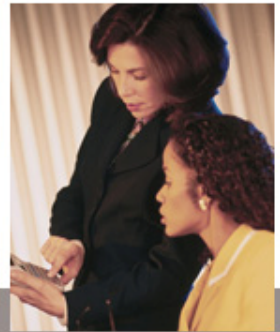




NATIONAL ASSOCIATION OF

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America's Voice for Community Health Care



NATIONAL ASSOCIATION OF
Community Health Centers

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) represents Community and Migrant Health Centers, as well as Health Care for the Homeless and Public Housing Primary Care Programs and other community-based health centers.

Founded in 1971, NACHC is a nonprofit advocacy organization providing education, training and technical assistance to health centers in support of their mission to provide quality health care to medically underserved populations.



NATIONAL ASSOCIATION OF
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The NACHC Mission

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.



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SAAS/NIATx Annual Conference

Behavioral Health Integration in FQHCs

Michael R. Lardiere, LCSW
Director HIT; Sr. Advisor Behavioral Health
National Association of Community Health Centers
mlardiere@nachc.com

July 11, 2011



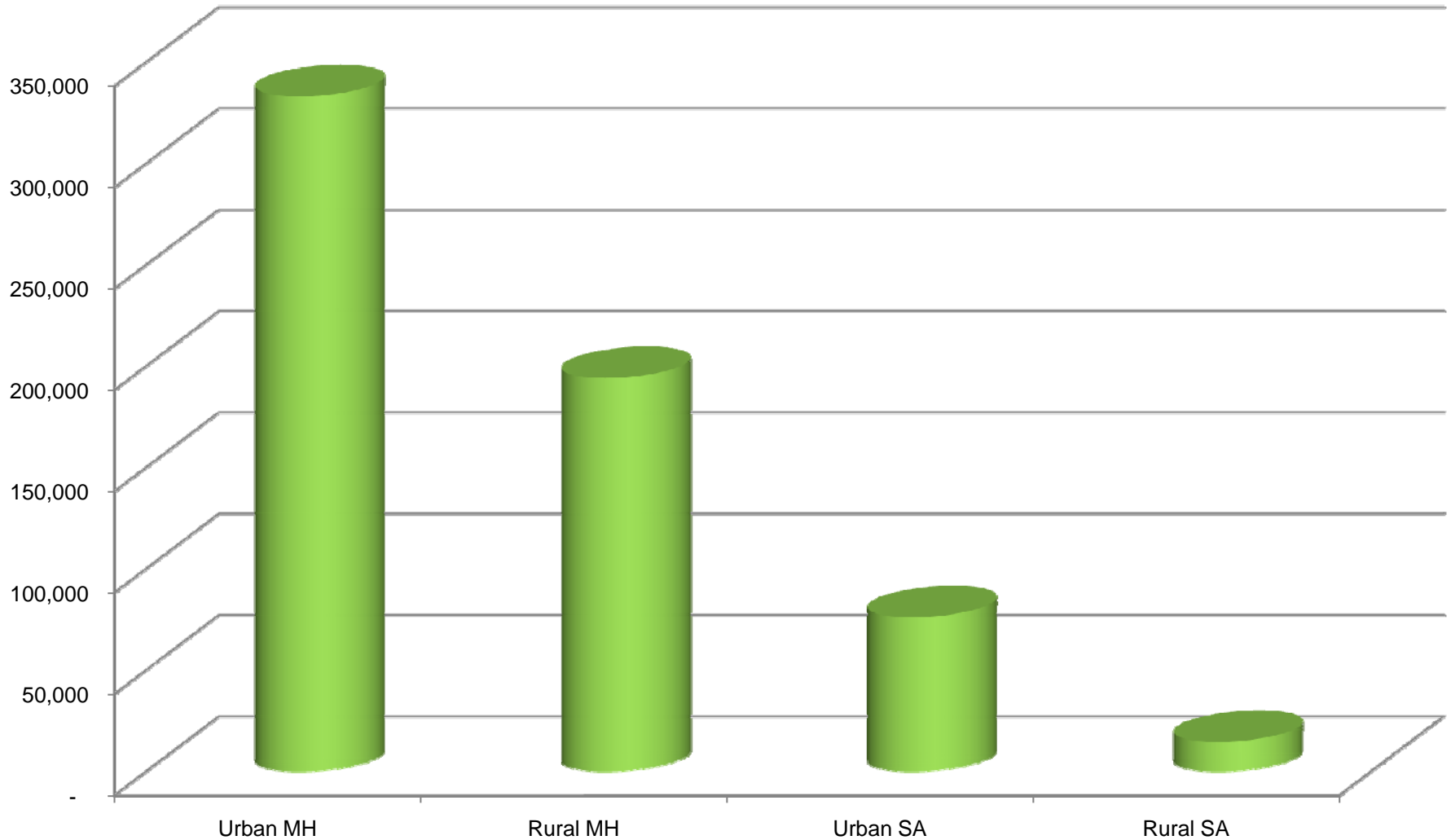
- **Overview of Current Behavioral Health Delivery in FQHCs**
- **Identification of the “Core Components” of Integrated Care**
- **Review of legal considerations when integrating care**



- **70% of Health Centers Currently Provide Behavioral Health Services**
- **All Health Centers are required to have a behavioral health intervention identified in their annual plan**

