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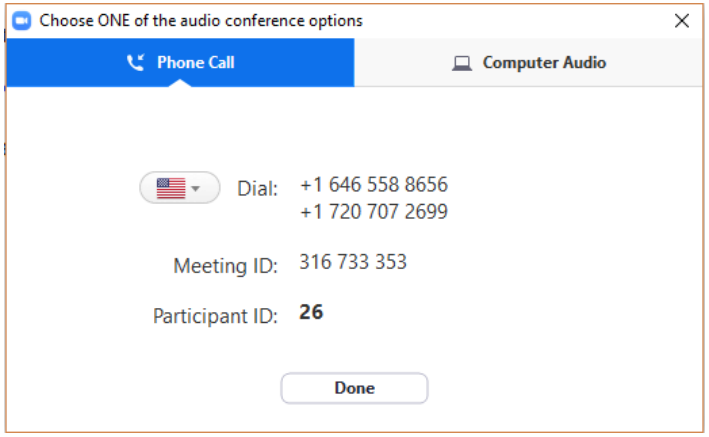
Opportunities for Medical Directors through CCBHC

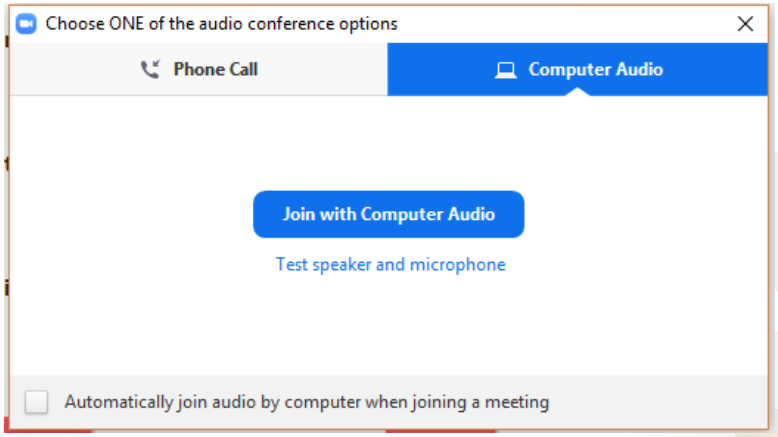
November 12, 2021

Zoom Logistics

Call in on your telephone, or use your computer audio option

If you are on the phone, remember to enter your Audio PIN





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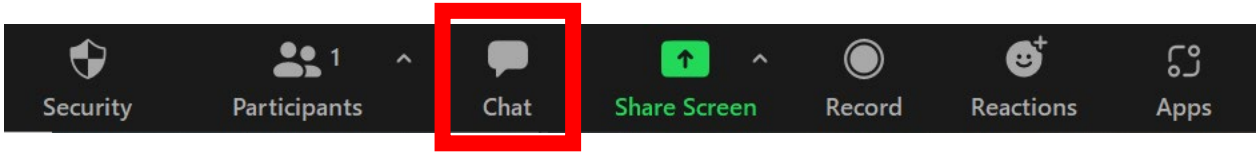
How to Ask a Question



Type in the chat box located at the bottom of your screen.

We'll answer as many questions as we can throughout today's session.

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Disclaimer

This session is not a CMS- or SAMHSA-funded or sponsored event. While this session is intended to provide context and information, the National Council team and presenters are unable to answer any inquiries on behalf of CMS or SAMHSA. Any questions related to the funding opportunity itself will need to be directed to your funding or project officer.

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Today's Presenters

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National Council for Mental Wellbeing
Medical Director

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University of Washington School of Medicine
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Jeffrey Eisen, MD, MBA |
Chief Medical Officer,
Behavioral Health
MultiCare Health System

Liberty Eberly, DO
innovaTel Telepsychiatry
Chief Medical Officer

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Agenda

Introduction *Joe Parks*	5 mins
Presentation: Opportunities for Medical Directors through CCBHC *John Kern, MD*	25 mins
Panel Discussion *Jeff Eisen, MD* *Liberty Eberly, DO*	15 mins
Audience Q&A	10 mins

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SAMHSA CCBHC Requirements Related to Medical Directors

- Two criteria explicitly reference Medical Director
  - 1.a.2 – Requires:
    - A psychiatrist as Medical Director.
    - The Medical Director is a member of the management team
    - Medical Director need not be a full-time employee
    - The Medical Director will ensure the medical component of care and the integration of behavioral health (including addictions) and primary care are facilitated
  - 1.a.3 - Allows non-psychiatrist with prescribing authority and with access to psychiatric consultation to be medical director in cases of psychiatric shortage
- 24 criteria require Medical Director involvement by reference to criteria 1.a.2

What if we focus on opportunities, rather than meeting requirements?

