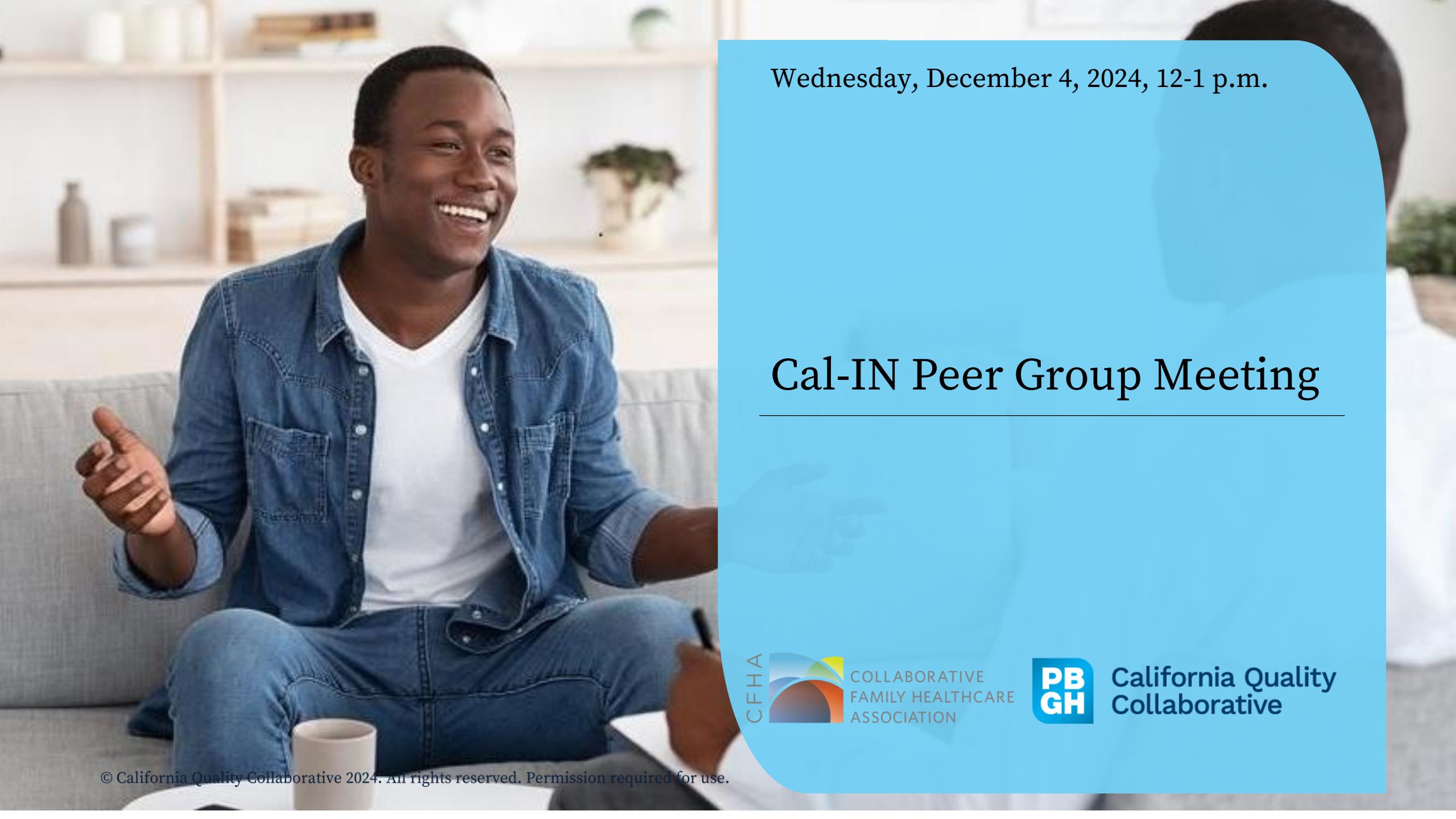
Welcome!

Please add your name, organization and role in the chat



Wednesday, December 4, 2024, 12-1 p.m.

Cal-IN Peer Group Meeting

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

PBGH California Quality Collaborative

California Quality Collaborative

Advancing the quality and efficiency of the outpatient health care delivery system by creating scalable, measurable improvement.

Launched in 2007, CQC is a **multi-stakeholder quality improvement program** of the Purchaser Business Group on Health. Core funding comes from health plans sharing a delivery system.

Identifies and spreads best practices across outpatient delivery system in California

Trains 2,000 individuals from 250 organizations each year

CQC's track record includes **20% relative improvement** in clinical outcomes and **10:1 ROI**

Sponsors

Anthem Blue Cross
blue california
blue california Promise Health Plan
California Health Care Foundation
CalOptima Public Agency Better. Together.
CVSHealth
aetna
health net
KAISER PERMANENTE
L.A. Care HEALTH PLAN
MOLINA HEALTHCARE
United Healthcare
VHP Valley Health Plan

Collaborative Family Healthcare Association

3 Pillars of CFHA

Where the Modern Healthcare Team Gathers

Content	Community	Consultation
• Learning Opportunities • In-Person & Virtual Conference • Listserv	• Special Interest Groups • Workgroups • Large BHI Community	• Technical Assistance • Tools & Resources for Organizations & Providers

https://www.cfha.net/#:~:text=Where%20the%20Modern%20Healthcare%20Team%20Gathers

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

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Connecting Today

How do you get teams engaged in BHI?