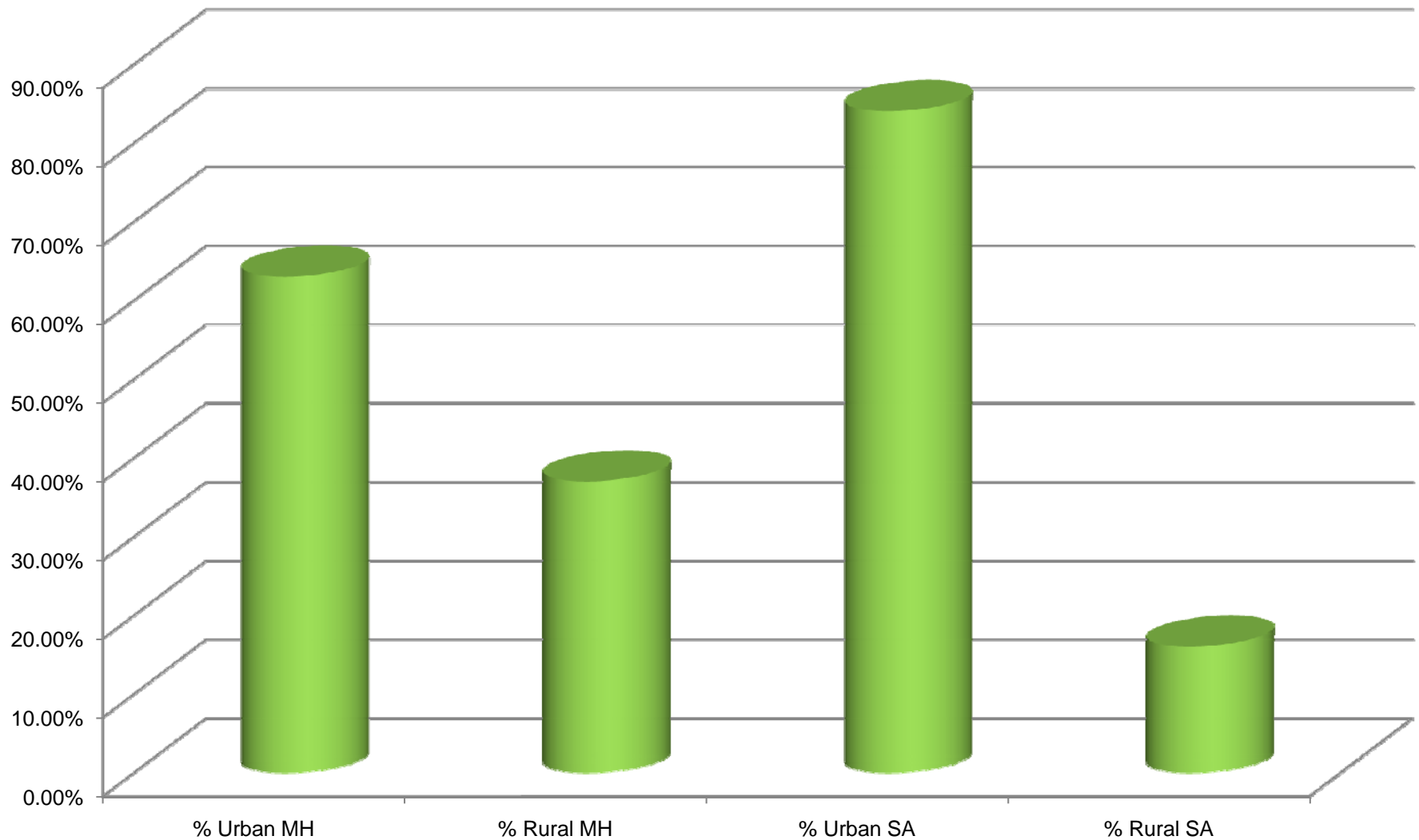
Behavioral Health - Rural vs Urban

Total Patient BH Visits by Type and Location

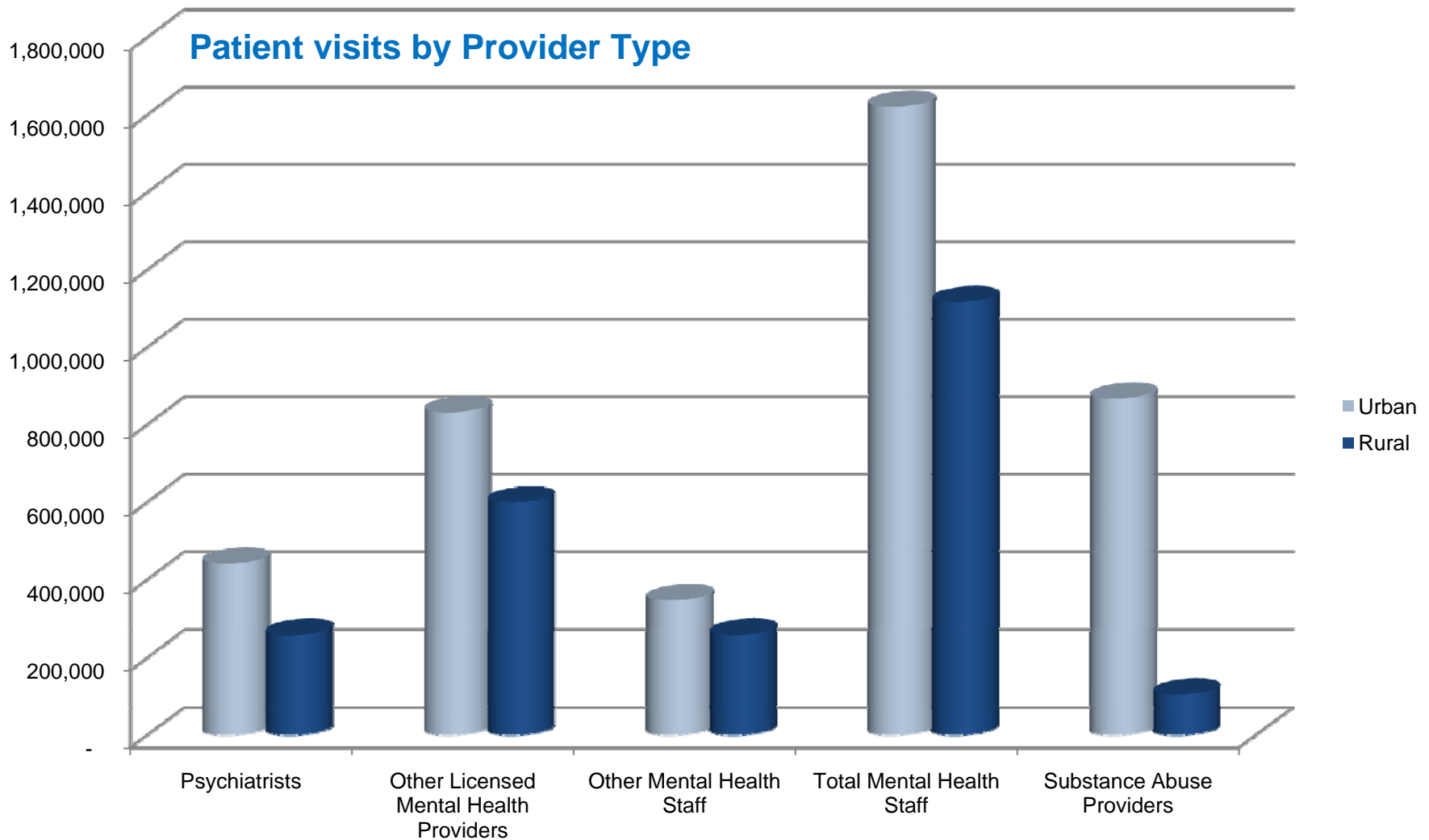