- What is the difference between minimal compliance with SAMHSA regs and the potential for leadership and support that the CCBHC framework permits?

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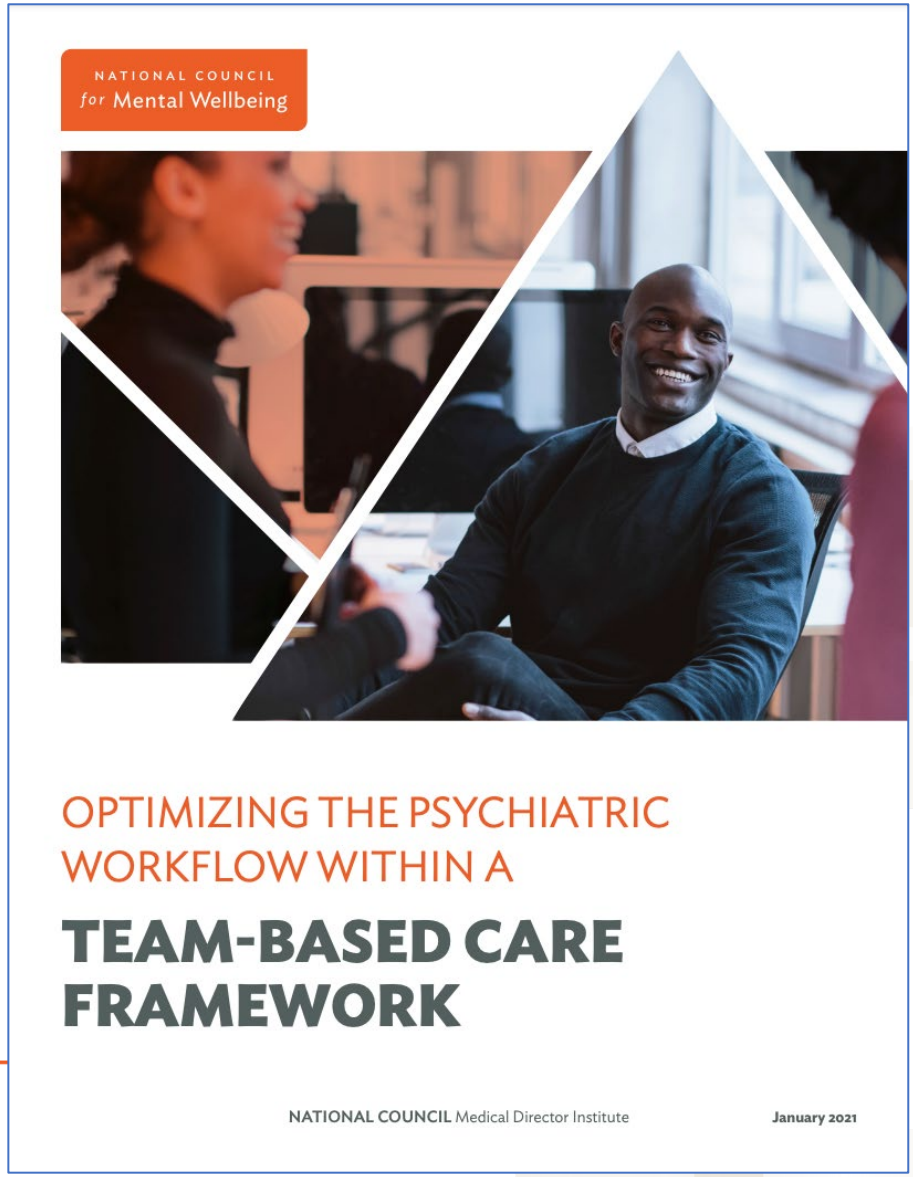
High-quality psychiatric services