Share in the chat or come off mute

Connecting today

Today, we'll:

Review lessons learned around BHI pilot project engagement, alignment and impact with Santa Rosa Community Health

Connect with behavioral health integrated leaders in California

PBGH California Quality Collaborative

Behavioral Health Integration at Santa Rosa Community Health

Santa Rosa Community Health

Tara Budinger, PhD, Manager of Primary Care Behavioral Health at Santa Rosa Community Health

Our Integration Journey

Santa Rosa COMMUNITY HEALTH
All of us. For all of you.

Session H01

PCBH Implementation in an FQHC:

Demonstrating Viability

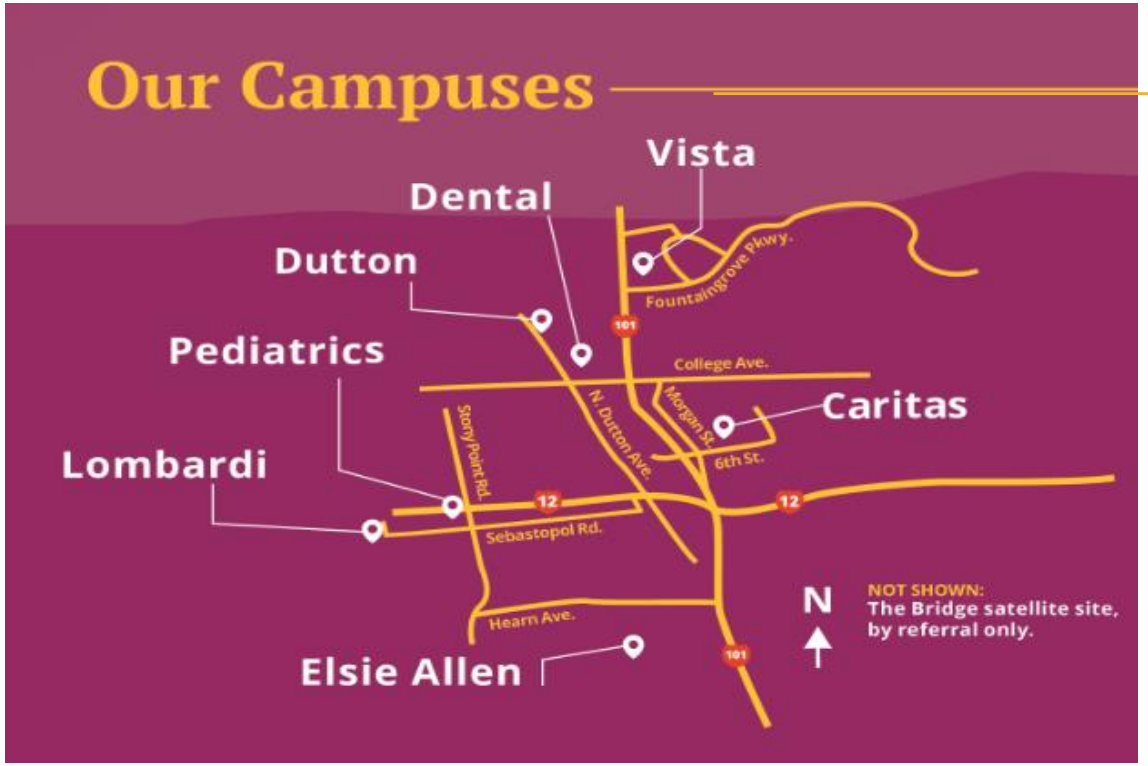
- Tara Budinger, PhD, Manager of Primary Care Behavioral Health
- (Theresa Allen, Director of Operations)

CFHA Annual Conference
October 24th-26th, 2024

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Mission

United in heart, health, and justice, SRCH provides excellent, comprehensive, culturally responsive health care that meets the needs of our diverse community.



Our Services

- Primary Care
- Dental Care
- Mental Health
- Pediatrics and Obstetrics
- Family Planning
- Immunizations
- Pharmacy and Lab
- Specialty Care
- Gender-Affirming Care
- HIV and Hep-C Care
- Opioid Addiction Services
- Health Education
- Insurance Application Help
- Case Management and Care Coordination
- Resource Support
- Transportation and Translation

41,000 patients & **209,000** visits

1 in 5 Santa Rosa residents get their care at SRCH

8 health centers, including two dental sites

600+ employees

RESIDENCY PROGRAMS AT SRCH

- MD RESIDENCY
  - COLLAB BETWEEN SUTTER & SRCH
  - 36 RESIDENTS PROGRAM ESTABLISHED IN 1969
- NP RESIDENCY
  - 3 PSYCH NP RESIDENTS
  - 8 FAMILY MEDICINE NP RESIDENTS

Santa Rosa COMMUNITY HEALTH
All of us. For all of you.

Why integrate services?

Community mental health system inadequate to meet the need. Private practice therapy difficult to access.

Majority of mental health care is provided in primary care, though PCPs have little training, expertise, or time.

FQHCs serve patients with higher SDOH needs and higher ACEs, putting them at higher risk for mental and behavioral health problems.

Triple Aim
Quadruple?
Quintuple?

