BCBSM Care Management Recognition Award Opportunity
Behavioral Health Interventions

Contact Information
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Physician Organization Name: Upper Peninsula Health Group
Practice Name: Upper Great Lakes Family Health Center- Gwinn
Practice Address: 135 E. M-35 Gwinn, MI 49841
How many physicians in practice: 2
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): 1 behavioral health provider (LMSW), 2 nurse practitioners, 4 registered nurses, 2 certified medical assistants, 3 patient service representatives

Executive Summary (5-8 bullet points, must include summary of results)
- Implemented behavioral health integration services in family practice setting
- Patients could see a behavioral health provider for support with both medical diagnosis and behavioral health diagnosis
- Implemented a Diabetes Distress Screening to be completed in behavioral health integration visits with diabetic patients
- Provided behavioral health integration education to clinical and front office staff to embed workflows into daily practice
- Behavioral health providers began attending morning huddle to help identify patients who could benefit from integration services
- Began integration visits in March of 2019, initially focusing on diabetic patients, in Gwinn Family Health Center
- Intervention resulted in an increase of integration visit volume
- Expanded the intervention and implemented behavioral health integration at all UGL clinics with a staffed behavioral health provider

Category of Submission (see page 1): Behavioral Health Interventions

Title of Submission: Integrating Behavioral Health into a Primary Care Setting

When did the intervention start and end? (1-2 sentences)
Intervention began March 2019. Initial analysis and process improvement continued through June 2019.

Goal of the Program/Intervention: (1-2 sentences)
To provide behavioral health integration services to patients during their appointment with a medical provider.

Who developed the program/intervention, and how? (2-4 sentences)
Quality department staff and behavioral health clinicians, along with the feedback of medical providers, clinic staff, and clinic managers, developed the program by performing an initial analysis on coding and documentation requirements to bill for integrated behavioral health services. Based on the findings of this analysis, progress note templates and a coding reference guide was created to assist behavioral health providers with documenting and coding

integration visits. Then a workflow was developed to illustrate the warm handoff process from the medical provider to the behavioral health provider.

Description of the Program/Intervention (2-3 paragraphs):
Our practice first introduced behavioral health providers in 2015, under a co-located model. Co-location means that the behavioral health providers and primary care providers were located in the same clinic, but were not necessarily providing team-based, integrated care. The initial process for connecting a patient to behavioral health services was through a referral from the PCP. Patients were scheduled for a future appointment with the behavioral health provider and would have to come back to the clinic at that time. Also, initially medical providers only referred patients to behavioral health provider for a behavioral diagnosis (depression, anxiety, etc.). Through the introduction of the behavioral health integration model, behavioral health providers were able to assist PCPs in managing patients with medical adherence difficulties (diabetes, hypertension, etc.), patients with mental health diagnosis (depression, anxiety, etc.), patients with stress or coping difficulties, grieving or dying patients, and patients needing assistance with health related behavior change (tobacco cessation, increasing exercise, diet changes, etc.). Behavioral health providers help patients to build self-management skills.

We initially focused the intervention on providing integrated behavioral health services to diabetic patients. After the medical provider sees the patient for their scheduled appointment, the medical provider and/or nurse discusses with the patient how the behavioral health provider can support them with their diabetes, and through a warm handoff, introduces the patient to the behavioral health provider. The behavioral health providers utilized a screening tool called the Diabetes Distress Scale to measure the patient's emotional burden, interpersonal distress, physician related distress, or medical care regimen distress in relation to their diabetes. Behavioral health providers used screening results to guide their conversation with the patient, and to focus on higher impact interventions. The behavioral health provider documents their progress note within the EHR (which is shared with medical providers) and communicates (verbally or within the EHR) relevant updates and information with the PCP and other necessary clinical staff. This communication is what allows for a team-based approach and integrated care. Since our initial focus, integration services are now provided to any patient for support with medical and behavioral health diagnosis.

