adapted to manage lifestyle changes for hypertension and obesity.

VA SHARED MEDICAL APPOINTMENTS FOR PATIENTS WITH DIABETES:  
*MAXIMIZING PATIENT & PROVIDER EXPERTISE to STRENGTHEN CARE  
MANAGEMENT*

<http://www.queri.research.va.gov/tools/diabetes/shared-med-appt.pdf>

- 2) The North Carolina Division of Aging and Adult Services (DAAS) and the Division of Public Health (DPH) have mobilized a statewide campaign to implement and sustain the Chronic Disease Self-Management Program (CDSMP) and the Diabetes Self-Management Program (DSMP), two evidence-based programs developed by researchers at Stanford University. The ultimate goal of implementing *Living Healthy* (i.e. CDSMP) and *Living Healthy with Diabetes* (i.e. DSMP), is to reduce the risk and occurrence of disease and disability among the rapidly increasing number of adults 60 and older.

<http://www.ncdhhs.gov/aging/livinghealthy/livinghealthy.htm>

- 3) Link for on-line diabetes works groups.

### Free Online Diabetes Workshop

The National Council on Aging is now offering a **free online diabetes workshop**. Better Choices, Better Health® - Diabetes is the online version of Stanford University's Chronic Disease Self-Management Program. Over six weeks, from the convenience of a computer, participants learn to manage their diabetes symptoms, eat well and exercise, communicate with their doctors, and live healthier. All participants also receive a free copy of the workbook, *Living a Healthy Life with Chronic Conditions*.

- 4) DAWN STUDY: Diabetes Attitudes and Wishes: Web pages contain tools and resources to help patients manage diabetes and the psychosocial aspects that come with this disease.

DAWN™ is about Diabetes Attitudes, Wishes and Needs. Initiated by Novo Nordisk in partnership with the International Diabetes Federation (IDF) and an international advisory panel of leading diabetes experts and patient advocates in 2001, the first DAWN™ study became the largest study of its kind carried out to **uncover the psychosocial challenges**

**faced by people with diabetes and the people helping them, and explore new avenues for improving care.** The study was undertaken in response to the fact that despite the availability of effective therapies, less than half of people with diabetes were achieving adequate glycemic control. It was realized by the partnering organizations and experts that new global and national knowledge was needed, taking a 360° view, to explore the barriers limiting more effective delivery of diabetes care and ongoing support to those in need. At that time there were no global studies like this, focusing on the non-medical attitudinal and psychosocial aspects of diabetes management in multiple countries.

<http://www.dawnstudy.com/default.asp>

**Patient Engagement:**

Partnering in Self-Management Support: A Toolkit for Clinicians

New Health Partnerships: Improving Care by Engaging Patients: May 2009

The New Health Partnerships initiative is a national program of the Robert Wood Johnson Foundation at the Institute for Healthcare Improvement funded to develop and test efficient approaches to empower patients and families to manage their chronic conditions. The program also engages patients and families as advisors to improve the design and delivery of health care services.

[http://www.improvingchroniccare.org/downloads/selfmanagement\\_support\\_toolkit\\_for\\_clinicians\\_2012\\_update.pdf](http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf)

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**Appendix E: BHAP Pre versus Post Comparison of Self-Assessment Ratings of the Integrated Care Practice Survey**

NOTE: ratings range from 1 to 10 with smaller number denoting the item does not exist or our, and larger numbers denoting more integration, access, support.

Survey Section / Item	FRANKLIN HD-VIM			MTW DISTRICT HD			POLK WELLNESS CTR.			RUTHERFORD CHC			PRE Item Average	POST Item Average
	Pre	Post	Post-Pre	Pre	Post	Post-Pre	Pre	Post	Post-Pre	Pre	Post	Post-Pre		
<b>INTEGRATED SERVICES</b>														
Co-location	2	9	7	6	5	-1	7	10	3	8	8	0	5.8	8.0
Screening, assess. of BH needs	9	8	-1	3	5	2	8	9	1	7	8	1	6.8	7.5
Treatment plan(s) integration	9	7	-2	6	5	-1	10	10	0	6	7	1	7.8	7.3
Evidence-based best practice	9	8	-1	3	7	4	7	9	2	6	7	1	6.3	7.8
SUM OF SECTION RATINGS	29	32	3	18	22	4	32	38	6	27	30	3		
AVERAGE SECTION RATINGS	7.25	8.00	0.75	4.50	5.50	1.00	8.00	9.50	1.50	6.75	7.50	0.75		
<b>PATIENT, FAMILY-CENTEREDNESS</b>														
Involvement in care plan	9	5	-4	3	6	3	9	9	0	5	5	0	6.5	6.3
Social support	5	7	2	4	6	2	9	9	0	5	7	2	5.8	7.3
Linkage to comm. Resources	2	9	7	6	6	0	7	8	1	6	9	3	5.3	8.0
SUM OF SECTION RATINGS	16	21	5	13	18	5	25	26	1	16	21	5		
AVERAGE SECTION RATINGS	5.33	7.00	1.67	4.33	6.00	1.67	8.33	8.67	0.33	5.33	7.00	1.67		
<b>PRACTICE / ORG. SUPPORTS FOR CHANGE</b>														
Leadership for providing BH care	9	10	1	3	6	3	10	10	0	8	5	-3	7.5	7.8
Provider engagement with integ. care	9	10	1	1	6	5	9	9.3	0.3	6	8	2	6.3	8.3
Continuity of care – primary & BH providers	6	8	2	5	8	3	9	9.5	0.5	7	7	0	6.8	8.1
Coord. of referrals for BH care	2	9	7	4	5	1	7	8.3	1.3	6	7	1	4.8	7.3
Data systems, patient records	2	9	7	1	4	3	6	7	1	6	4	-2	3.8	6.0
Educ, training for integrated care	2	7	5	3	7	4	8	9.4	1.4	4	5	1	4.3	7.1
Funding sources/resources	2	1	-1	1	1	0	9	9.5	0.5	6	6	0	4.5	4.4
SUM OF SECTION RATINGS	32	54	22	18	37	19	58	63	5	43	42	-1		
AVERAGE SECTION RATINGS	4.57	7.71	3.14	2.57	5.29	2.71	8.29	9.00	0.71	6.14	6.00	-0.14		
<b>GRAND SUM OF RATINGS</b>	77	107	30	49	77	28	115	127	12	86	93	7		
<b>GRAND SUM as percent of perfect score</b>	55.0%	76.4%		35.0%	55.0%		82.1%	90.7%		61.4%	66.4%			
<b>GRAND AVERAGE OF RATINGS</b>	5.50	7.64	2.14	3.50	5.50	2.00	8.21	9.07	0.86	6.14	6.64	0.50		
Elapsed mos.days between Pre and Post	9.10			10.4			10.1			9.5				