SAMHSA Levels of Integration

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformation / Merged Integrated Practice

Progression of BH integration at SRCH:

Level 2 – Coordination with community partners (Family Services Agency)

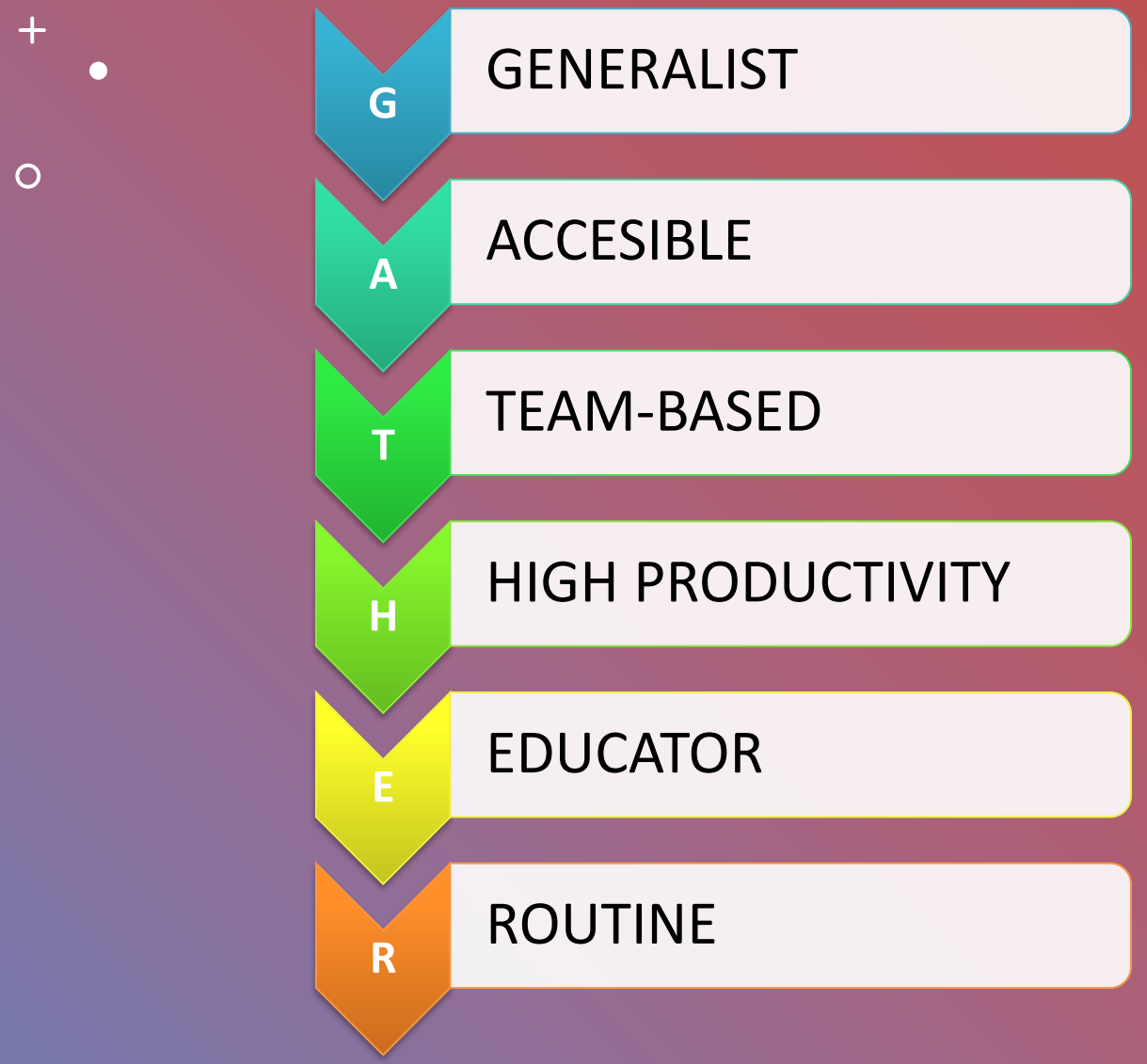
Level 3 – Hired our own providers

Level 4 – Share records, billing, scheduling. Offer on-call shifts for provider support.

Level 5 – Consultation model – brief treatment and return to primary care. Frequent collaboration.

Level 6 – Team-based care including BHCs adopted throughout. Routine part of primary care. Familiar to all staff and patients.

