

Behavioral Health Integration



Seneca Nation Health System



SENECA NATION HEALTH SYSTEM



Goals



- Seneca Nation Health System overview
- Previous behavioral health model
- New vision for Integrated care
- Collaborative Care Model
- HIPAA & 42CFR Part 2
- Sustainability
- Challenges/Lessons Learned





Seneca Nation Health System



- 638 Tribally run system
- 2 tribal outpatient clinics
 - Cattaraugus Indian Reservation Health Clinic, Irving, NY
 - Lionel R. John Health Center, Salamanca, NY
- Provide Medical, Dental, Optical, Behavioral Health, Pharmacy, Lab, some specialty services, Peer Recovery, Child & Family Services
- MOU with Cayuga Nation



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<https://gardenwarriorsgoodseed.com/2015/01/29/food-is-our-medicine-seneca-nation-new-york/>



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Previous System Design



- Medical etc. on a separate electronic health record no access to behavioral health information
- Poor inter-department communication and little to no consultation regarding medication
- Psychiatric care documented in two different EMR and if a controlled substance charted in yet another





Previous System Design



- Outpatient team
 - Addiction Counselors (CASAC)
 - Behavioral Health Counselors (LMSW, LCSW, LMHC)
 - Psychiatric care (NP, MD)
- Separate treatment plans for all patients providers (not including medical)
- Only outpatient counselors would be included in case review every 90 days (not psychiatric or medical)





Previous System Design



- Psychopharm managed by Psychiatric provider with little consultation or referral back to primary care
- Created deep silos within care collaboration and coordination
- MAT provided off site by contracted provider documenting in still yet another system





Integration Vision



- Seamless communication between healthcare providers
 - Improved referrals, collaboration of care, medication management
 - Access to behavioral health care quickly and easily
 - Reduce stigma of behavioral health care
- Improved patient health outcomes





Collaborative Care thru Collaboration



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University at Buffalo

Research Institute on Addictions

Behavioral Health Integration in a Native American Primary Care Clinic

Chang | [Dermen](#) | Nisbet | Campbell-Heider | Casucci | Loomis | Moss
The grant aims to integrate behavioral health into primary care services within the Seneca Nation Health System, thereby increasing access to mental health and substance abuse screening and treatment.

The UB School of Nursing and the Seneca Nation Health System will collaborate to develop an interprofessional collaborative practice (IPCP) team to augment traditional primary care with integrated behavioral health services in the practice setting. SBIRT (Screening, Brief Intervention, and Referral to Treatment) and IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) will be implemented as part of the behavioral health services to increase patient access to mental health and substance abuse care. The project also will include educational and experiential emphasis on cultural sensitivity about Native American health care beliefs, customs, family dynamics, communication patterns and social determinants of health, which can impact access and adherence to mental health care, and provide clinical training to graduate students in the School of Nursing and UB School of Social Work

https://www.buffalo.edu/ria/research/research_2/disc_ria_treatment.host.html/content/shared/www/ria/research/researc_projects/current_research/UD7HP30924.detail.html



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Collaborative Care thru Collaboration



 University at Buffalo
Research Institute on Addictions

- Provides project support
 - EMR system support
 - Clinical training
 - Project evaluation

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- Provides administrative support
 - Behavioral health providers
 - Social Worker
 - Psychiatrist
 - EMR infrastructure & data management (SNHS retains all rights to data)
 - Manages implementation team



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Collaborative Care Effectiveness



- Most evidence based on Primary Care settings
- More than 80 randomized controlled trials have shown Collaborative Care to be more effective than usual care for
 - Depression
 - Anxiety
 - Co-morbid medical conditions (heart disease, diabetes, cancer)
- 30-50% of patients have a full response to the first treatment, meaning 50-70% of patients need at least one change in treatment

<https://aims.uw.edu/collaborative-care/evidence-base>



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Principles of Collaborative Care



- Patient-Centered Team Care
- Population-Based Care
- Measurement-Based Treatment to Target
- Evidence-Based Care
- Accountable Care

<https://aims.uw.edu/collaborative-care/principles-collaborative-care>



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Patient-Centered Team Care



- Primary care and behavioral health providers collaborate using shared care plan
- Ability to get both physical and behavioral healthcare at the same familiar location is comfortable (reduces stigma)

<https://aims.uw.edu/collaborative-care/principles-collaborative-care>



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Population-Based Care



- Tracked using a registry to ensure no one falls through the cracks
 - Locally stored and managed data by SNHS
- Allows team to reach out to patients who are not improving

<https://aims.uw.edu/collaborative-care/principles-collaborative-care>



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Measurement-Based Treatment



- Routine screening using assessments
 - PHQ-2 & 9
 - GAD
 - AUDIT
 - DAST
- Provide clinicians opportunities to track/trend/respond to patient needs
- Conducted on paper and using tablets with integration into EMR

<https://aims.uw.edu/collaborative-care/principles-collaborative-care>



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Evidence-Based Care*



- Problem Solving Therapy (PST)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Interpersonal Counseling (IPC)
- Behavioral Activation (BA)
- Screen, Brief Intervention & Referral to Tx (SBIRT)
- Psychopharmacology