Behavioral Health - Rural vs Urban

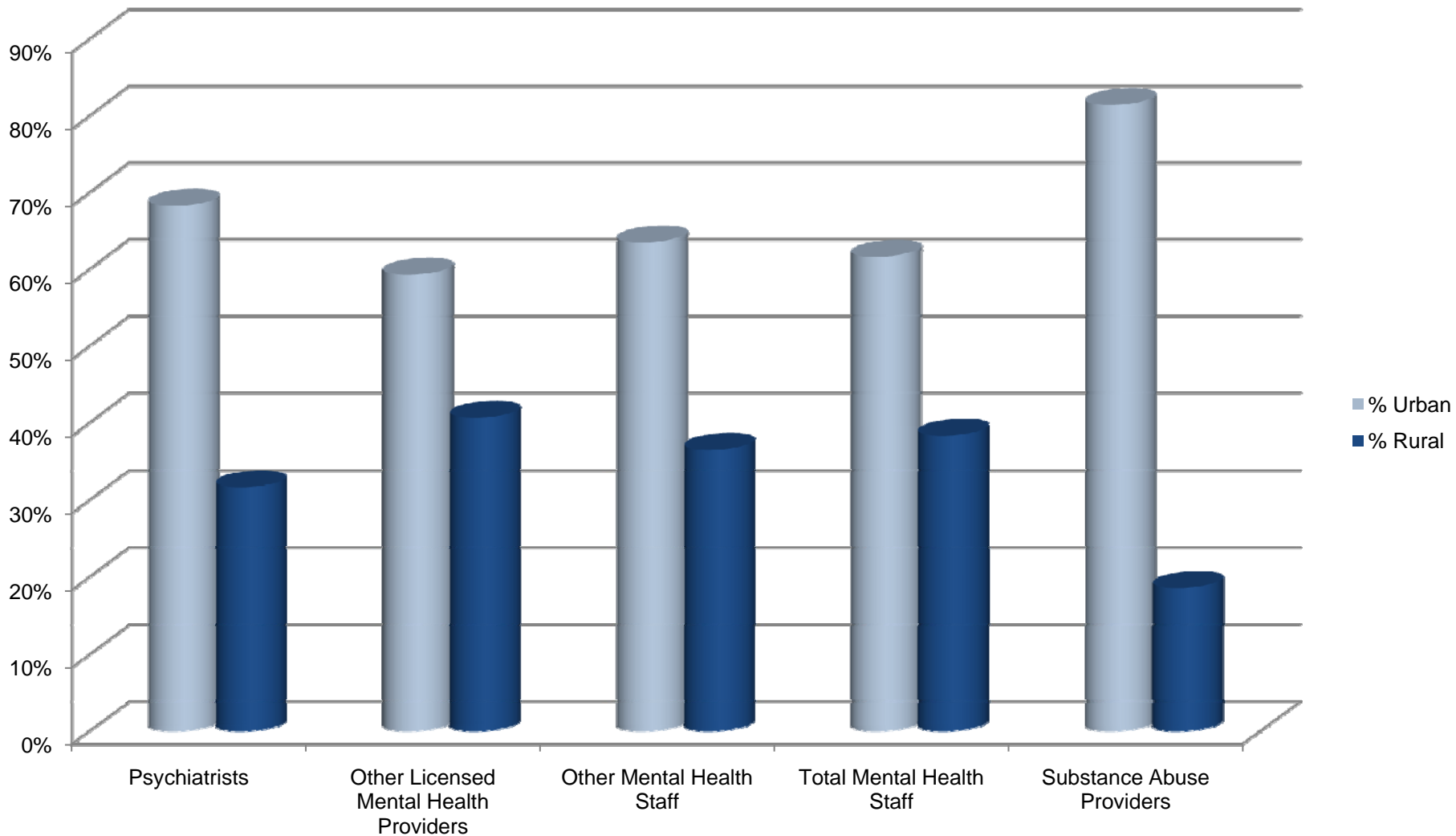
% BH Visits by type and Location



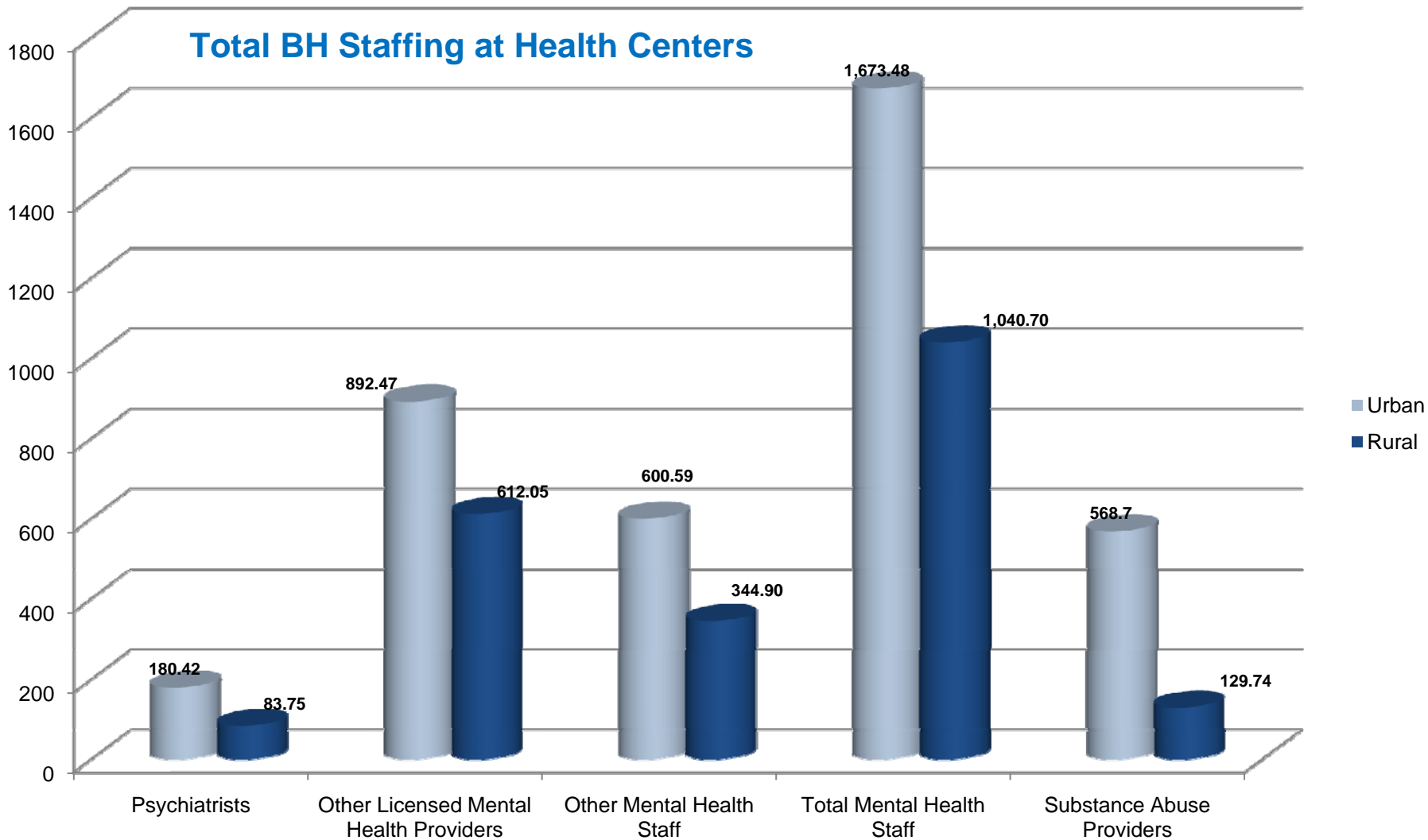