- Including evidence-based prescribing and monitoring, and **the development of a team-based psychiatric model, like that in the recent Workflow paper:**



SAMPLE TEAM-BASED PSYCHIATRIC CLINIC WORKFLOW

Patient Arrival

- Check-in
- Communicate visit process, wait times
- Prepare for appointment (e.g., Common Grounds model)
- Complete clinical rating scales
- Staff: Front desk, administrator, peer

Psychiatric Visit Preparation

- Chief complaint/reason for visit, new concerns
- Structured interval history
- Vital signs
- Medication reconciliation
- Review clinical rating scales
- Review lab monitoring status
- Pre-document in EHR
- Staff: Medical assistant, nurse

Psychiatric Visit

- Review records
- Welcome and engage client, family
- Review interval history and pre-documentation
- Conduct mental status exam
- Diagnostic review
- Risk assessment, and if necessary, safety plan
- Assess treatment side-effect response
- Review physical health and lab monitoring status
- Shared decision-making (provide psychoeducation, elicit client goals, preferences)
- Psychotherapeutic interventions
- Activate treatment plan (medication, other treatment orders, lab orders, care coordination with primary care, linkage with other team members and care modalities)
- Staff: Psychiatric provider, scribe

Examples of Care Pathways/Algorithms Organizing Care:

- Antipsychotic monitoring
- Lithium management
- Depression tracking with rating scales
- Standard responses to abnormal physical
- Findings, e.g., elevated blood pressure
- Follow-up of emergency department visits
- Follow-up of psychiatric hospitalizations
- Follow-up of medical hospitalizations

Post-Provider Tasks

- Injections
- Lab draw or facilitation
- Disability and prior-authorization paperwork
- Health coaching
- Response to abnormal physical findings, e.g., elevated blood pressure
- Staff: Medical assistant, nurse

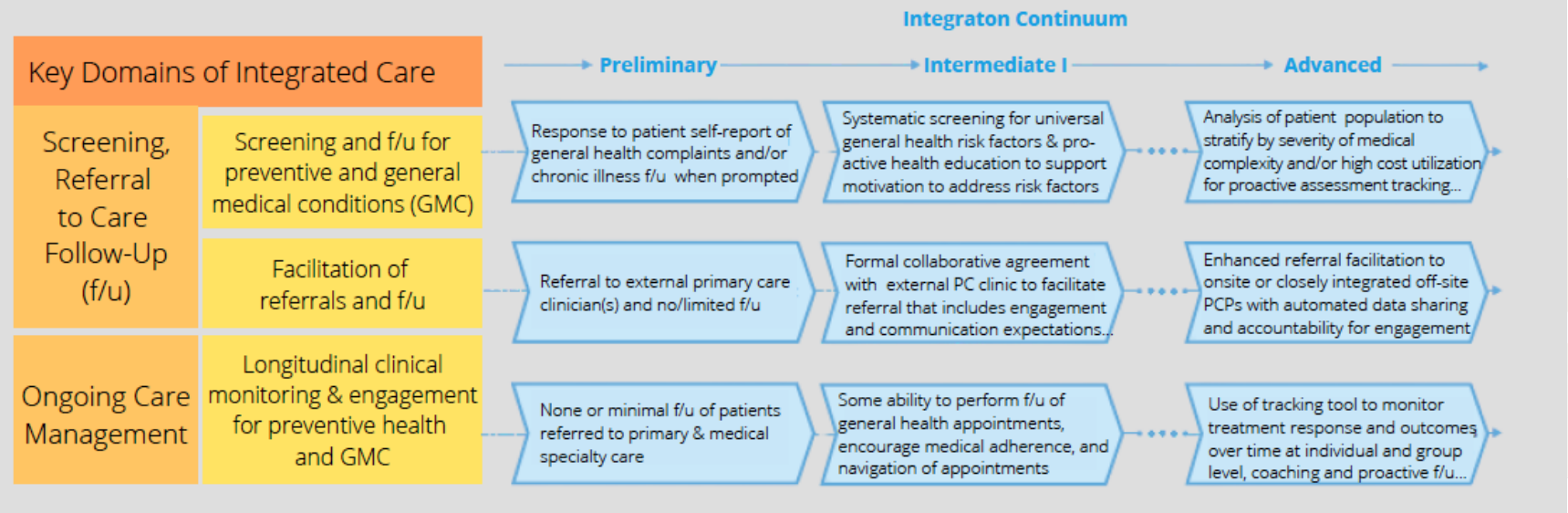
Patient Departure

- Provide visit summary
- Review new plan of care
- Arrange linkage with other services (primary care, case management, social agencies, transportation)
- Schedule next appointment(s)
- Staff: Front desk, administrator, peer