PCBH GATHER MODEL



Pandemic Effects

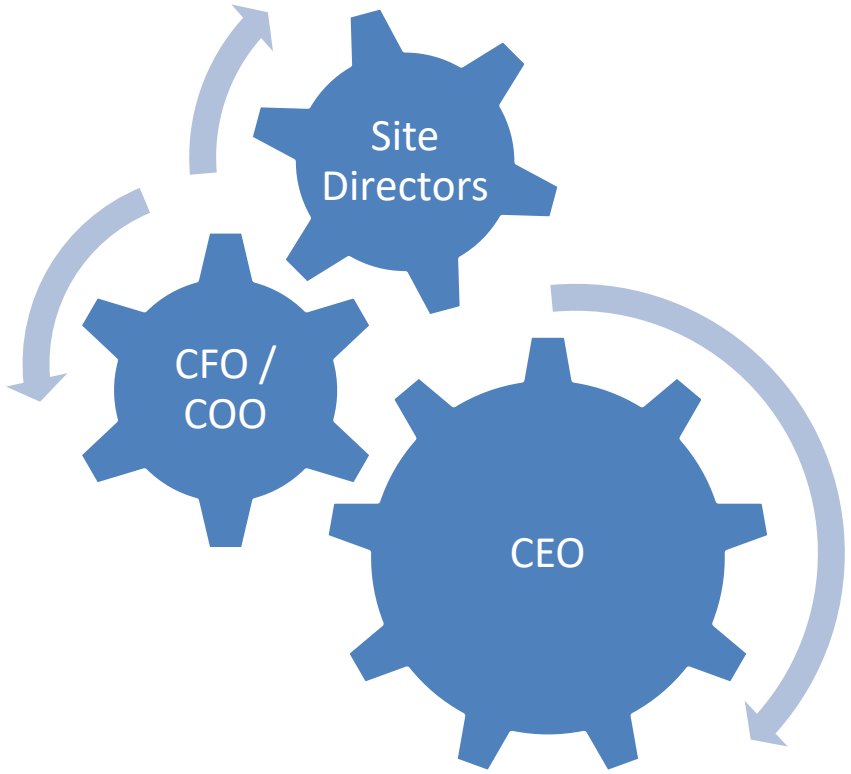
- All MH/BH providers sent to work from home
- Reversed the trend of integration as it became referral-based instead of warm handoff-based.
- Allowed us to serve patients of all clinics as a remote team, but providers felt abandoned during the toughest of times.
- Reintegration meant realigning goals and values of the program, but high attrition in the subsequent months made this challenging.
- Financial aftereffects of the Pandemic and other challenges meant new requisitions were not forthcoming.
- Low productivity numbers to allow for warm handoffs compared to the pandemic practice of 6 scheduled visits per shift did not seem to justify them.
- Yet providers were thrilled to have their BH partners back and patients seemed to love the option of “on demand, as needed” services.

How do we get from "How can we do *this*?" to "How can we *do* this?

Consultation question for the PCBH Leadership Cohort

Operations & Clinicians - UNITE

"I shadowed a warm hand off and walked out thinking, **I am ALL IN**. I watched a patient go through the BH Process and saw the patients face recognize their own issue and agree to next steps in their own care. The crazy thing? The interview was in Spanish, which I don't speak, but I could see the patient's transition."



It takes a village to introduce a new not-as-yet-known service into production.

TIPS

1. Start with a BEACON that EVERYONE can buy into.
2. ALIGN Operations & Clinicians
3. EVANGELIZE the VALUE
4. FIND a way to make it work

While Tara was gaining buy in from the clinicians, I was gaining buy in with the operational leaders: CMO, COO, CFO, and even the CEO and partnering with our Site Directors

We call this Making Friends!

PCBH Demonstration Pilot – Dutton Campus

Jan 15, 2024 – June 14, 2024

Are two more than twice as good as one?

Pilot Outputs:	Pilot Theory:	
Onboarding Training Package BH Competencies Check List Shadowing Program Creating interdisciplinary teamwork	2 BH providers working side by side are more than double 1 BH provider. Based on a complimentary schedule, this maximizes each provider to see 4 scheduled / billable visits + WHO visits. 1 FTE: .1 Admin, .1 Passion Project, .8 Clinical .8 shifts will yield at least 4 visits and allow room for WHO's The more BH providers, the more return visits that can be scheduled and allow greater availability for WHO to support Primary Care. this would tilt the projection to more billable visits than WHO's to drive sustainability.	
1st Month	**2nd Month**	**3rd Month**
Getting Acclimated to the PCBH Model Learning interview methodology Connecting to clinicians & Staff	Starting to see patients Baking in the contextual interview process and the GATHER model Earning the trust of clinicians and staff Starting to see patients more robustly	Fully integrated into Primary Care Seeing 4 patients per shift plus 1-2 WHO. *New Providers to BH practices 3 visits/shift initially. Expect 1 year to full productivity and 3-5 years to full proficiency.

Measures:

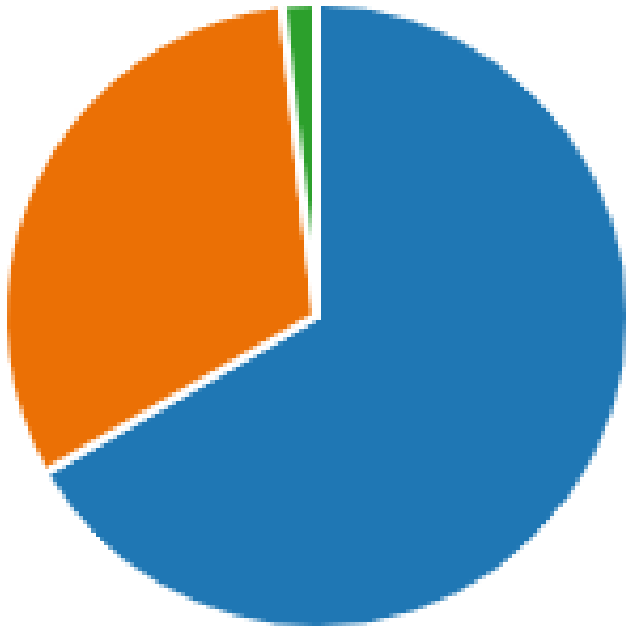
- Provider satisfaction
- BHC productivity
- Population reach
- (Patient satisfaction) – next time!

