Integrating Primary Medical Care and Behavioral Health Services: The New Mexico SBIRT Experience

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NIATx NACHC Learning Collaborative
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Overview of Today’s Webinar

- Why Integrate Behavioral Health and Primary Medical Care Services?
- What is meant by true Integration?
- Essential Tools and Resources for Integration
  - Clinical Side Integration
  - Business Model and Administrative Integration
- New Mexico Behavioral Health Integration: What did we Learn?
  - Clinical Side Integration
  - Business Model and Administrative Integration
- Summary and Benefits of Integration
- Acknowledgements
About Sangre De Cristo Community Health Partnership

- A New Mexico 501© 3 Organization
- Administrative organization sub-grantee to administer and implement the SAMHSA Screening, Brief Intervention and Referral to Treatment Pilot Program 2003-2008
- Integrated medical care and behavioral health services in 35 partner sites throughout New Mexico consisting of: FQHCs, School Based Health Clinics and Public Health Offices
- Hired, trained, assigned and supervised 24 masters level behavioral health counselors to these 35 partner sites.
- After 2008—SAMHSA federal funding ended, SDCCHP has continued with the SBIRT model but has downsized the program significantly to ½ the sites and geographic area of what it previously covered.
Why Integrate Behavioral Health and Primary Care?
Who Are We Trying to Reach?

Spectrum of Alcohol Use

1% (1.25) Addicted

25% engaged in risky, harmful or hazardous drinking

5% (6.25 million) Daily Harmful Drinking or dependence behavior

32.5 million people could benefit from brief intervention

20% (26.25 Million) At Risk Exceed daily limits

Individuals in need of behavioral health treatment often don’t perceive the need for treatment.
70% of all healthcare visits driven by psychosocial factors
50% of all mental health care is provided in primary care
92% of elderly patients receive Behavioral Health support/services solely from PCP

70% (87.5 Million) Occasional or non drinkers, seldom exceed daily limits for alcohol consumption
Why Integration?
Integration of SBIRT is specifically designed to identify at risk individuals, to enhance their awareness of the risks of their drinking, and motivate them to either reduce their consumption or seek treatment.
What do We Mean by Integration

- Not merely Co-Location of Behavioral Health Services close to the medical setting
- Although important it is not simply making the PCP better at managing Behavioral Health Problems of his/her patients.
- Often defined as an Expanded View of Behavioral Health to include:
  - Traditional Components of Behavioral Health
  - Addiction Medicine
  - Pain Management
  - Wellness Medicine
- Early Integrative models focused on providing training to primary care providers to enable them to feel more comfortable managing behavioral health problems in primary care.
- While this concept is often well received by the PCP’s, time and the concern about the crowding out of other components of primary care become the major barriers to successful implementation to the following extent:
  - “I am too stressed for time to take this on”
  - “I just want someone to see the patient for me”
What do We Mean by Integration Cont’d

- More than simply co-location Behavioral Health Counselor is considered a legitimate partner within the health care team
- Ideally the health care team Integrated would consist of:
  - Primary Care Provider
  - Psychiatry
  - Psychologist
  - Behavioral Health Counselors
- The BHC is located with the primary care providers for easy access by them for the warm handoff of the patient.
- BHC bills for MH services as part of the host organization
- BHC documents services in the patient medical record
- BHC attends medical staff meetings as part of the medical team and to provide input and information on patients when requested.
Training for medical clinic staff and behavioral health counseling staff on Integration and Motivational Interviewing

Implementation of Universal screening tools to identify at risk patients.
  - AUDIT and/or the PHQ2 for depression screening

On site behavioral health counseling capacity full time
  - Hiring/placement of a behavioral health counselor on clinic staff
  - Contracting with outside agency for the time/placement of behavioral health counselor on clinic staff

The warm handoff from the Provider (PCP) to the Behavioral Health Counselor.

