Scripps

Team members: Maggie Carmona, Josh Steenstra, Siu-Ming Geary, Vicki Diamond, Gurinder Dabhia, Denise Coyle, Leslie Reynolds, Jessica Guevara, Amanda Schena

Vision Statement: Bringing comprehensive, compassionate, and supportive behavioral health to Southern California today, tomorrow, and forever forward.

Model: CoCM	**BHI Population of Focus:** CoCM requirements, focus on mild to moderate Anxiety & Depression	**Staffing:** 10 providers (care team), BHCM, psych consultant	**Pilot Site:** Scripps Clinic Rancho Bernardo

Vision Statement Board

Biggest Accomplishment

- Advocating for Scripps Health to be willing to step forward with a new process which is new and innovative for the group.
- Provider and leadership involvement speaks to the acknowledgement and importance of addressing mental health for our patients
- Provider engagement and enthusiasm for the program has supported plan to spread CoCM program beyond the pilot.

Aim Statement

We Scripps Health will improve screening and treatment at Rancho Bernardo Clinic, for patients presenting with mild to moderate anxiety and depression. By incorporating behavioral health treatment in the primary care setting for patients 12+ with scores between 10 to 19 on the GAD-7/PHQ9 or with presenting symptoms. We will improve screening rates from 57% to 65% by 1 year from CoCM launch.

Measurement Plan

Measure Type	Measure
Outcome	Depression Remission or Response for Adolescents and Adults
Process	Depression Screening and Follow-Up for Adolescents and Adults
Patient Experience	Measures
Workforce	Collaboration
Financial	Revenue Generation: Screening codes and visits

Biggest Lesson Learned

- Don't underestimate the complexity of the process
- Surprised with how many disciplines were required to approve a program in primary care
- There was always another "rung on the ladder" of stakeholders

Where We Are Going Next

1. Final signature on the dotted line
2. Establishing staffing and workflows
3. EPIC build
4. Establishing expectations for the new working relationship with LifeStance, while keeping the Scripps Health vision intact
5. Launch!

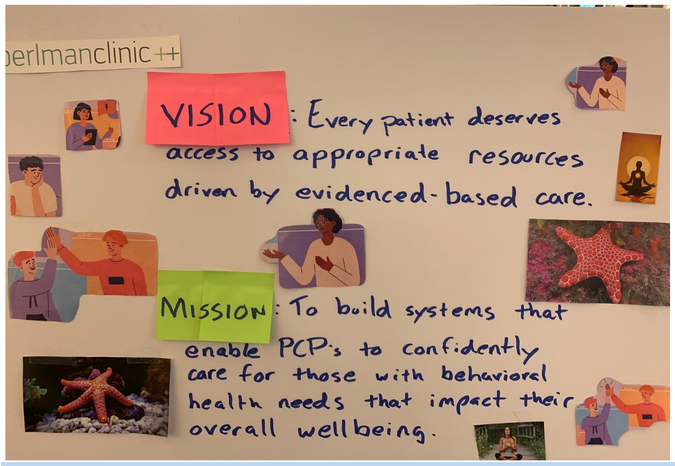
Perlman Clinic

Team members: Parag Agnihotri, Mike Rufo, Bill Perry, Carrie Garrigus, Lauren MacGregor, Elisa Rosales, LC Russell, Michaal Klade, Victoria Harris

Vision Statement: Every patient deserves access to appropriate resources driven by evidenced-based care..

Model: PCBH	**BHI Population of Focus:**	**Staffing: Provider, BHC**	**Pilot Site:** Hillcrest

Vision Statement Board



Aim Statement

We Perlman Clinic will improve Patient Experience related to mental health care by increasing percentage of penetration of patients seen by and serviced by our mental health services / team (BHC, Therapists, Psych) for all of our adult (18 yrs +) patients from 0 to 18 % by December 2025.