BH PROVIDER SATISFACTION SURVEY

57 responses

HOW OFTEN DO YOUR VISITS WITH PATIENTS INVOLVE A BEHAVIORAL HEALTH NEED?

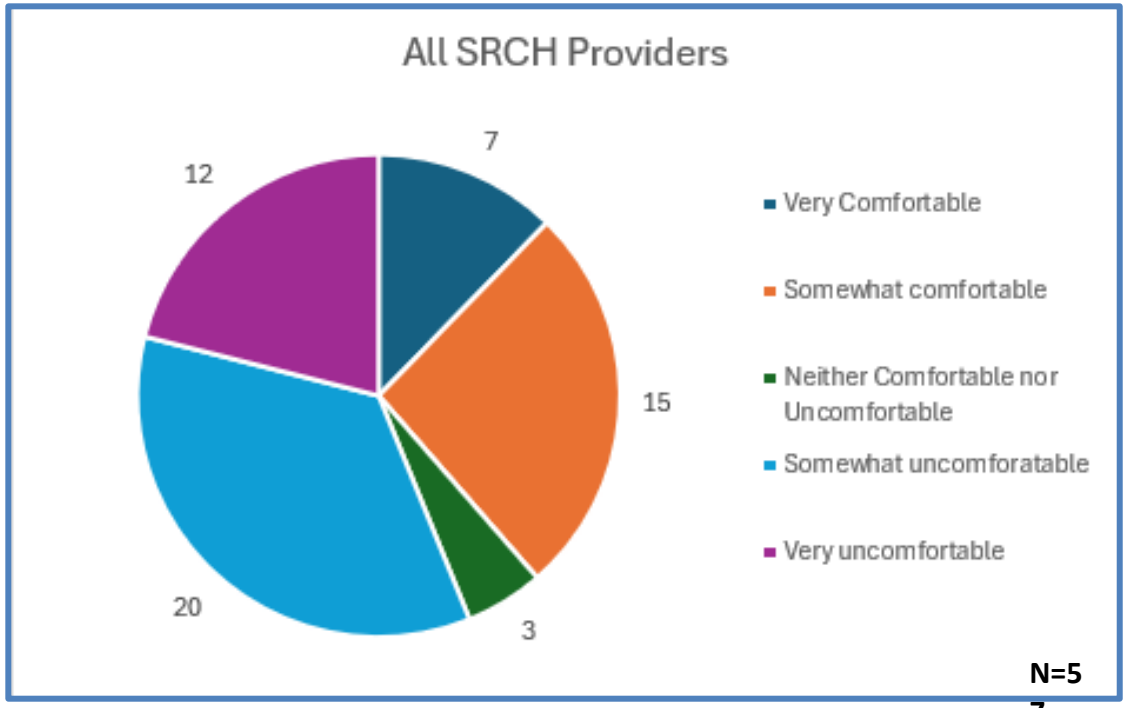
HOW IMPORTANT IS IT FOR YOU TO HAVE REAL-TIME ACCESS TO BH SUPPORT TO HELP YOU HELP YOUR PATIENTS?

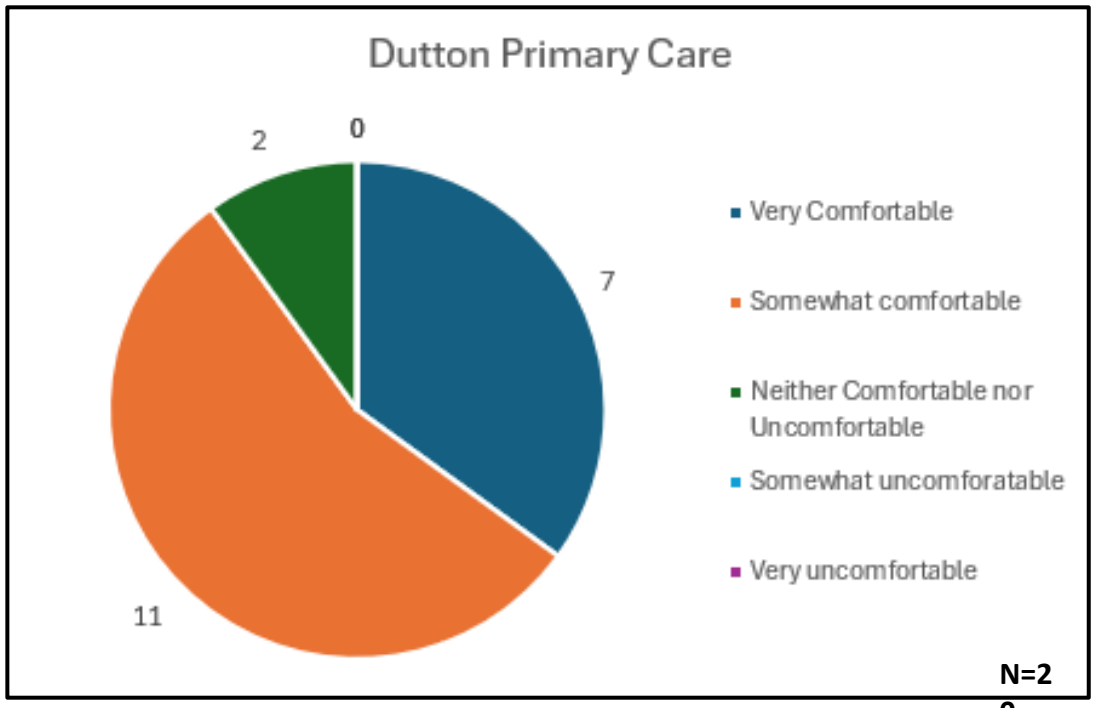


Essential - wouldn't work witho...	38
Very important	18
Nice but not necessary	1
Not important	0

HOW COMFORTABLE DO YOU FEEL MANAGING YOUR PATIENTS' COMPLEX NEEDS WITH CURRENT MH/BH RESOURCES?