Implementation of a Screening, Brief Intervention, and Referral to Treatment Model

Implementation and coaching on Motivational Interviewing Techniques
Integrated Model Core Clinical Components

- **Screen**
  - Identification of substance related and depression problems

- **Brief Intervention**
  - Uses Motivational Interviewing to raise awareness of risks and motivate client toward treatment engagement

- **Brief Treatment**
  - Cognitive behavioral treatment (Community Reinforcement Approach, IMPACT, Community Reinforcement Approach and Family Treatment) with clients who elect further treatment or need follow-up care (Including co-occurring disorders)

- **Referral to Treatment**
  - Referral of those with more serious or emergent treatment needs.
Integrated Model: Clinical Patient Flow

- Patient Universal Screening - nurse, medical assistant, front desk
- Motivational Interviewing
  - 1-3 Sessions
- Brief Treatment with BHC on site
  - 8-12 Sessions
- Warm handoff to BH Counselor by Medical Provider
- Referral to Community Specialty Treatment Providers as indicated
- Patient Score Feedback to PCP
- Continuous Feedback to PCP
- Brief Intervention with BHC Assessment & Feedback
  - Motivational Interviewing
  - 1-3 Sessions
- Warm handoff to BH Counselor by Medical Provider
- Referral to Community Specialty Treatment Providers as indicated
- Continuous Feedback to PCP
One of the major Clinical Tools
What is Motivational Interviewing?

A person centered goal orientated approach for facilitating change by exploring & resolving ambivalence (Miller 2006)

...a method of communication rather than a set of techniques. It is not a bag of tricks for getting people to do what they don’t want to do; rather, it is a fundamental way of being with & for people – a facilitative approach to communication that evokes change” (Miller & Rollnick 2002)
“It’s some new thing called an intervention.”
When working with a client, would you rather be

or
<table>
<thead>
<tr>
<th>Spirit of Motivational Interviewing</th>
<th>Key Elements for Using Motivational Interviewing in a Brief Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ COLLABORATION VS. CONFRONTATION</td>
<td>☐ Ask-Provide-Ask</td>
</tr>
<tr>
<td>☐ EVOCATION VS. EDUCATING</td>
<td>☐ Reflection/Roll with Resistance</td>
</tr>
<tr>
<td>☐ AUTONOMY VS. AUTHORITY</td>
<td>☐ Importance (or Interest) Ruler</td>
</tr>
<tr>
<td></td>
<td>☐ Confidence Ruler</td>
</tr>
<tr>
<td></td>
<td>☐ Summary</td>
</tr>
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<td></td>
<td>☐ Menu of Options</td>
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<tr>
<td></td>
<td>☐ “What do you think you’ll do”</td>
</tr>
</tbody>
</table>
Before giving advice or information…

- **Ask:** “Would it be okay with you to share some information/advice I have about smoking”

- “Elicit the patient’s own ideas and knowledge on the subject?”

- **Provide** the information/advice

- **Ask:** “What do you make of that?”
Readiness to Change
Assessing Interest, Importance, & Confidence with Rulers

- Importance Ruler
  “On a scale of one to ten how important is it to make a change in your behavior (smoking)?”
  Query: “What makes it an 8 and not a 2?”

- Confidence Ruler
  “On a scale of one to ten how confident do you feel that you can make a change in your behavior?”
  Query: “What would it take to move it up to an 8?”
Summarize and Offer Options

- Summary of information and change talk
- Menu of choices
- Ask the client: “What do you think you will do?”
Using Motivational Interviewing to Dialogue and Work with Partner Sites

Motivational Interviewing Techniques are useful when addressing partner site staff’s:

- Concerns/resistance about adapting the SBIRT model to the clinic needs
- regarding integration of behavioral health
- Concerns about patient autonomy and confidentiality
- Reluctance to change established routines
- Feeling overwhelmed by the addition of new tasks/roles
- Concerns

Remember, we want to dance, not wrestle with our clinic partners
New Mexico Behavioral Health Integration: Clinical Integration Lessons Learned

- Choose a screening tool well suited to the FQHC and/or mental health agency
- Initial training and orientation for all clinical staff important in order to gather staff feedback and suggestions
- Training of the on-site behavioral health counselor improved changes of integration and also facilitated ongoing training of the clinical staff
- Weekly clinical supervision either on site or by Telehealth when available added to success of integration.
- Normalizing Screening and Brief Intervention into the FQHC system was important:
Clinical Integration Lessons Learned

Common Challenges for Medical providers in integrating an early Screening and Intervention Model like SBIRT

- Adding one more priority task to an already overworked provider staff
- Broadening provider role
- Addressing non-acute issues
- Developing confidence in new team member i.e., the Behavioral Health Counselor
- Demanding support staff cooperation
Clinical Integration Lessons Learned