Between Visits

- Team huddles
- Team meetings
- Population health activities
- Patient calls between appointments

Leadership in care coordination efforts, such as those organized in the GHI model



Advancing Integration in Community Behavioral Health:
Using a New General Health Integration Framework

Driving quality metrics, especially those related to access, medical screening and outcomes.

- For example, Washington State Common Measure Set includes:
  - Access to Preventive / Ambulatory Health Services
  - Antidepressant Medication Management
  - DRR
  - Follow up after ED visit for Mental Illness
  - Follow up after Hospitalization for Mental Illness
  - DM control
  - HTN control
  - Med Adherence
  - Statin therapy for pts with CV disease…

Using leverage as medical professional to foster connections **Inside the organization**

- Leadership with your psychiatric providers – engagement with integration, institution of EBP's, alliance with QI efforts.
- Leading medical care coordination efforts

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Using leverage as medical professional to foster connections **outside the organization**

Becoming part of the medical community:

- Credibility as physician with medical organizations,
- Primary Care partners in the community
- Hospitals / consultants

Involvement with MH community

- e.g., state involvement with CCBHC planning
- Physician involvement relatively rare and often welcomed

Drive flexible care approaches

- Staff working at top of license, culture of data-driven QI on clinical quality, efficiency and pt experience, like Patient-Centered Medical Homes (PCMH.)
- Look at list of PCMH criteria and compare:

- **Team-Based Care and Practice Organization:** Helps structure a practice's leadership, care team responsibilities and how the practice partners with patients, families and caregivers.
- **Knowing and Managing Your Patients:** Sets standards for data collection, medication reconciliation, evidence-based clinical decision support and other activities.
- **Patient-Centered Access and Continuity:** Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.
- **Care Management and Support:** Helps clinicians set up care management protocols to identify patients who need more closely-managed care.
- **Care Coordination and Care Transitions:** Ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care.
- **Performance Measurement and Quality Improvement:** Improvement helps practices develop ways to measure performance, set goals and develop activities that will improve performance.

Implied Medical Director Requirements

- The Medical Director must have sufficient administrative time not directly involved in direct patient care to ensure the medical component of care and the integration of behavioral health and primary care criteria are met. There is not a requirement that the CCBHC Medical director provide direct care themselves

- The Medical Director must have a sufficient authority (direct or indirect) to ensure the medical component of care and the integration of behavioral health and primary care criteria are met

- The Medical Director must have sufficient frequency and duration of interaction with the CEO and other management team members to effectively function as a management team member

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How much time will this take?

- Of course depends on size and complexity of agency. (Just for our thinking: My old agency had 15,000 pts, including the FQHC and an IP unit so I had to deal with CMS, the state and Joint Commission and I was 0.6-0.8 administrative)
- Effectively leading team to meet VBP metrics could defray much of this.
- How to use support staff to optimize medical director time investment, e.g., assistance to wrangle data gathering and management for physical outcomes, psychiatric quality measures, day-to-day clinic supervision.
- Link to team-based population-based care in general and to the TBC workflow paper.

How much will this cost?

- VBP participation often tied to physical care coordination.
- Team-based care can be made to scale up medical expertise.

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Discussion

- **Jeffrey Eisen, MD, MBA** | Chief Medical Officer, Behavioral Health **MultiCare Health System**
- **Liberty Eberly, DO:** innovaTel Telepsychiatry, Chief Medical Officer

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Q&A

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Resources

CCBHC SUCCESS CENTER

https://www.thenationalcouncil.org/ccbhc-success-center/

MTM SERVICES

https://www.mtmservices.org/

innovaTel telepsychiatry

https://innovatel.com/

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