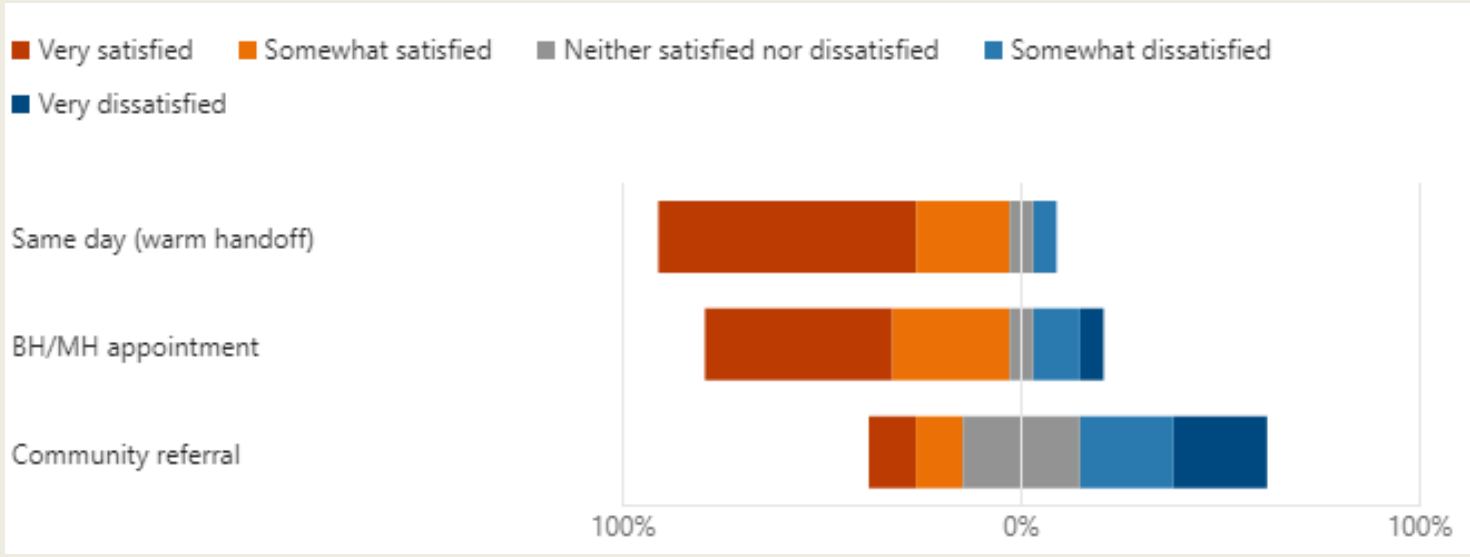
Comparison of SRCH Providers' Comfort vs Dutton Providers' Comfort Managing Complex Needs