Biggest Accomplishment

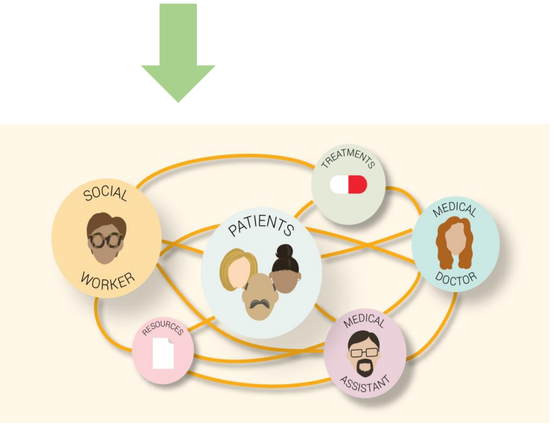
Our BIGGEST Accomplishment up to this point has been establishing who our Behavioral Health Coach will be! We are transitioning our therapist team member to coaching and she is very excited to be a part of integrating the PCBH Model.

Biggest Lesson Learned

Primary Care Providers and Mental Health Therapists who are already on our team will need to become more educated on the purpose of PCBH and mental health integration through Primary Care in order for this program to succeed.

Where We Are Going Next

- We are currently working to establish and create workflows for our Primary Care Providers that will encourage a hand-off to the Behavioral Health Coach on our team.
- We are working to improve our e-check in process which encourages patients to complete PHQ questionnaires prior to their appointment, providing a reminder and suggested care plan for our Primary Care Providers.



Measurement Plan

Measure Type	Measure
Outcome	Percentage of patients improved PHQ score with BHI involvement
Process	Percentage of patients 18 and up with Depression Screenings completed
Patient Experience	Percentage of patients participating in BHI program, score 4+
Workforce	Assess if staff members feel adequately equipped with the necessary resources to implement the program
Financial	Percentage of PCP team members that utilize the PHQ screen billing code

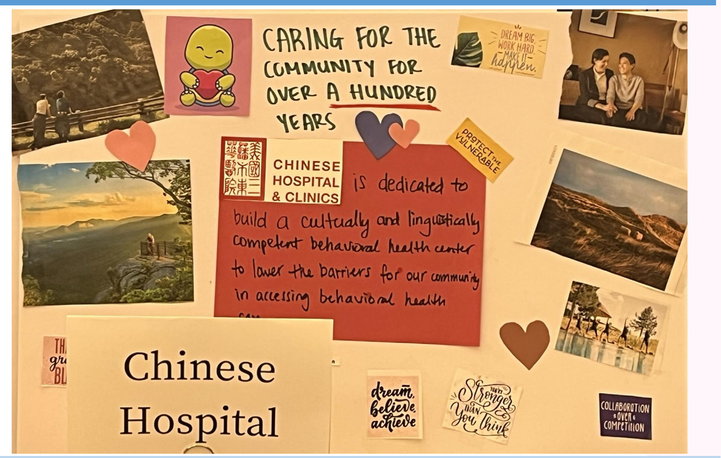
Chinese Hospital

Team members: Jiami Wu, Rain Zhang, Dr. Scott Huang, Dr. Henry Poon, Kaier Guan, Abel Lai, Ruby Li

Vision Statement: Chinese Hospital & Clinics is dedicated to build a culturally and linguistically competent behavioral health center to lower the barriers for our community in accessing behavioral health care.

Model: COCM	**BHI Population of Focus:** common chronic mental illness, such as depression and anxiety	**Staffing:** LCSW, Psychiatric Consultant, PCP, Medical Assistant	**Pilot Site:** Gellert Health Services

Vision Statement Board



Aim Statement

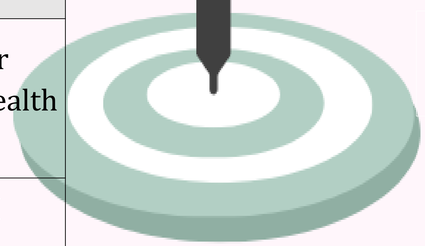
By December 31, 2025, Chinese Hospital & Clinics will reduce 80% of the gap between Asian and non-Asian patients (ages 12+ with a PHQ-9 score of 10+ or a common chronic illness such as depression and anxiety) who receive follow-up care within 30 days of a positive depression screen finding. Additionally, the overall follow-up care rate of positive screens will be improved from 45% to 60%.

