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Ohio Cardiovascular and Diabetes Health Collaborative

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

In partnership with:

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

COLLEGE OF MEDICINE AND LIFE SCIENCES THE UNIVERSITY OF TOLEDO

OHIO UNIVERSITY Heritage College of Osteopathic Medicine

Northeast Ohio MEDICAL UNIVERSITY

University of CINCINNATI FAMILY AND COMMUNITY MEDICINE

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Ohio Department of Medicaid

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Ohio Department of Medicaid

Integrating Behavioral Health and Primary Care Services: Lessons Learned from Three Ohio Practices

February 10, 2021

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Welcome

Michael W. Konstan, MD

PI, Cardi-OH

Case Western Reserve University School of Medicine

Shari Bolen, MD, MPH

Co-PI, Cardi-OH

Case Western Reserve University School of Medicine

About Cardi-OH

CARDI·OH

Ohio Cardiovascular and Diabetes Health Collaborative

Founded in 2017, the mission of Cardi-OH is to improve cardiovascular and diabetes health outcomes and eliminate disparities in Ohio's Medicaid population.

WHO WE ARE: An initiative of health care professionals across Ohio's seven medical schools.

WHAT WE DO: Identify, produce and disseminate evidence-based cardiovascular and diabetes best practices to primary care teams.

HOW WE DO IT: Utilize monthly newsletters and an online repository of resources at Cardi-OH.org, podcasts available on Cardi-OH Radio, and the Project ECHO® virtual training model.

Learn more at cardi-oh.org

Special Thanks

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Special Thanks

Zoom Webinar Logistics

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- **If joining as a group, please use the Chat feature to record names and emails of all attendees**

- **Submit Questions for Discussion**
  - Use the Q&A feature to submit questions at any point
  - Questions will be answered during the 'Question and Answer' portion of the program
  - Please specify which speaker should answer

- **Post Webinar Evaluation Survey**
  - The survey link will be shared at the end of today's webinar and also sent by email
  - Please complete by COB Wednesday, February 17

Continuing Medical Education (CME)

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- 1.00 AMA PRA Category 1 Credit is available for this webinar
- You must complete the CME Evaluation and claim credits by March 10, 2021
- If you do not receive an email to complete your CME evaluation or need other assistance, contact Cathy Sullivan, csullivan1@metrohealth.org

Disclosure Statement:

- The speakers, moderators, and planners of the CME activity have no financial relationships with commercial interests to disclose.

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Agenda

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Topics	Presenter(s)	Timing
Welcome and Overview	Michael Konstan, MD Shari Bolen, MD, MPH	5 mins.
Next Generation of Ohio's Medicaid Managed Care Program	Donald Wharton, MD	10 mins.
Introduction to Integrated Care	Trygve Dolber, MD	15 mins.
Clinic Site #1: University of Cincinnati	Hilja Ruegg, MD	6 mins.
Clinic Site #2: The Ohio State University	Laurie Greco, PhD Mark Rastetter, MD	6 mins.
Clinic Site #3: Northeast Ohio Medical University (NEOMED)	Alicia Bond, MD	6 mins.
Facilitated Question & Answer	Aleece Caron, PhD All	10 mins.
Next Steps and Wrap-Up	Shari Bolen, MD, MPH	2 mins.

Speakers

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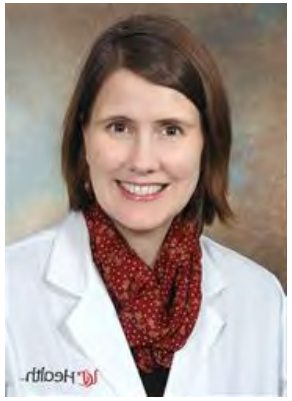
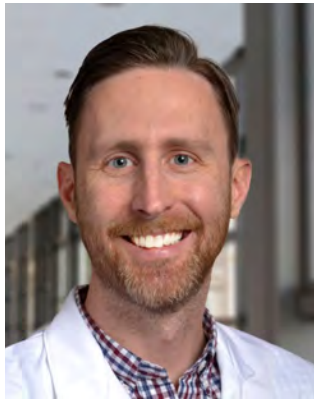
Donald Wharton, MD
Ohio Department of Medicaid

Trygve Dolber, MD
Case Western Reserve University



Hilja Ruegg, MD
University of Cincinnati



Mark Rastetter, MD

Laurie Greco, PhD
The Ohio State University

Alicia Bond, MD
Northeast Ohio Medical University

Aleece Caron, PhD
Case Western Reserve University

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Next Generation of Ohio's Medicaid Managed Care Program