Behavioral Health Visits by Type of Provider



% Behavioral Health Staffing by Discipline



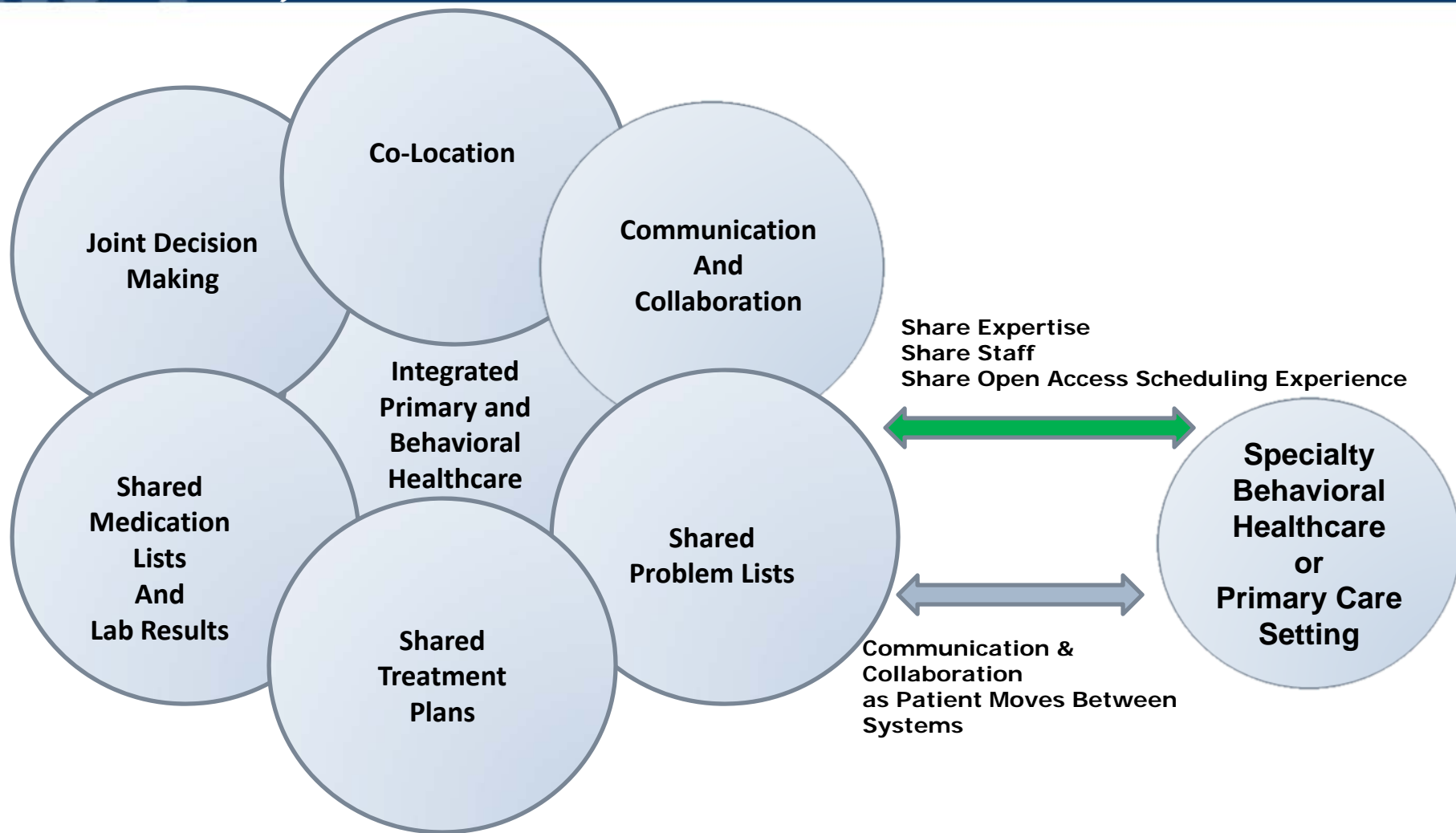
Total Behavioral Health Staffing by Discipline