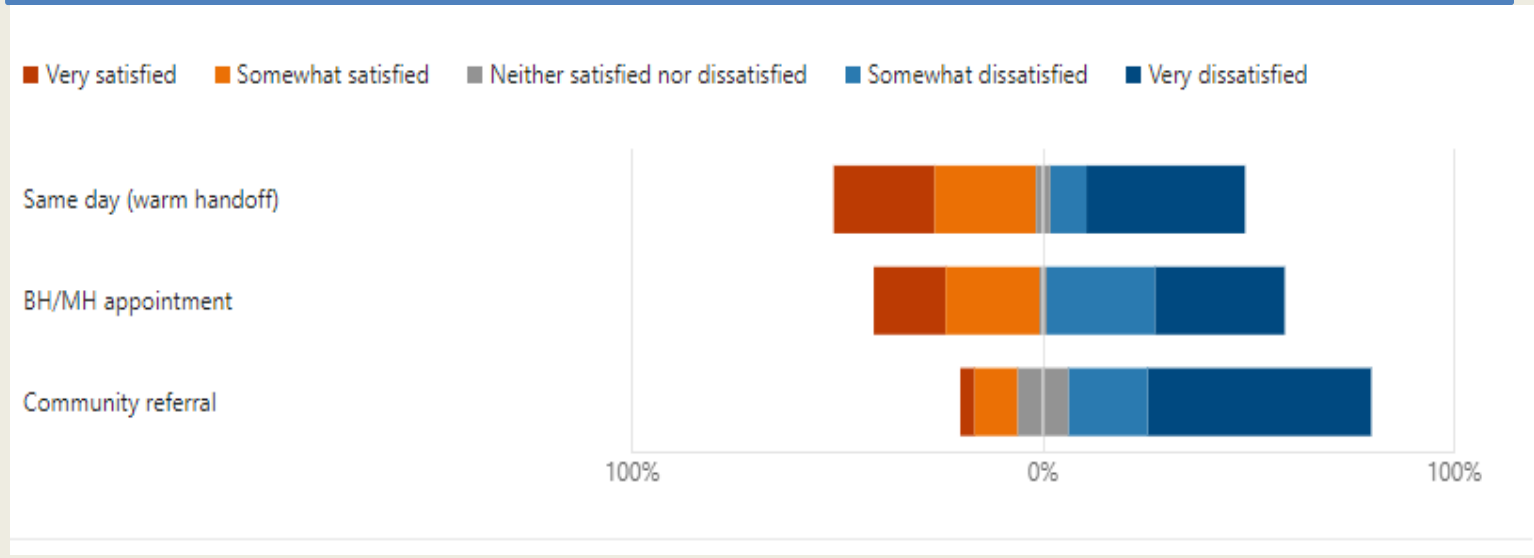


HOW SATISFIED ARE YOU WITH PATIENTS' ACCESS TO BEHAVIORAL HEALTH SERVICES?

Dutton

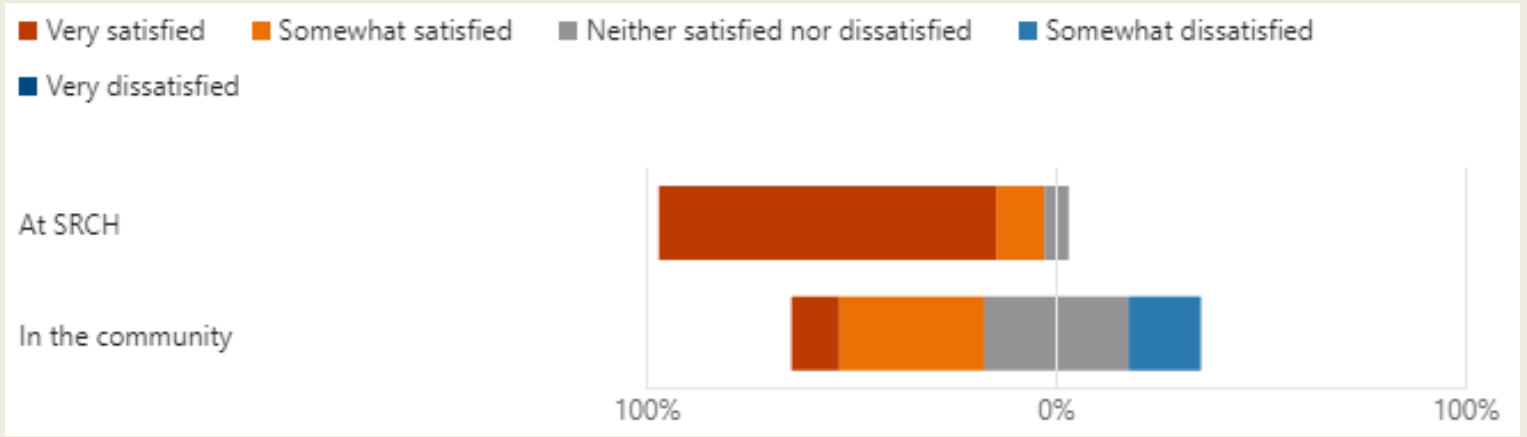


SRCH

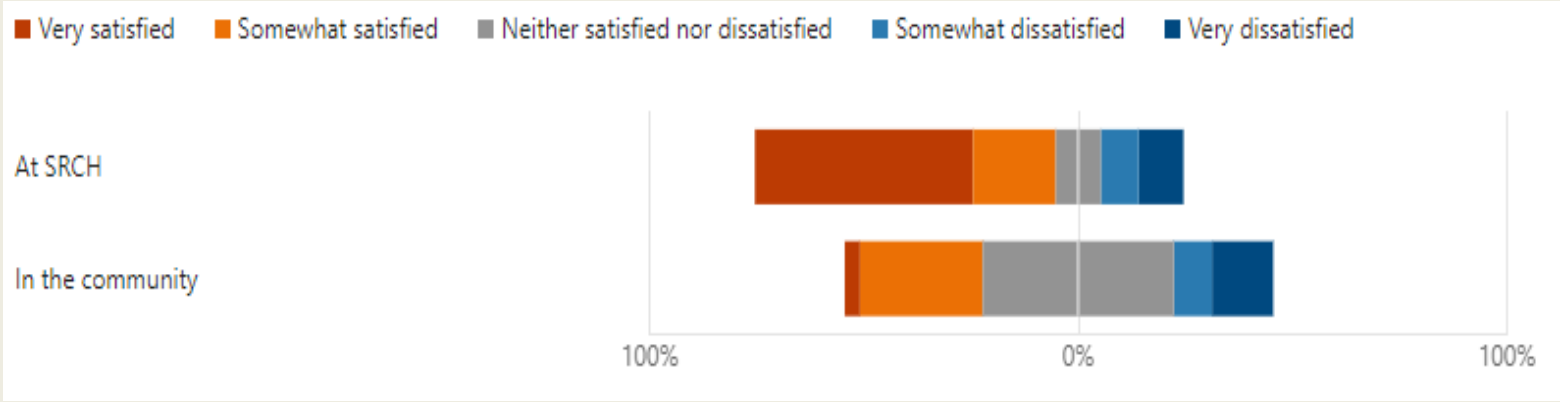


HOW SATISFIED ARE YOU WITH THE QUALITY OF BH SERVICES YOUR PATIENT RECEIVES?