Measurement Plan

Measure Type	Measure
Outcome	Depression Remission or Response for Adolescents and Adults; Changes in health status or satisfaction through PHQ-9
Process	Percentage of patients referred to BHI that agree to services
Patient Experience	Patient perceptions across continuum of care
Workforce	Provider and staff experience with the project
Financial	BHI Visit Revenue

Biggest Achievements

- Psychiatric Consultant (01)
- Buy In from Physicians and Staff (02)
- Data Source and Measurement of Success (03)
- Training and Education (04)
- Billing and Coding (05)



We successfully secured a highly qualified psychiatric NP with extensive experience in psychiatric care to champion our program, with a potential to offer one-on-one direct counseling to patients on an as-needed basis.

Clinic providers and staff have demonstrated remarkable enthusiasm and engagement in the topic of mental health. Notably, they've started identifying potential enrollees from their patient panels and actively contributing insights to our refining the workflow designs

We secured data sources and standardized definitions within our EMR system, enabling consistent data reporting and trend analysis. Additionally, we established benchmarks to measure success in patient experience, care outcomes, and financial stability.

Our initial in-service (BHI 101) at the pilot site significantly boosted awareness and engagement, earning positive feedback for its benefits and effectiveness from a diverse group of stakeholders.

We developed an integrated billing workflow for CoCM, enabling efficient monitoring and tracking of BHI claims submissions and denials. Additionally, we implemented chart review systems to ensure documentation compliance with CoCM billing requirements. Our billers and providers now possess a strong understanding of CoCM's billing structure.

Biggest Lessons Learned

1. We are making a big impact!
2. "Rome wasn't built in a day" - BHI takes a great amount of patience, time, and effort to develop
3. Engagement and buy in from stakeholders: leadership, providers, staff, patients, are crucial elements for success
4. Emphasis on holistic approach: mental health is interconnected with physical health. We're adopting a team-based approach involving multidisciplinary teams ensures comprehensive care

Our Next Steps

Step 1: Confirm codes are billable and payable from major payers
Step 2: Comprehensive training with providers & staff on CoCM related skillsets and workflow
Step 3: Launch & Implement! Putting our plans into action
Step 4: Monitor & Assess - ensure project deliverables meet quality standards and expectations. Adapt to changes and refine the process as challenges arise

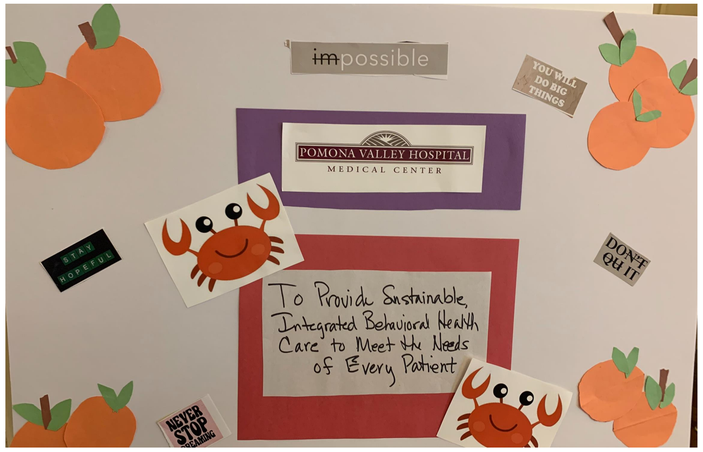
Pomona Valley Hospital

Team members: Jon Berends, Samira Ali, Dan Blocker, Darlene McPherson, Calvin Ky

Vision Statement: To provide sustainable integrated behavioral health care to meet the needs of every patient