Donald Wharton, MD
Assistant Medical Director
Office of Health Innovation and Quality
Ohio Department of Medicaid

Next Generation of Ohio's Medicaid Managed Care Program

Improving design, delivery and timeliness of care coordination

Ohio Medicaid Today

Challenges, Risks, & Feedback

Jan 2019

ODM Listening Tour
Request for Information 1
Request for Information 2

Pharmacy Benefit Managers lack accountability and oversight

Providers are burdened with duplicative and confusing administrative processes

Gaps and inconsistencies in data result in hidden / unnecessary financial costs; risks to program integrity

Children with complex challenges involved with multiple state systems lack a comprehensive care package

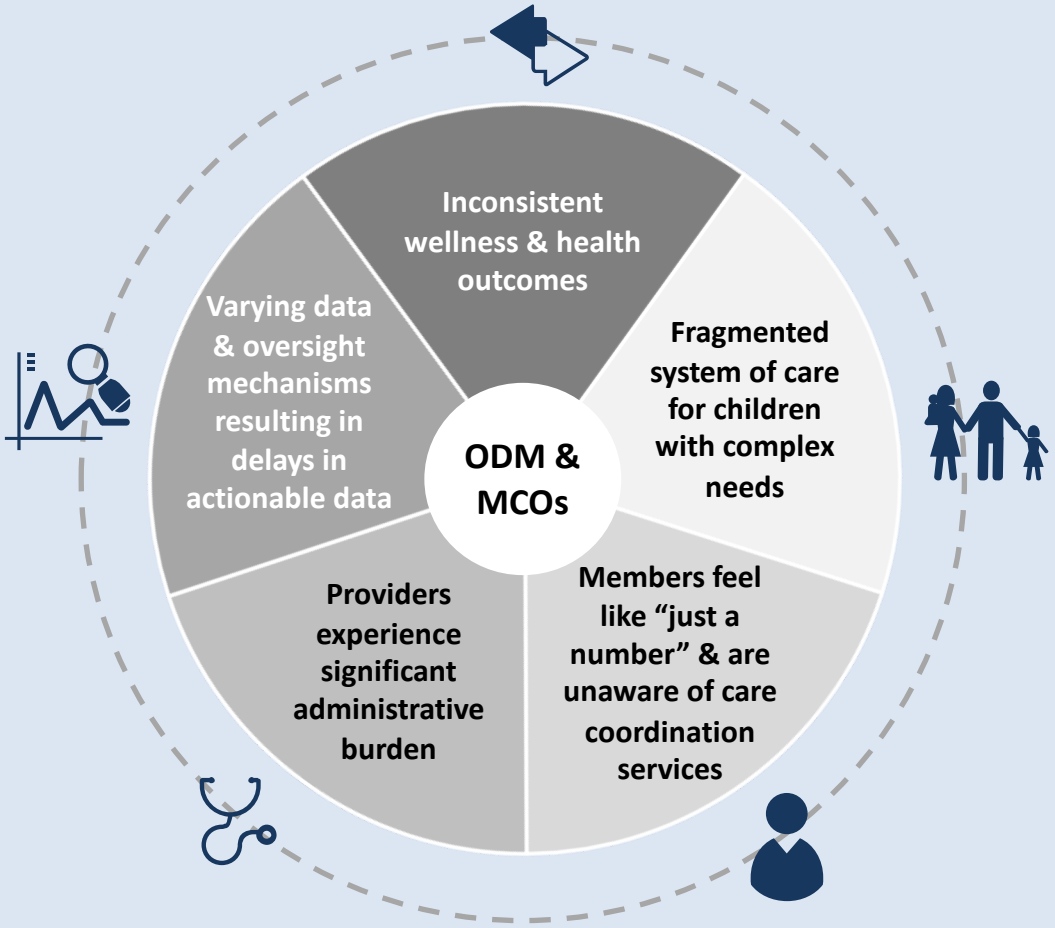
Member care is fragmented and inconsistent in experience and quality

Ohio Governor Mike DeWine called on Ohio Medicaid ***"to ensure Ohioans get the best value in providing quality care"***