- **But is the Treatment health centers provide Integrated Treatment?**
- **What do we mean by Integrated Treatment?**
 - **What are the Core Components?**

Behavioral Health Integration in Primary Care: Making it Real (Morehouse University, Carter Center, HRSA, SAMHSA Oct. 2008)



Core Components of Successful Integrated Models



Why Provide BH Services?

➤ Statutory requirement

➤ Under Section 330 of the Public Health Service Act (42 USC §254b), all FQHCs must provide –

➤ “Required primary health services,” which are defined to include “referrals to providers of ... other health-related services (including substance abuse and mental health services) – 42 USC §§254b(a)(1) & (b)(1)(A)(ii)

➤ **NOTE:** Programs receiving targeted Health Care for the Homeless funds must provide additional substance abuse services (detoxification, risk reduction, outpatient treatment, residential treatment, rehabilitation in non-hospital settings) - 42 USC §254b(h)



Why Provide BH Services?

- **HRSA priority (as evidenced by service expansion funding opportunities)**
- **Important components**
 - **Enhances ability to provide comprehensive primary care**
 - **Increases access to essential services which assist in ensuring the overall health and well-being of community and patients served**



➤ **Includes Mental Health Services**

- **Such as pharmacological management, assessment, psychiatric diagnostic interview, individual and group counseling, crisis intervention**

➤ **Includes Alcohol and Drug Services**

- **Such as ambulatory detoxification, assessment, case management, crisis intervention, individual and group counseling, lab urinalysis, medical/somatic, methadone administration, Buprenorphine administration, SBIRT**



- **BH program should include the following components (cont.)**
 - **Application of exemplary practices and lessons learned**
 - **Effective risk management practices**
 - **Incorporation of program activities into the FQHC's quality plan**
- **Services can be provided on-site or off-site through an established contractual arrangement**
- **HRSA strongly encourages using an integrated primary MH/SA care model in developing the service delivery plan**
 - **Delivery of brief patient-centered MH/SA consultations**
 - **Co-management of patients by MH/SA providers (who are “members” of primary care team) and medical providers**



Traditional Key Differences Between FQHCs and BH Providers

➤ FQHC

- National System
- Safety Net Provider
- Need-Based Services
- Prevention-Oriented
- Lifespan Care

➤ CMHC

- State-Defined
- Medicaid Provider
- Eligibility-Based Services
- Rehab-Oriented
- Episodic Care



Methods of Integration

- **FQHC takes sole responsibility for providing BH Services**
- **FQHC Purchases Services from BH Specialty Provider**
- **Referral Relationship**
 - **BH Specialty Provider locates their services in same location as FQHC**
 - **BH Provider located off site at another location**



- **FQHC takes sole responsibility for providing BH Services**
- **Easiest to Implement**
- **No Special Legal considerations**
 - **Requires Clinical Expertise**
 - **Supervision**
 - **Linkages with BH specialty Providers are still required for patients that require services beyond FQHC clinical capacity/expertise**



Purchase of Services/Capacity

- **FQHC purchases BH services and/or personnel from BH Provider - services provided on behalf of FQHC**
- **FQHC maintains control over and is legally and financially responsible for contracted services**
 - **Patients are considered FQHC patients**
 - **BH Provider provides assurances to meet FQHC's**
 - **Professional standards**
 - **Clinical and other pertinent policies, procedures and protocols**
 - **Quality assurance standards**
 - **Data collection standards**
 - **Medical records preparation**
 - **Financial and programmatic reporting**
 - **Standards of care**
 - **Productivity standards (as applicable)**



➤ Other BH Provider assurances

➤ Act consistent with Section 330 rules

➤ Eligible to participate in Federal health care programs (not suspended or excluded)

➤ FQHC can evaluate BH Provider and, if necessary

➤ Suspend services or assigned personnel

➤ Terminate assigned personnel or contract in its entirety

➤ FQHC provides payment to BH provider based on arm's length negotiated, fair market value rate (reasonable, in accordance with federal cost principles of OMB Circ A-122)