Model: PCBH	**BHI Population of Focus:** all patients with behaviorally influenced health conditions	**Staffing:** LMFT	**Pilot Site:** PVHC - Pomona

Vision Statement Board



Aim Statement

Pomona Valley Health Center- Pomona will improve patient care and health outcomes by increasing our annual depression screening rates for all patients, but with an emphasis on our Latino/Latinx population to a screening rate of 90%

Measurement Plan

Type	Measure	Baseline/Target or Goal
Outcome	Depression response rates	Unknown/50%
Process	Annual Depression Screening	65.3/90%
Patient Experience	Bi-Annual Interviews with Patients about experience	Completion of Interviews
Workforce	Annual survey of staff and providers about their satisfaction with integrated care and workflows	Completion of Interviews
Financial	Utilization of appropriate codes for visits as a marker of fiscal value	Unknown/75% of all behavioral health visits will have a code

Biggest Accomplishments

- All of the work that has been done by the PVHMC financial department to implement codes, and work with insurance companies to get the mental health provider empaneled.
- Expanding the behavioral health team from 1 to 5 with 4 new MFT trainees joining the site.
- Making system wide changes to how and when the PHQ-9 is given and clarifying the process with staff and providers

Where We Are Going Next

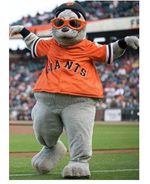
- In June, we move from just talking about the integration to doing it.
- Working with the MFT trainees to be able to do brief interventions
- Every two months having training and workflow trouble shooting with providers and staff
- Continuing to build partnerships with other providers in the community to connect patients in needing of services

Biggest Lesson Learned

- Our eyes can be bigger than our stomachs when it comes to timelines and goals
- Building and adding things take time and it will be a process
- Not everyone is as excited about things as the champions are

SAN FRANCISCO HEALTH NETWORK

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH



CalHIVE Workgroup Members: Saba Shahid, Rachel Clee, Rita Perez, Danielle Guidry, Hamilton Holt, Paul Glantz, Joseph Pace, Megan Stevenson, Natasha Lalani, Blake Gregory, Carol Taniguchi, Jane Ng-Lara, Kimberly Rivera
In partnership with our pilot site, represented by the Maxine Hall Health Center Leadership Team: Diana Wright-Aveson, Edward Lew, Rafael Pena, Tonya Thompson

Vision Statement: To promote & support the well-being of all SFHN patients through seamless care team collaboration.

BIGGEST ACCOMPLISHMENTS

ACCESS

- Developed pilot with Centralized Call Center (CCC) to **remove barrier** of requiring PCP referral as pathway to appointment with BHCs.
- Developing workflow with Nurse Advice Line (NAL) so patients with symptoms can also be **directly scheduled** with BHC.
- **Front Desk/Eligibility Workers (EWs) and Medical Assistants(MEAs)/Nursing are now supporting** with IDing pts for WHO/scheduling pt visits onto BHC templates same-day.

BH SERVICES

- **BHC schedule templates have been updated** so that all visits are 30 minutes and 1 scheduled visit followed by 1 "open"/WHO slot to increase access; BHCs doing chart scrubbing to aid efforts to find WHO opportunities.
- BAs now **incorporating SDOH screening** in addition to addressing presenting SDOH need during patient-facing visits.
- **Psychiatry has launched e-consult platform** to increase capacity to support patients with psychiatric concerns across primary care.
- **Weekly PCBH meetings being readjusted** to include complex case discussions/support from psychiatry as standard across network.
- Continued **partnering with specialty mental health/BHS** to support step-up/step-down efforts, now also on EPIC with us!