*Evidence-based doesn't mean they are effective with our patient population, we also include culturally appropriate treatment options/referrals





Care continued



- To be effective in primary care, a behavioral health intervention should:
 - Include a patient engagement component
 - Be time efficient, running no more than 20-30 minutes
 - Follow a structured patient centered approach

<https://aims.uw.edu/collaborative-care/principles-collaborative-care>



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Accountable Care



- Patients get better quicker
- Commercial insurance companies reimburse for services and/or value based payments

<https://aims.uw.edu/collaborative-care/principles-collaborative-care>



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Care Team



- Patient
- Behavioral Health Care Manager
 - Performs all care management tasks including offering psychotherapy if appropriate
- Primary Care Provider (PCP)
 - Provides all care for patient in consultation with BH care manager and psychiatric provider
- Psychiatric Consultant
 - Assist team with dx, tx planning and recommendations about changes in tx when patient not at least 50% improved after 10-12 weeks
- Peer Recovery Advocates* (SNHS Model addition)
- Child & Family Case Workers* (SNHS Model addition)

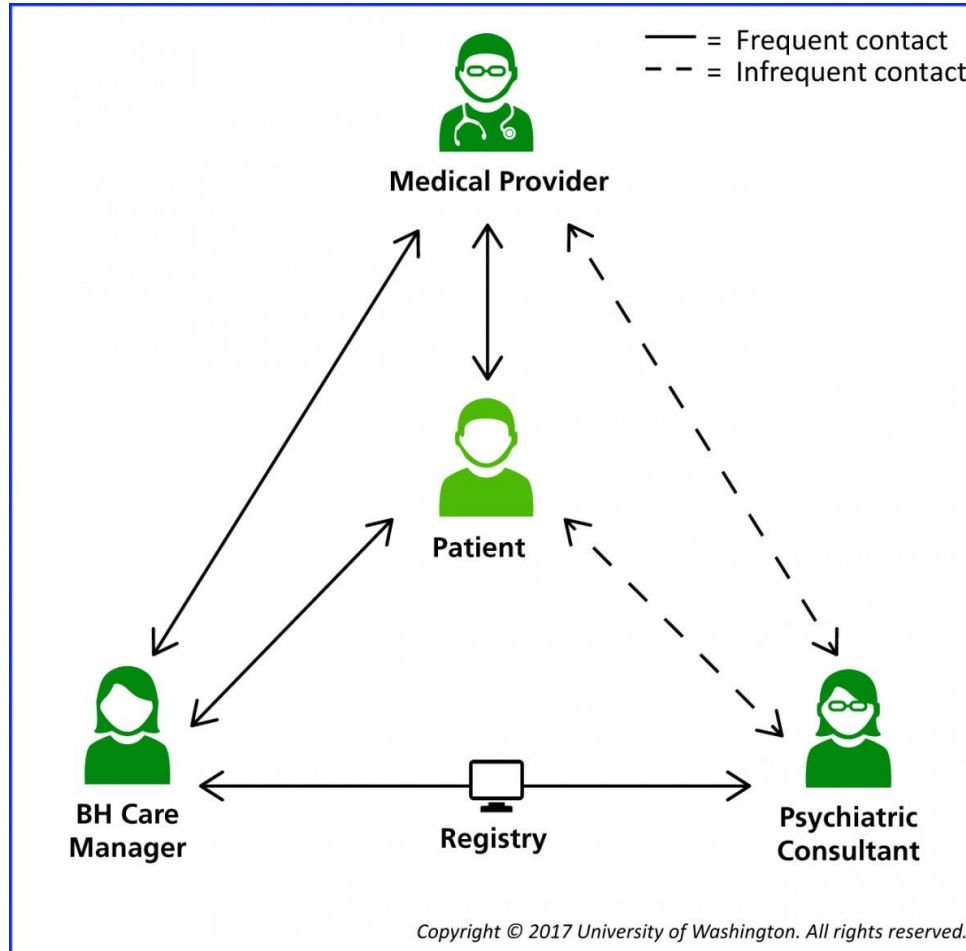
<https://aims.uw.edu/collaborative-care/principles-collaborative-care>



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Collaborative Care



<https://aims.uw.edu/collaborative-care/team-structure>



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Implementation





Lay the Foundation



- Understand Collaborative Care
- Assess Organizational Readiness
- Create a Shared Vision
- Develop a Sustainability Plan
- Identify Your Champions

<https://aims.uw.edu/collaborative-care/implementation-guide/lay-foundation>



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Plan for Clinical Practice Change



- Build Your Team
- Create a Clinical Workflow
- Identify a Population-Based Tracking System
- Make an Action Plan

<https://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change>



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Build Your Clinical Skills



- Care Team Training
- Behavioral Health Care Manager Training
- Primary Care Provider Training
- Psychiatric Provider Training

<https://aims.uw.edu/collaborative-care/implementation-guide/build-your-clinical-skills>