**Challenges for Behavioral Health Counselors**

- Medical clinics run at a different often frantic pace
- Office space is often less than adequate
- Intimidated by Physicians
- Learning new communication styles
- Undoing old ‘counseling’ habits
- Being a new service ‘promoter’ of integration
Clinical Integration Lessons Learned

**Normalizing Screening and Brief Intervention**

- When framed as a routine part of the clinic visit, very few patients refused screening.
- Providers found a “scripted” warm hand-off initially helpful.
- When properly done, patient choice is maintained; Clinic Staff more comfortable and cooperative and patient resistance is minimized.
New Mexico Behavioral Health Integration:
Business and Administrative Lessons Learned

- Determining the Organization’s readiness for change to integrated behavioral health is critical
- Find a champion (s) for the integrative model within the clinic
- Regular and continuous communication with clinic leadership: Executive and Medical Directors, Nursing Supervisor, etc.
- Buy-in is critical at all levels: providers, nursing, and administrative staff
- Behavioral Workforce Capacity will become an issue with Health Care reform initiatives. Need for additional training on evidenced based initiatives including screening and brief intervention
- Expansion of SBIRT into Hospital ED settings and Correctional Settings, working with Veterans etc, Employee Assistance Programs
- Expansion and reimbursement for Telehealth services into rural areas for behavioral health treatment interventions for greater access to services.
New Mexico Behavioral Health Integration: Business and Administrative Lessons Learned

- Implementation of a Behavioral Health Collaborative Model Agreement of Scope of Services, Compensation and Fair Market Value
  - Defines expectations from the FQHC in terms of hosting the behavioral health counselor—(Universal Screening, Office Space, Supervision of BHC)
  - Defines expectations of the Behavioral Health Counselor working in the FQHC and expectations of the outside sponsoring agency of the BHC if that is the model. (Supervision, Documentation within the clinical medical record, billing procedures, # of patients to be seen etc.)
  - Defines the clinical model to be implemented and roles of the Behavioral Health Counselor, Front Desk staff, Nursing staff and PCP.

- **Compensation:** Contract payment is directly (and exclusively) linked with only the costs of providing integrated behavioral health services

- **Fair Market Value:**
  - Establishing a benchmark by comparing the average salaries of BHC providers with the average salaries of similar providers in the area or region.
  - No attempt to include any consideration reflecting past or future referrals or business (an arms length transaction)
New Mexico Behavioral Health Integration:  
Business and Administrative Lessons Learned  Cont’d

☐ Implementation of AMA/CMS approved SBI Billing Codes  
  ■ If not already adopted will require work with State Medicaid  
    Directors to include within the State Medicaid Plan.

☐ Adequately trained and credentialed BH workforce that will allow for  
  billing with the health plans and Medicaid and Medicare and trust of the  
  PCP.

    Providers can be  
    reimbursed for SBI

http://www.ensuringsolutions.org/resources/resources_show.htm?doc_id=385233&cat_id=2005
<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
<th>Fee Schedule</th>
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<tbody>
<tr>
<td>Commercial Insurance</td>
<td>CPT 99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
<td>$33.41</td>
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<tr>
<td></td>
<td>CPT 99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
<td>$65.51</td>
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<tr>
<td>Medicare</td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
<td>$29.42</td>
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<td></td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
<td>$57.69</td>
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<tr>
<td>Medicaid</td>
<td>H0049</td>
<td>Alcohol and/or drug screening</td>
<td>$24.00</td>
</tr>
<tr>
<td></td>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 min</td>
<td>$48.00</td>
</tr>
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</table>
New Mexico Behavioral Health Integration:
Business and Administrative Lessons Learned

**Partner Site Selection**
- Initial enthusiasm was a poor predictor of success
- Readiness for organizational change to integrated behavioral health is critical
- Find a champion in the clinic!
- Choose a screening tool well-suited to the clinic
- Develop and implement a detailed MOA
- Maintain frequent contact between SBIRT clinical and executive management and key clinic staff

**Level of integration of the SBIRT model/program into the partner site.**
- Ability/willingness of partner site to help SDCCHP financially sustain some of the salary for the assigned behavioral health consultant and
- Ability/willingness of the partner site to implement 3rd party billing for behavioral health services under the Integrated Behavioral Health SDCCHP contract model of payment to SDCCHP for fair market value for behavioral health services provided to the site.
New Mexico
Individuals Served
10/01/2003 – 10/01/2008