CARE TEAM

- **Other disciplines (e.g., EW, MEA, CCC) are now expressing increased satisfaction** at being able to partner more effectively with BH team, resulting in a reduction in siloed work.
- **Increased utilization of EPIC tools** (e.g., secure chat, pools) to improve communication and increase WHO across disciplines.
- **Launched the inaugural multidisciplinary Primary Care Quarterly (PCQ)** in support of teaming and collaborative learning opportunities in January 2024—the next in July 2024 will include **all disciplines for the first time**!

OVERALL

- The enthusiasm has been contagious—due to our efforts to further BHI via CalHIVE participation, **BHI is currently 1 of 2 top priority initiatives for SFHN/Primary Care!**

LESSONS LEARNED

MODEL DRIFT/CONFUSION

- Since we had technically launched BHI in 2011, many medical providers were **reluctant to make changes** since "it's already working."
- **Re-launching PCBH** at a time of 40% BH staffing vacancy meant needing to obtain buy-in/provide un-learning opportunities for seasoned staff AND develop new trainings in alignment with the PCBH model in support of all staff.
  - *Unrelated staffing shortages/challenges were regularly occurring throughout pilot launch.*
- **Psychiatry isn't part of the PCBH model**—how do we leverage and standardize to maximize as a resource for both patients and the care team?
- **Lack of Behavioral Assistant (BA)** position at other orgs has made it challenging to support standardization of the work.

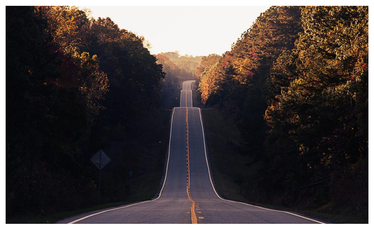
WORKFORCE NEEDS

- All disciplines/teams at our pilot site **needed more frequent guidance and direct involvement** in developing and implementing workflow changes, including template changes, develop structure for pilot efforts so provider time could be protected, etc. from the outset.

TRUST YOUR PARTNERS

- Although BH has been a historically siloed discipline, there has been **overwhelmingly positive receptivity to our partnering** with other disciplines and teams, such as CCC and the NAL!

WHERE ARE WE GOING NEXT



- **CoCM being concurrently developed** to support patients with elevated (15)/persistent PHQ-9—***SFHN will have a blended PCBH + CoCM model!***
- **BHC + PCP mini huddles**—clinic's schedule will shift to start at 8:15 to accommodate further teaming efforts. ***Go live planned for 7/1.***
- **BA schedule template** being developed to support sustainability and care teaming.
- **Patient surveys in development** with an initial survey being translated into threshold languages and **vetted by our PAC at FHC** (Family Health Center).
- **Model spread**—BHI will be spreading to 2 more primary care clinics, 1 campus and 1 community, starting in Q3 of 2024
- **PCQ in July 2024** – An inaugural all-discipline quarterly meeting in support of integrated care!

AIM STATEMENT

The San Francisco Health Network will improve Patient Access to behavioral services by increasing Warm Handoffs to BHCs and BAs for our active patient population from 34% in CY2023 to 50% by June 30th, 2025, with an increase of 4% per quarter.

Model	BHI Population of Focus	Staffing	Pilot Site
PCBH (+ CoCM!)	Our focus is on supporting whole-person health utilizing a care team approach, addressing common/chronic mental illness (e.g., depression, anxiety) and behaviorally-influenced physical health conditions for all patients across our network.	Behavioral Health Supervisor/Clinicians, Behavioral Assistants, Psychiatry, Medical Providers, Nursing/MEAs as well as Eligibility Workers/Front Desk.	Maxine Hall Health Center

Measurement Plan

Measure Type	Measure
Outcome	Increase the number of new patients (unduplicated) seen by BHC/BA.
Process	Increase the # of WHOs from & appointments scheduled by other disciplines (CCC, NAL, MEA/nursing, EW).
Patient Experience	Increase patient access to services and improve care team experience.
Workforce	Increase provider/staff satisfaction across disciplines.
Financial	Decrease the use of long-term therapy CPT codes.