➤ Note: If the health center is paying less than fair market value, the agreement should meet the requirements of the health center safe harbor (42 C.F.R. §1001.952(w))

➤ FQHC bills and collects from patients and third party payors



- **FQHC assumes operations and financial authority over the BH program that is integrated into the FQHC's delivery system**
- **BH provider's clinicians may be integrated into the FQHC workforce or their time/services may be purchased by the FQHC through a purchase of services/clinical capacity agreement**



Referral Relationships

- **BH Provider agrees to furnish services to FQHC patients referred by the FQHC, regardless of ability to pay (subject to capacity limitations)**
- **BH Provider retains control and liability**
 - **Patients are considered BH Provider's patients**
 - **FQHC disclaims liability for services provided by BH Provider – BH Provider is solely liable for damages related to the services it provides**
- **BH Provider policies/procedures/standards govern**
- **BH Provider furnishes services consistent with prevailing standards of care (at a minimum)**



- **BH Provider keeps separate financial system and bills and collects from patients and third party payors for services rendered**
- **BH Provider agrees to refer patients back to the FQHC for clinically appropriate primary and preventive care**



Referral Relationships

- **PIN #2008-01: Requirements for in “in-scope” referral arrangements**
 - **If referral provider provides and bills for service, the service itself is not in scope**
 - **However, the formal referral arrangement and the follow-up care provided by health center will be in-scope if health center:**
 - **Executes a formal, written agreement that describes**
 - **How referral will be made and managed**
 - **Process for referring patient back to health center for follow-up care**
 - **Maintains responsibility for treatment plan**
 - **Provides, pays for and/or bills for appropriate follow-up care**
 - **Informal referral arrangements CANNOT be used to provide required services or any other “in-scope” services**



Referral Relationships On-Site

- **Similar to referral relationship, but BH Provider is physically located in and provides services to FQHC patient at FQHC facility**
- **Need to ensure that the patient can distinguish between the FQHC and BH Provider (i.e., separate signage, entrances, registration etc.)**
- **Control/liability: same as referral relationship**
 - **Circuit riding (contracts on as-needed basis)**
 - **Co-location**
- **Standards of care: same but FQHC may want right to review and approve them**
- **Financing: same as referral relationship**



Additional Considerations: Extra Privacy Protections for Substance/Alcohol Diagnosis, Treatment, Referral Information

- **42 CFR Part 2 prohibits the transfer of individually identifiable information about a patient that is receiving substance use or alcohol treatment services without valid written specific authorizations, called consents**
 - **Also applies to past patients**
- **More prohibitive than HIPAA, which generally allows individually identifiable “protected health information” to pass for the purposes of treatment, payment, health care operations**



Additional Considerations: 42 CFR Part 2

- Applies to programs, which are:
- Individuals or entities (other than general medical facilities), or identified units within general medical facilities,
 - that hold themselves out as providing, and actually provide alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
- Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers



Additional Considerations: 42 CFR Part 2

Part 2 allows certain information to pass without specific patient consent:

- **Communications within a program or between a program and an entity having direct administrative control over that program;**
- **Communications between a program and a qualified service organization (“QSO”);**
- **Medical emergencies, research activities and audit or evaluation activities.**

Caveat: Re-disclosures — secondary disclosures stemming from an initial one — are prohibited unless made back to the program from which the information was obtained



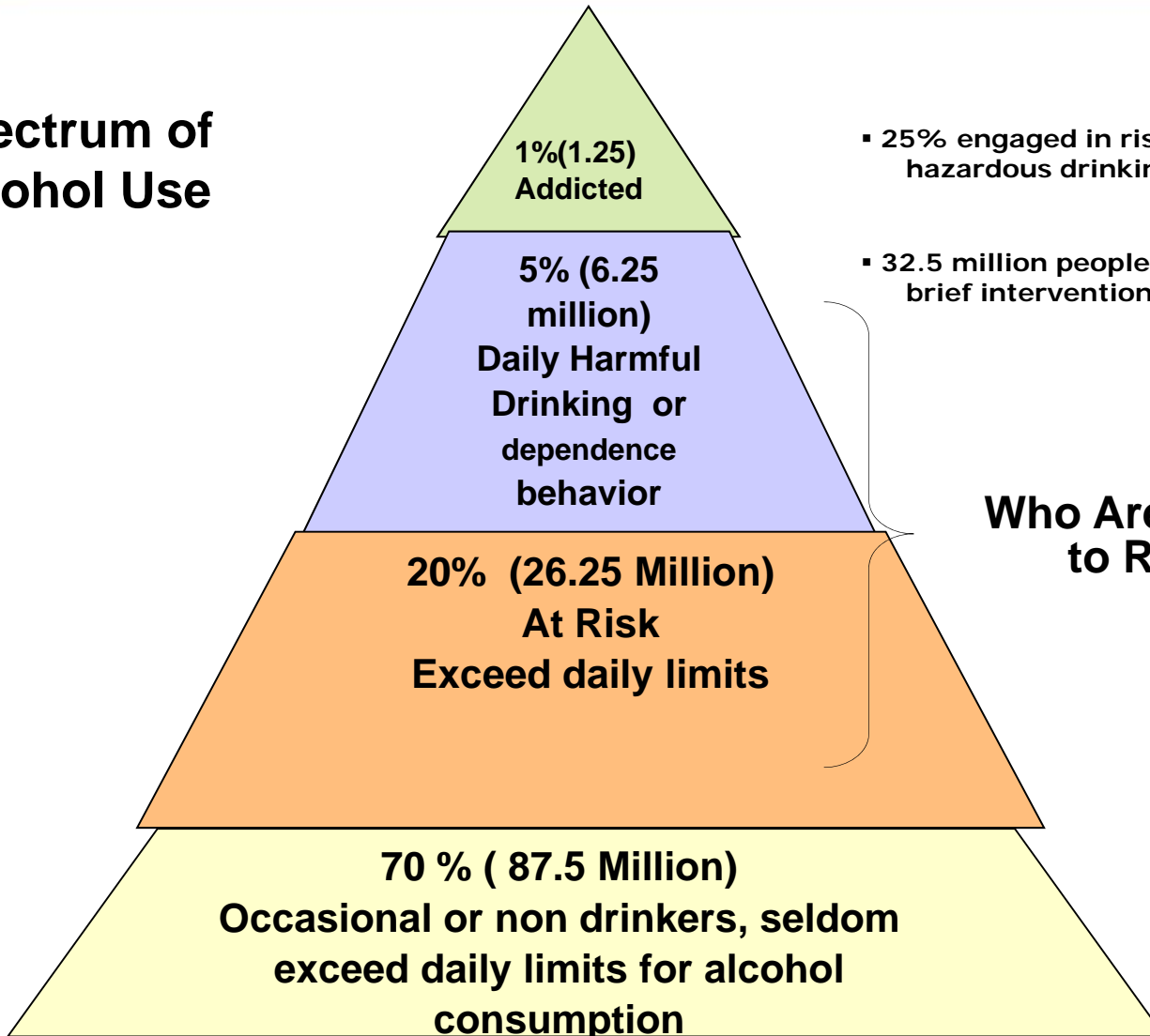
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Contact Information