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Launch Your Care



- Educate Your Patients
- Address Unanticipated Challenges
- Monitor Implementation Process and Clinical Outcomes
- Relapse Prevention Planning

<https://aims.uw.edu/collaborative-care/implementation-guide/launch-your-care>



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Nurture Your Care



- Monitor implementation process and clinical outcomes and merge into QI projects
- Incorporate training and support
- Expand Collaborative Care to other locations and populations
- Be mindful of new hires as they come on board

<https://aims.uw.edu/collaborative-care/implementation-guide/nurture-your-care>



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Integrating HIPAA & 42 CFR Part 2



- Many HIPAA Provisions PERMIT something but don't mandate it
- 42 CFR Part 2 PROHIBITS all disclosures unless specifically allowed by the regulation
- Possible areas of conflict: disclosure of payment, patient rights, administrative requirements, personal representatives, re-disclosure of information, disclosure to other providers, medical emergencies, disclosure to public health, court orders, disclosure of abuse

www.ehcca.com/presentations/HIPAA10/6_04.ppt



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Integration Action Steps



- Conduct risk assessment and gap analysis
- Determine Privacy Officer and privacy structure
- Determine which services are covered by law
- Combine Privacy Notices and acknowledgment
- Combine the Qualified Service Organization Agreement and Business Associate Agreement
- Formulate written policies and formalized procedures around patient rights and administrative requirements

www.ehcca.com/presentations/HIPAA10/6_04.ppt



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Action Steps Continued



- Set up training for team
- Set up complaint system
- Formulate sanction policy
- Add a system to track and document disclosures
- Change authorizations: format
- Develop process for written revocation of authorization
- Develop auditing system

www.ehcca.com/presentations/HIPAA10/6_04.ppt



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Sustainability



- Medicare
 - Behavioral Health Integration Services
 - 99492- First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating provider
 - 99493- First 60 minutes in a subsequent month for behavioral health care manager activities
 - 99484- Care management services for behavioral health conditions- At least 20 minutes of clinical staff time per calendar month

https://aims.uw.edu/sites/default/files/CMS_FinalRule_BHI_CheatSheet.pdf



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Sustainability



- Medicare
 - FQHC & Rural Health Clinics
 - G0511- General Care Management Services: Minimum of 20 minutes per calendar month
 - G0512- Psychiatric Collaborative Care Model services: Minimum of 70 minutes in the first calendar month of psychiatric CoCM services and at least 60 in subsequent calendar months for CoCM services

https://aims.uw.edu/sites/default/files/CMS_FinalRule_FQHCs-RHCs_CheatSheet.pdf



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Medicare Payment Summary 2018



Code	Description	Payment/Pt (Non-Facilities) Primary Care Setting	Payment/Pt (Fac) Hospital & Facilities
99492	Initial psych care mgmt, 70 min/mon	\$161.28	\$90.36
99493	Subsequent psych care mgmt, 60min/mon	\$128.88	\$81.72
99494	Initial/Subsequent psych care mgmt, add 30min	\$66.60	\$43.56
99484	Care mgmt. services, min 20 min	\$48.60	\$32.76
FQHC & Rural Health Clinics		Payment	
G0511	General Care Mgmt. Services- 20min/mon	\$62.28	
G0512	Psychiatric CoCM- Min 70 min initial month and 60 min subsequent months	\$145.08	

*Every clinic/program is different, check with your billing/finance department



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Sustainability



- Accountable care and value-based purchasing strategies
- Psychotherapy fee-for-service
 - Case rates
 - Bundled service rates
- IHS all inclusive rates (Medicaid & Medicare)





Sustainability (SBIRT)



Payer	Code	Description	Fee Schedule
Commercial Insurance, Medicaid	99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	\$33.41
Commercial Insurance, Medicaid	99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	\$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	\$29.42
Medicare	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	\$57.69
Medicare	G0442	Prevention: Screening for alcohol misuse in adults including pregnant women once per year. No coinsurance; no deductible for patient http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Reduce-Alcohol-Misuse-ICN907798.pdf	\$17.33
Medicare	G0443	Prevention: Up to four, 15 minute, brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse; No coinsurance; no deductible for patient http://www.cms.hhs.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249	\$25.14
Medicaid	H0049	Alcohol and/or drug screening (code not widely used)	\$24.00
Medicaid	H0050	Alcohol and/or drug service, brief intervention, per 15 min (code not widely used)	\$48.00

https://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf



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Sustainability (Peer Services)



- NYS Specific Info
 - Peer support is a face-face service & is coded as a procedure-based weight that recognizes units
 - Each unit is 15 minutes, and only 4 units can be coded per visit date (1 hour max per day)
 - HCPCS procedure code is H0038 and the description category is Self-Help/Peer Services
 - 822 Clinics Upstate: \$11.15 per unit
 - Some programs may seek IHS All Inclusive Rate which may also enhance sustainability





Challenges/Lessons Learned



- Leadership support is really important
- Strategic department Champions needed
- EMR changes always take longer than expected
- Don't forget to include coding/billing
- Don't forget to inform patients of the change with understanding of why





Questions??



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