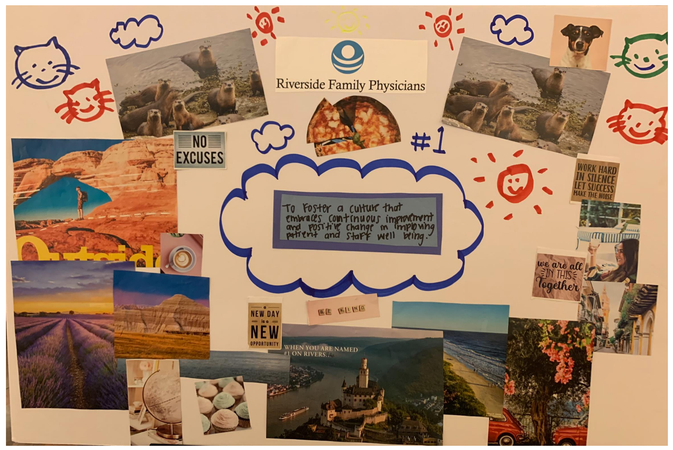
VISION STATEMENT BOARD

Riverside Family Physicians

Team Members: Tarek Mahdi, Benjamin Mahdi, Wendy Torres, Harneel Sandhu, Kacie Paik, Zana Shirwan, Rosie Moreno, Nancy Zepeda

Model: PCBH	**BHI Population of Focus:** Patients with mild to moderate behavioral health needs that can be identified through screenings	**Staffing:** LCSW	**Pilot Site:** Riverwalk Location

Vision Statement Board



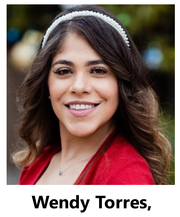
Aim Statement

- We, Riverside Family Physicians, will improve our depression screening process by utilizing technology to promote patient self-response to depression screenings and by implementing efficient workflows for all patients from 20% as of 12/18/23 to 60% by December 2024.

