



WEBINAR SERIES

Behavioral Health, Primary Care Integration

WEBINAR 2
Questions
and
Answers

BLENDING BEHAVIORISTS INTO THE PATIENT-CENTERED MEDICAL HOME

Thank you to all who attended the webinar on January 11, 2012. This follow-up document contains questions asked during the webinar and answers provided by the faculty, Dr. Dennis Freeman. If you have questions in addition to those listed below, please contact Dr. Freeman directly at dennis.freeman@cherokeehealth.com. A recording of the webinar and the presentation materials can be accessed on the Michigan Primary Care Association's Resource Library webpage at www.mpca.net/resource-library.html (scroll to "Behavioral Health").

Webinar Overview:

This webinar discussed Cherokee Health System's primary behavioral health integrated care practice model and the role that behavioral health plays in enhancing the Patient-Centered Medical Home. Cherokee Health System's president/CEO discussed the community-based provider's model and the interplay between the providers, and how the model is an imperative part of a successful Patient-Centered Medical Home.



Faculty:

Dennis S. Freeman, PhD, President/CEO, Cherokee Health Systems. Cherokee Health Systems, Inc. is a community-based provider of integrated primary care and behavioral health services in East Tennessee. It is both a Community Mental Health Center and a Federally Qualified Health Center.

Questions & Answers:

Q: Are psychologists and social workers required to have addiction certification?

A: BHCs must have expertise in addictions but no certification is required. This is a generalist not a specialist role and parallels that of the PCP who has broad knowledge but is not boarded, i.e. "certified" in the variety of medical specialties.

Q: Are any PC physicians or psychiatrists, addictionologists?

A: We do not have any certified addictionologists on our staff although all our psychiatrists, all of our BHCs and many of our PCPs have expertise in working with patients who have addictions. Unfortunately, addictionologists are few and far between in our part of the world.

Q: Do you ever use peer recovery specialists for MH, addiction or co-occurring disorders?

A: We do have a few peer recovery specialists in our community mental health care continuum. Securing financial support for peers has been a challenge in our state.

Q: You mentioned substance abuse tx being included, how have you overcome 42 CFR p2 issues?

A: Substance abuse screenings and brief interventions take place in primary care. Treatment occurs further along the care continuum outside of the primary care suite. Patients sign consent to treatment and sharing of information among members of our multi-disciplinary staff.

continued



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Q: *Have you ever explored telehealth scenarios for those who have difficulty in recruiting professionals for psychiatry and therapists? Can you advise how this might be possible and have an integration of services, perhaps monitors in exam rooms? What about reimbursement of such models?*

A: We use a lot of telehealth applications—telepsychiatry, telepharmacy and even tele-primary care. We employ a psychologist who lives in Miami and telecommutes daily to East Tennessee to provide her clinical work. Our psychiatrists often teleconference into our primary care practices to see patients and consult with PCPs. We've worked to include payment for these telehealth visits with our major payers.

Q: *Do your clinics serve people with Medicaid/Medicare/Prostate Insurance and those with no insurance?*

A: We serve anyone who wants to be seen on an ability to pay basis. About 30% of our patients are uninsured/self-pay and around 40% have Medicaid. Medicare and commercial insurance each cover around 10%.

Q: *How are CSW's used?*

A: Most of our social workers, whatever their level of certification or licensure, are providing psychotherapy in the "specialty" part of our care continuum.

Q: *How does/has your facility and services offered relate to services provided by local CMH clinics? Are they separate and independent of Cherokee?*

A: We are a state licensed community mental health center. We overlap service areas with two other CMHCs. They are major referral sources of uninsured patients since both organizations have stopped serving those folks.

Q: *I work with children and families at our CMHC and I was curious how this works best at Cherokee with children, as their situations often require more intensity, follow up, and consistency in treatment?*

A: The work of the BHC in pediatrics includes more education and developmental screenings. These BHCs are part of the well child (EPSDT) visits, for example. However, their contacts with kids and their families are relatively brief and aperiodic. When more intensive work with these kids and their families is indicated, that is provided by therapists on our staff rather than the BHC embedded on the primary care team.

Q: *How did it take to get the program running smoothly, Did you have BH specialists who had to transition from traditional therapy and if so how did you handle the transition for the provider and patients?*

A: We began primary care services in 1984 with a co-located behaviorist in the same office. Over the years, a few of our behavioral clinicians have transitioned to the embedded (BHC) role, however, most of our BHCs were hired for that role and had the skill set expected for that position.

Q: *Do you use other master level clinicians besides LCSWs?*

A: Over the years, we've employed a few Professional Counselors and Marriage and Family Therapists, but we often cannot get them on insurance panels in our state. Of course, Nurse Practitioners are Master's level clinicians and we currently have 33 NPs—23 in primary care and 10 who practice psychiatry. ■