SBI RT

Screening Brief Intervention and Referral to Treatment

Spectrum of Alcohol Use



- 25% engaged in risky, harmful or hazardous drinking
- 32.5 million people could benefit from brief intervention

Who Are We Trying to Reach?

NIDA Single-Item Drug Use Screen

“How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?”

- Identifies overall drug use
- Positive screen = 1 or more
- Provide BI /RT

Barclay, Laurie (2010). Single Screening Question May Identify Drug Use in Primary Care. *Arch Intern Med.* 2010;170:1155-1160



NIAAA Single-Item Alcohol Use

"How many times in the past year have you had X or more drinks in a day?"

- X = 5 for men, 4 for women
- Identifies unhealthy alcohol use
- Positive screen = 1 or more (provide BI)

Barclay, Laura (2009). Single Screening Question May Accurately Identify Unhealthy Alcohol Use. J Gen Intern Med.

AUDIT-C

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. (see below, What is a Standard Drink?) Code answers in terms of “standard drinks”. Place the correct answer number in the box at the right.

Questions*	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
AUDIT-C Score (add items 1-3) <i>Positive screen=4 men/3 women and adults over age 65</i>						

Box 10**The Alcohol Use Disorders Identification Test: Self-Report Version**

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

AUDIT***Alcohol Use Disorder Identification Test****•Developed by WHO**

English:http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Spanish:http://www.who.int/substance_abuse/activities/en/AUDITmanualSpanish.pdf

•Detects Alcohol Problems in the Last Year

•AUDIT-C <2 min

•AUDIT <5 min





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What is Brief Intervention?



BI: Definition & Implications

- A practice to identify a real or potential substance use problem, and to motivate an individual to do something about it.
- Non-confrontational, short health counseling technique.
- Not a quick fix treatment.



Elements of BI Protocol

- Screening score feedback
- Education (risks, guidelines)
- Normative feedback
- Simple advice and expression of clinical concern
- Provide resources
- Close on good terms
- Make referral linkage for high risk of dependency or complicated cases

Screening Score Feedback

- **Using a non-judgmental tone...**

"From your responses, your drinking puts you at higher risk for many health and emotional concerns than those who drink at lower ranges. These questions have been given to thousands of people, so you can compare your drinking to others. Your score was [#]...on a scale of 0-40 which places you in the category of [moderate or high] risk."

- *72% of adults do not drink or drink at low risk levels, 20% drink at moderate risk levels, and 8% drink at the high risk levels*

- **Discuss health risks of alcohol and other substances**

“Unhealthy alcohol use can put you at risk for injury, accidents, and health problems such as depression, diabetes, cancer, insomnia, high blood pressure, stroke, heart and gastrointestinal problems, and other conditions.”



Review drinking guidelines

“The recommended guidelines for healthy adults are no more than 1 drink per day (or 7 drinks per week) for women and adults over age 65, and no more than 2 drinks per day (or 14 drinks per week) for men.”

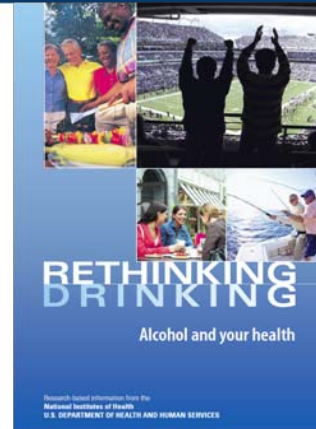
Simple Advice and Expression of Clinical Concern


- *“Reducing your consumption to safer drinking levels can decrease your risk of health problems.”*
- *“I advise you to Cut Back your (alcohol/drug) consumption.”*
- **10-30% clients will significantly reduce (alcohol/tobacco/diabetic) risky behavior.**



Provide Resources

- *Rethinking Drinking* (booklet, online) <http://rethinkingdrinking.niaaa.nih.gov/>
- *Tips for Cutting Down on Your Drinking*
<http://pubs.niaaa.nih.gov/publications/Tips/tips.pdf>
- *Harmful Interactions: Mixing Alcohol with Medications*
[http://pubs.niaaa.nih.gov/publications/Medicine/Harmful Interactions.pdf](http://pubs.niaaa.nih.gov/publications/Medicine/Harmful%20Interactions.pdf)





Exploring Motivation using MI and CBT Strategies

- Explore Ambivalence
 - Pros and Cons of Alcohol Use
- Explore Readiness
 - Importance and Confidence Rulers
- Explore Goals
 - quit, cut down, make no change?
- Elicit Change Talk – *“I really want to cut-back on drinking with the guys after work.”*