How were patients identified for the program/intervention? (1-2 paragraphs)
Patients are identified for integration services during morning huddle. Clinical staff, medical providers, behavioral health providers, and front office staff all participate in huddles where they discuss the patients who are scheduled to come in, and they work together to identify diabetic patients who could benefit from behavioral health support. An appointment is created on the behavioral health provider's schedule in the EHR for patients who were identified, so the behavioral health provider has a plan for which patients they are going to meet with.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)

Success was measured by demonstrating an increase in the number of patients with a behavioral health integration visit compared to baseline data (outcome based). Success was also measured through a review of the behavioral health provider's progress notes for correct documentation and coding (process-based). Staff and provider feedback was also taken into consideration throughout the intervention. After maintaining this intervention for a longer period of time, we plan to analyze clinical outcomes to find out if behavioral health integration positively impacts clinical measures including the measure for A1Cs.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)

Behavioral health providers reported that many patients they meet with once or twice for integration visits end up coming to see them for long term therapy visits as well, and patients frequently appreciated that a LMSW is working directly in their provider's office.

Integration Visit Volume

Diabetes patients seen in Gwinn	14
Diabetes patients seen at all clinics	41
Total number of patients seen in Gwinn	100
Total number of visits in Gwinn	155
Total number of patients seen at all clinics	272
Total number of integration visits at all clinics	698

We found that providers were utilizing behavioral health providers for a wider variety of medical problems than just diabetes.

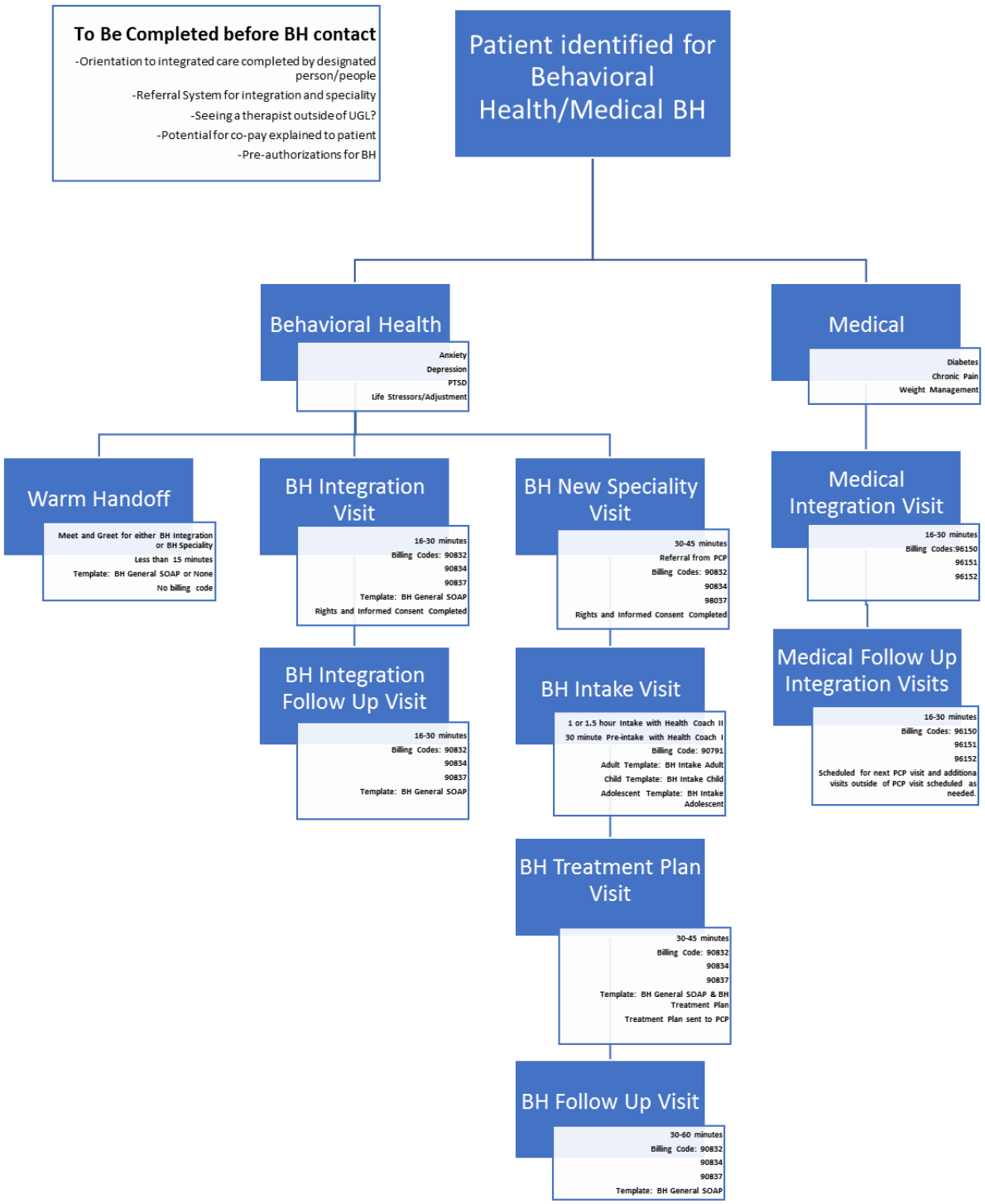
Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)
We developed a process for clinical staff to complete a daily list of possible integration patients. The list was turned in to front office staff and appointments for integration were made ahead of time. This allowed the whole clinic team to know who was identified for an integration visit.