Dutton



SRCH



Provider Comments

"I appreciate that patients can be seen for a concern, such as grief or anxiety in real time."

"Great patient care and communication with other providers."

"the BH care coordinators are also very responsive and helpful."

"...patients... tend to have a really good experience."

"I trust our BH providers to do an excellent job once they're actually able to see the patient. Access is the problem in my opinion not quality"

"Long waits for an appointment when a warm handoff is not needed yet patient can benefit from meeting once or twice with BH specialist."

Dutton Campus BH Year-on-Year Comparison

2023 **1 BHC** **3 scheduled visits per shift**

Month	Total BH Visits	Warm Handoffs	Billable Visits	Clinic Pts.	BH Pts.	Reach
Feb - May	370	145	225	7,763	279	3.0%

2024 **2 BHCs** **4 scheduled visits per shift**

Month	Total BH Visits	Warm Handoffs	Billable Visits	Clinic Pts.	BH Pts.	Reach
Feb - May	891	251	640	9,059	506	5.6%
Increase	141%	73%	184%	17%	81%	87%

- Almost tripled Billable visits
- 73% increase on WHOs
- Not quite double the reach, but that means more return visits are being scheduled

SHIFT	1 BH Schedule	2 BH Schedule		3 BH Schedule (economy of scale & win-win)		
HOUR 1						
		RETURN/NEW		RETURN/NEW		RETURN/NEW
	RETURN/NEW		Return/New		RETURN/NEW	
HOUR 2				RETURN/NEW		RETURN/NEW
		Return/New			RETURN/NEW	
	RETURN/NEW		Return/New	RETURN/NEW		
HOUR 3					RETURN/NEW	
		Return/New		RETURN/NEW		RETURN/NEW
	RETURN/NEW		Return/New	RETURN/NEW		
HOUR 4					RETURN/NEW	
		Return/New		RETURN/NEW		RETURN/NEW
			Return/New		RETURN/NEW	

More BH Providers CREATES More Productivity without sacrificing access

Stories of PCBH:

- Every clinician at Dutton has collaborated with our behavioral health colleagues for “warm hand offs”. We have asked our BH colleagues to step in to help with depression and suicidal ideation, but also to help support people who are trying to quit drinking or quit using opiates, folks who are trying to quit smoking and need help making a plan, patients with insomnia, teens who are cutting themselves, patients with obesity or struggling with their relationship to food, people with acute anxiety, patients with diabetes having difficulty controlling blood sugars. These joint visits have been so helpful, even lifechanging, for patients, but they have also been lifechanging for us as a clinician group. Knowing that we have someone who can help us with these difficult encounters helps us to run on time, to be able to see more patients in our day and makes us better clinicians. We learn from our BH colleagues how we can better handle these challenges in the future. It decreases the stress of feeling powerless to help people who are struggling on a personal and community level. It lessens burn out and clinician turnover, or clinicians feeling that the only way they can survive in their work is to decrease clinical FTE.

Results

Presented preliminary results to the CEO

Requisitions approved for 5 new positions!

Presented to Clinical Leadership Team

Presented the results to the Board of Directors

Chief Development Officer cited the Demonstration Pilot to secure new grants

Any Questions?

Thank you for your attention.

Discussion Questions

- How does Santa Rosa Community Health's experience align with your experience around building buy in for BHI?

- How do you change the culture for existing programs?

Open Discussion

- Burning questions?
- Needs?
- Resources?

BHI Resources

- **Collaborative Care Implementation Support** Primary Care Providers can access this Collaborative Care (CoCM) Service Organizations Directory, cataloguing organizations assisting providers in the implementation and delivery of the Collaborative Care Model

- UCSF Center for Advancing Dyadic Care in Pediatrics – many resources about implementing dyadic care and will be launching a webinar series in 2025; sign up for update on their website.

- California Child and Adolescent Mental Health Access Portal (Cal-MAP) – a CalHOPE pediatric mental health care access program designed to increase timely access to mental health care for youth throughout California's communities, especially in the state's most underserved and rural areas.

- HealthySteps program – provides early childhood development support to families where they are most likely to access it – the pediatric primary care office.

BHI Events

- CQC Webinar: **Behavioral Health Integration Spread & Sustain**
  - Wed. Jan 8 (12-1 p.m.)
  - Register
  - Speakers: CFHA & UCSD Health
- CFHA Community Conversation: EPIC EHR
  - Wed. Jan 22 (10 – 11 a.m.)
  - Register

Wrapping Up

- 2025 Cal-IN Meetings (12 p.m. – 1 p.m.)
  - Wednesday, March 26 | Topic: BHI Training and Development
  - Wednesday, June 18 | Topic: TBD
  - Wednesday, September 24 | Topic: TBD
  - Wednesday, December 3 | Topic: TBD
- Cal-IN Collaboration Space
  - Basecamp
- Peer Group Roster [link]
  - Opt-in document; link will be posted on Basecamp
  - Members can add: name, org, email, how long integrated, your strengths, what you want to talk about