Exploring Pros/Cons

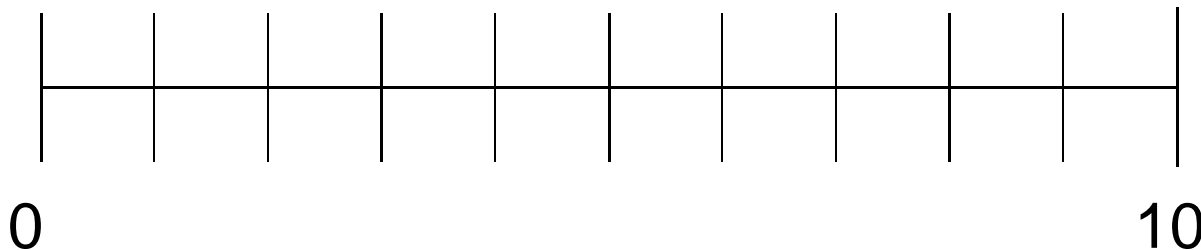
- *What are the good things about your _____?*
- *What are some of the less good things?*
- *What concerns do you have about your _____?*
- *If you were to change, what would it be like?*
- *Where does this leave you now?*

Source: Mary Velasquez, HOT EAPA Motivational Interviewing Training, September 1, 2010

Importance Ruler

How important is it to you to _____ (e.g., quit using, begin treatment)?

If 0 was “not important,” and 10 was “very important,” what number would you give yourself?”



Source: Mary Velasquez, HOT EAPA Motivational Interviewing Training, September 1, 2010



Exploring Importance

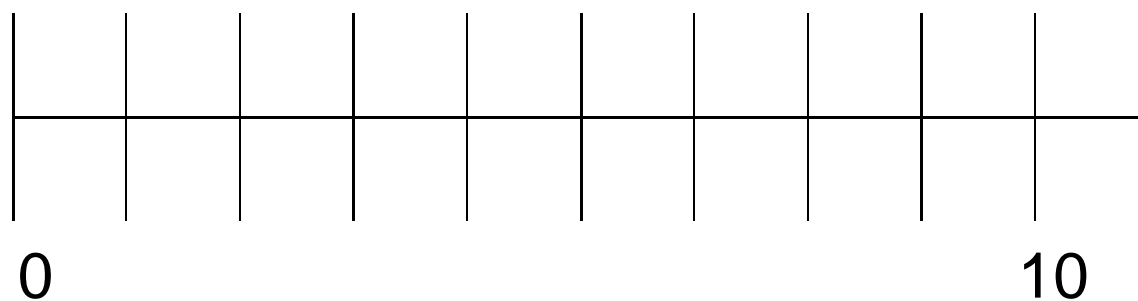
- *Why are you at x and not y?*
(always start with the higher number)
- *What would have to happen for it to become much more important for you to change?*

Source: Mary Velasquez, HOT EAPA Motivational Interviewing Training, September 1, 201

Confidence Ruler

“If you decided right now to ____ (e.g., stop drinking, using drugs, enter treatment), how confident do you feel about succeeding with this?

If 0 was ‘not confident’ and 10 was ‘very confident’, what number would you give yourself?”



Source: Mary Velasquez, HOT EAPA Motivational Interviewing Training, September 1, 2010



Building Confidence

- *What would make you more confident about making these changes?*
- *Why have you given yourself such a high score on confidence?*
- *How could you move up higher, so that your score goes from x to ?*
- *How can I help you succeed?*

Source: Mary Velasquez, HOT EAPA Motivational Interviewing Training, September 1, 2010



Assist with Action Plan

- *If you were to decide to change, what might your options be?*
- *What is your next step?*
- *How will you do that?*
- *Are there any ways you know about that have worked for other people?*
- *Is there anything you found helpful in any previous attempts to change?*

Source: Mary Velasquez, HOT EAPA Motivational Interviewing Training, September 1, 2010



Close on Good Terms

- Say “Thank You”

“Thank you for taking a few minutes to talk with me about your alcohol / drug use. I appreciate your openness and sharing your experiences / thoughts with me today.”



Provide Referral

- *“Based on the information you provided, I would encourage you to consider getting additional help for dealing with issues related to [alcohol / drugs].”*
- *“I would like to refer you to...”*



Putting it all together, what does it look like?

http://www.youtube.com/watch?v=TGhj06-sM2Y&feature=player_embedded

Showing that you truly hear and care:

<http://www.youtube.com/watch?v=4smHqphkBgs> [\(4:25-5:00\)](#)

Helping Patients Who Drink Too Much



A CLINICIAN'S GUIDE

http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

- **Free Online Training**
- **Video Cases: Helping Patients Who Drink Too Much**
- **Free CME/CE credit for physicians or nurses**



[http://www.niaaa.nih.gov/Publications/
EducationTrainingMaterials/CME
_CE.htm](http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/CME_CE.htm)



SCREENING FOR DRUG USE IN GENERAL MEDICAL SETTINGS

Resource Guide

NIDA NATIONAL INSTITUTE
ON DRUG ABUSE

[http://www.nida.nih.gov/nidamed/
resguide/resourceguide.pdf](http://www.nida.nih.gov/nidamed/resguide/resourceguide.pdf)



Concluding Comments

- Alcohol and Other Drug abuse/addiction are medical conditions.
- Substance abuse services can effectively be provided in health care setting.
- Many benefits to integrative PCP and BHC services.
- SBIRT codes now provide financial support to health care settings using behavioral health care.
- Screenings, interventions, and referrals are the tools used for integrative substance abuse services.
- Co-occurring disorders are more effectively treated with integrative health care services.
- Ultimately, the patients' care and treatment experience are enhanced.



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