One of our behavioral health providers developed a decision tree to assist the behavioral health providers with determining the appropriate visit type to use for an integration visit and traditional counseling visits (see appendix 1). Our quality manager developed a reference chart to help behavioral health providers to determine which template to merge into the progress notes and the visit appropriate visit code (see appendix 2)2.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)
We are proud to have implemented a process that makes it easier for patients to access behavioral health support. Rather than having to come back a different day to see a behavioral health provider after receiving a referral from their PCP, patients can see the behavioral health provider the same time they see their medical provider. This reduces barriers to care including transportation, getting time off work, or childcare issues. By focusing integration first on diabetic patients, we have also shifted the culture in our organization to better understand the social and behavioral factors that influence how a patient self-manages their chronic condition.

How will your organization use the funds if your submission wins? (1 paragraph)
We would plan to use the funding to support our behavioral health program. With the increased number of patients who are being identified and connected with integrated behavioral health services, we are faced with an increased demand for behavioral health providers and support staff.

Appendix 1


To Be Completed before BH contact
-Orientation to integrated care completed by designated person/people
-Referral System for integration and speciality
-Seeing a therapist outside of UGL?
-Potential for co-pay explained to patient
-Pre-authorizations for BH
Patient identified for Behavioral Health/Medical BH
Behavioral Health
Anxiety
Depression
PTSD
Life Stressors/Adjustment
Medical
Diabetes
Chronic Pain
Weight Management
Warm Handoff
Meet and Greet for either BH Integration or BH Speciality
Less than 15 minutes
Template: BH General SOAP or None
No billing code
BH Integration Visit
16-30 minutes
Billing Codes: 90832
90834
90837
Template: BH General SOAP
Rights and Informed Consent Completed
BH New Speciality Visit
30-45 minutes
Referral from PCP
Billing Codes: 90832
90834
90837
Rights and Informed Consent Completed
Medical Integration Visit
16-30 minutes
Billing Codes:96150
96151
96152
BH Integration Follow Up Visit
16-30 minutes
Billing Codes: 90832
90834
90837
Template: BH General SOAP
BH Intake Visit
1 or 1.5 hour Intake with Health Coach II
30 minute Pre-intake with Health Coach I
Billing Code: 90791
Adult Template: BH Intake Adult
Child Template: BH Intake Child
Adolescent Template: BH Intake Adolescent
Medical Follow Up Integration Visits
16-30 minutes
Billing Codes: 96150
96151
96152
Scheduled for next PCP visit and additiona visits outside of PCP visit scheduled as needed.
BH Treatment Plan Visit
30-45 minutes
Billing Code: 90832
90834
90837
Template: BH General SOAP & BH Treatment Plan
Treatment Plan sent to PCP
BH Follow Up Visit
30-60 minutes
Billing Code: 90832
90834
90837
Template: BH General SOAP

Appendix 2

Appointment Type	Appointment Length	Templates	Codes
BH Intake	1 hr. 45 mins	• BH General SOAP • BH – Adult Intake • BH – Adolescent Intake (13-17) • BH – Child Intake (0-12)	• 90832 • 90834 • 90837
BH Integration	15 Mins	• BH SOAP - General	**MED DIAGNOSIS** • 96150 • 96151 • 96152 **BH DIAGNOSIS** • 90832 • 90834 • 90837
BH New Pt	30 mins	• BH General SOAP	• 90832 • 90834 • 90837
BH Follow-Up	45mins	• BH General SOAP • BH Treatment Plan	• 90832 • 90834 • 90837