Our Team

Tarek Mahdi, MD

Benjamin Mahdi, MD, MPH

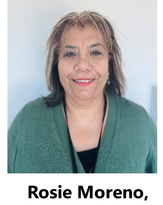


Wendy Torres, MSHSA

Harneel Sandhu, MPH

Kacie Paik, MD

Zana Shirwan, MD

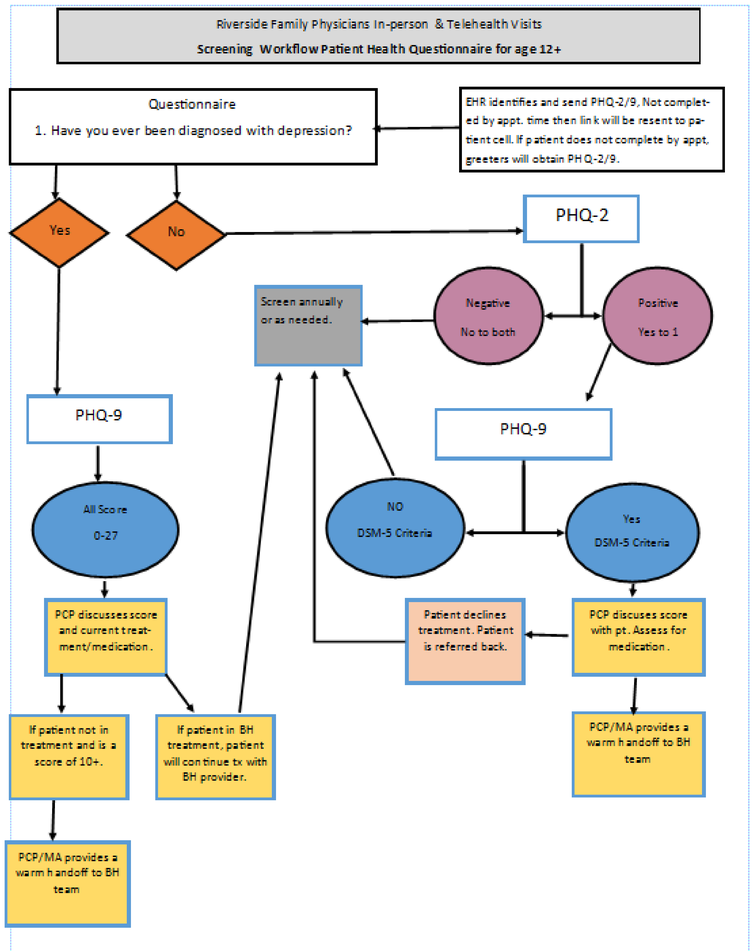


Rosie Moreno, LCSW

Nancy Zepeda

Biggest Accomplishment

- Our Director of Behavioral Health, Rosie, getting licensed
- Expanding our Behavioral Health team - we currently have 1 LCSW and 4 MSWs
- Engaged leadership
- PHQ-9 Workflow



Where We Are Going Next

- Focus on staff training by implementing monthly sessions to ensure they all feel comfortable with integrating Behavioral Health into Primary Care
- Continue to grow our team
- Send depression screenings to patients electronically

Biggest Lesson Learned

- Screening for depression can be very challenging; it requires a multidisciplinary team approach and staff education but with committed leadership, teamwork, educated staff, and efficient workflows, RFP is determined to tackle this challenge and improve depression screening and follow up for our patients.

Measurement Plan

Measure Type	Measure
Outcome	Depression screening (12+)
Process	Referrals
Patient Experience	Patient Satisfaction Survey
Workforce	Staff Knowledge Survey
Financial	BHI Visits

Sharp Rees-Stealy

Andrea Snyder, Scott Heimer, Rene Kreitlow, Janet Appel,
Aasif Parekh, Sarah Pouliot, Ashton Harris, Maggie Kube

Aim Statement

Sharp Rees-Stealy will improve depression screening using the standard PHQ-2 tool by implementing a Best Practice Alert in Epic along with site education for HMO patients at SRS Genesee from 16.7% to 20%, while also closing the gap between seniors and patients 18-64 (currently 70%, 3%, goal 75%, 10%), patients age 12-64 = 5752; patients age 65+ = 1674 by Jan 1, 2025.

Vision Statement Board

Biggest Accomplishments

- Social workers started working in clinic
- Over 170 physician referrals in clinic since October 2023
- Continued progress during Epic transition
- Developed relationships in the clinic

Measurement Plan

clinical outcome

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120-240 days (4–8 months) of the elevated score

process

Numerator: Screened with PHQ2 or PHQ9
Denominator: Patients 18 and up years of age at end of msrmnt year.
Numerator: Patients with an initial BHI appointment within 30 days of referral to BHI
Denominator: Patients that have a referral documented in EHR to BHI program

patient experience

Survey – Via text message after visit
- To what extent were your behavioral health needs met at this visit?
- How would you rate the behavioral health visit you received today?

financial

Ability to capture charges placed by BHI visit and revenue generation for the provider group. Which visit type, consider copayments (cost sharing with patients). List/link to specific CPT codes.

workforce

Survey during huddle via Teams or via rounding

> "THE BEST PLACE TO START AND SUPPORT YOUR JOURNEY TO HAPPINESS"

Model: PCBH
BHI Population of Focus: anxiety, depression, substance abuse, and bipolar disease
Staffing: Behavioral health clinician (LCSW)

Biggest Lesson Learned

It is great to just get started and learn as we go

What's Next?

- Gather feedback from providers and patients
- Work with finance to learn how to drop bills for social work services in clinic
- Work with Epic team to build changes in EHR that facilitate BHI