<table>
<thead>
<tr>
<th>Modality</th>
<th>NM SBIRT Client Targets</th>
<th>NM SBIRT Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Intervention</td>
<td>9,100</td>
<td>8,313</td>
</tr>
<tr>
<td>Brief Treatment</td>
<td>1,950</td>
<td>2,258</td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>1,300</td>
<td>566</td>
</tr>
<tr>
<td>Screening</td>
<td>52,650</td>
<td>54,038</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65,000</strong></td>
<td><strong>65,175</strong></td>
</tr>
</tbody>
</table>
Sangre-CHP NM SBIRT Clinical Partner Sites
Current (Downsized)

First Choice
Albuquerque
Rio Grande
High School

First Choice
Edgewood

LCDF
Anthony

LCDF
Chaparral

LCDF
Santa Teresa
High School

LCDF
Sunland Park

LCDF
East Mesa

Pecos Valley
Medical Center

First Choice
Albuquerque
South Valley

SDCCHP
Adm. Office

Telehealth Interactive Video Sites
Department of Corrections Sites
Distance Education Interactive Video Sites
<table>
<thead>
<tr>
<th>GPRA Measures</th>
<th>Percent at Intake</th>
<th>Percent at 6-month follow-up</th>
<th>Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence: did not use alcohol or illegal drugs</td>
<td>29.1%</td>
<td>46.0%</td>
<td>58.0%</td>
</tr>
<tr>
<td>Drinking: Mean Days of Alcohol use/month</td>
<td>8.2%</td>
<td>4.9%</td>
<td>40.4%</td>
</tr>
<tr>
<td>Binge Drinking—Alcohol to Intoxication</td>
<td>7.4%</td>
<td>2.9%</td>
<td>60.3%</td>
</tr>
<tr>
<td>Drug Use Mean days of Drug use/month</td>
<td>13.9%</td>
<td>6.4%</td>
<td>53.9%</td>
</tr>
<tr>
<td>Employment/Education: were currently employed or attending school</td>
<td>53.5%</td>
<td>56.9%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Health/Behavioral/Social Consequences: experienced no alcohol or illegal drug related health, behavioral, social consequences</td>
<td>58.4%</td>
<td>82.5%</td>
<td>41.5%</td>
</tr>
<tr>
<td>Stability in Housing: Had a permanent place to live in the community</td>
<td>62.4%</td>
<td>63.9%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>
### Additional Outcomes
**New Mexico Behavioral Health Integration**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Utilization</td>
<td>76% Reduction</td>
</tr>
<tr>
<td>Average days of Depression</td>
<td>50% Reduction</td>
</tr>
<tr>
<td>Criminal Justice Involvement</td>
<td>31% Reduction</td>
</tr>
<tr>
<td>Average Wages</td>
<td>42% Increase</td>
</tr>
<tr>
<td>Monthly Savings to System</td>
<td>$97,356.00</td>
</tr>
<tr>
<td>Annual Savings to System</td>
<td>$2,920,700</td>
</tr>
</tbody>
</table>
Keys for Sustainability of the Integrated Model?

- Understanding and adapting to the complexity of rural sites in terms of diversity and residents
- Need for flexibility and adaptability of the model Reducing stigma and patience involved in earning trust
- Expansion and integration of the model beyond substance abuse to mental health and other areas
- Understanding and planning where the Integration of behavioral health and medical care fits into future Health Care Reform.
- Implement CMS Screening and Brief Intervention Codes within the State Medicaid Programs
Summary
Integration of Behavioral Health and Medical Care Services
The New Mexico SBIRT Experience

**Significant impact in service delivery-- For the Consumer**
Provides a care continuum that allows care to happen at the community level seamlessly and without stigma to the patient.
On site care avoids disconnect for the patient.

**Significant impact in service delivery-- For the Provider**
Extends the range of expertise of what a counselor and medical provider can accomplish individually.
The team on site engagement is enhanced because of the collegiality of the model.
The model bridges the gap between diagnosis and therapeutics on site providing for the right level of patient care.
Creates confidence between the provider and the behavioral health counselor knowing that the supervisory and psychiatric consultation support is there.
Sangre model and structure can be duplicated anywhere in the state.

**Significant impact in service delivery-- For the State**
Projected savings to the health care delivery system of $97,356 per month or $2.9 million annually.
Implemented access to a fully connected and operational statewide Telehealth network as a conduit for clinical supervision, training and patient case consultations.
Acknowledgements and Thanks

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  George Washington University Medical Center