Ohio's Medicaid Managed Care Program

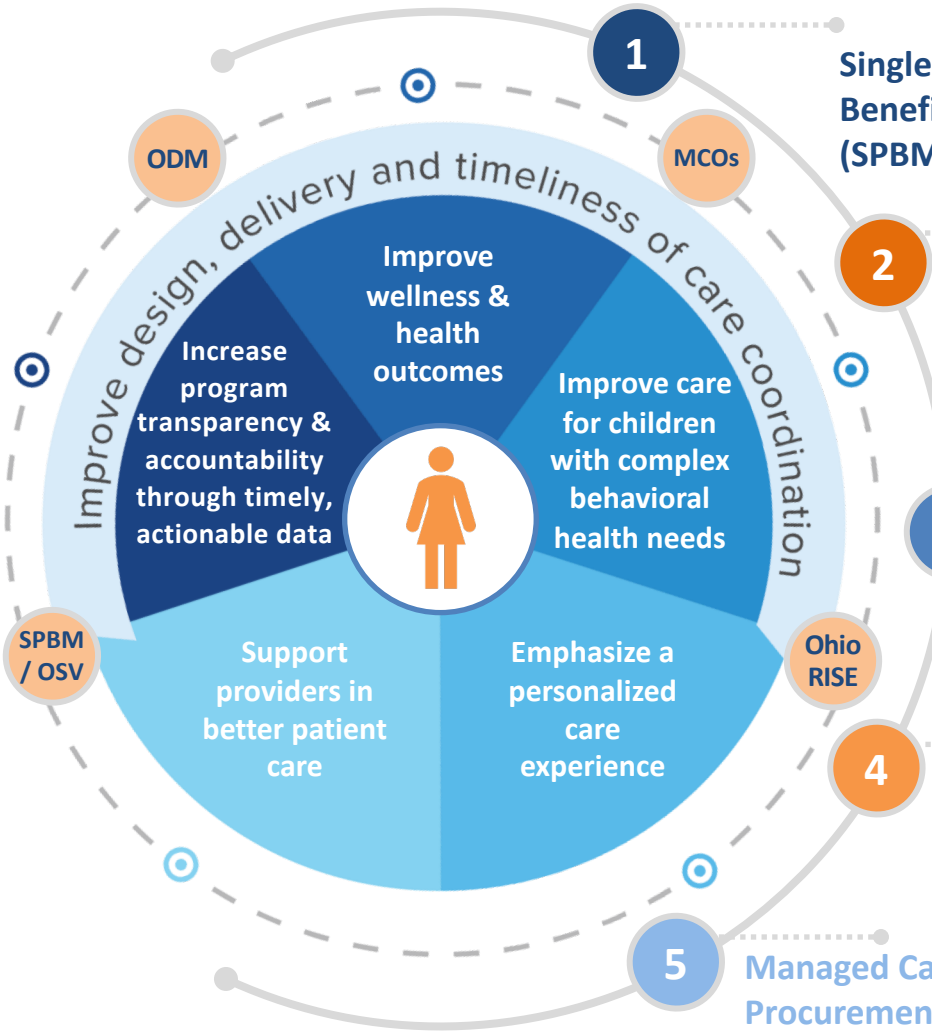
Today's Ohio Medicaid Managed Care Program

Members are impacted by business decisions that don't always take their needs or circumstances into consideration. Providers are not always treated as partners in patient care. We want to do better for the people we serve.



"Next Generation" of Managed Care in Ohio

The focus is on the individual with strong coordination and partnership among MCOs, vendors & ODM to support specialization in addressing critical needs.



Next Generation of Medicaid Managed Care

Improve design, delivery and timeliness of care coordination

Goals of Ohio's Future Managed Care Program

- Improve Wellness and Health Outcomes
- Emphasize a Personalized Care Experience
- Support Providers in Better Patient Care
- Improve Care for Children and Adults with Complex Needs
- Increase Program Transparency and Accountability

Timeline of Key Procurement Events

Award, Systems Integration & Implementation

SPBM RFP

- Contract awarded January 2021

Managed Care RFA

- Applications under review
- Award Winter 2021

OhioRISE

- Applications under review
- Award Winter 2021

Fiscal Intermediary

- Contract awarded December 2020
- Operational December 2021

Operational Support Vendor for the Single PBM (POSV)

- Applications under review
- Award June 2021

Centralized Credentialing **PHASE 1 GO LIVE SUMMER 2021**

Throughout 2021

- Start up, complete design/implementation, including rules
- Systems and data integration
- Education and training
- Transition members

Managed Care and OhioRISE services **BEGIN JANUARY 2022**

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Introduction to Integrated Care

Trygve Dolber, MD
Departments of Psychiatry and Internal Medicine
Associate Director of Population Behavioral Health
University Hospitals Cleveland Medical Center
Case Western Reserve University

Objectives

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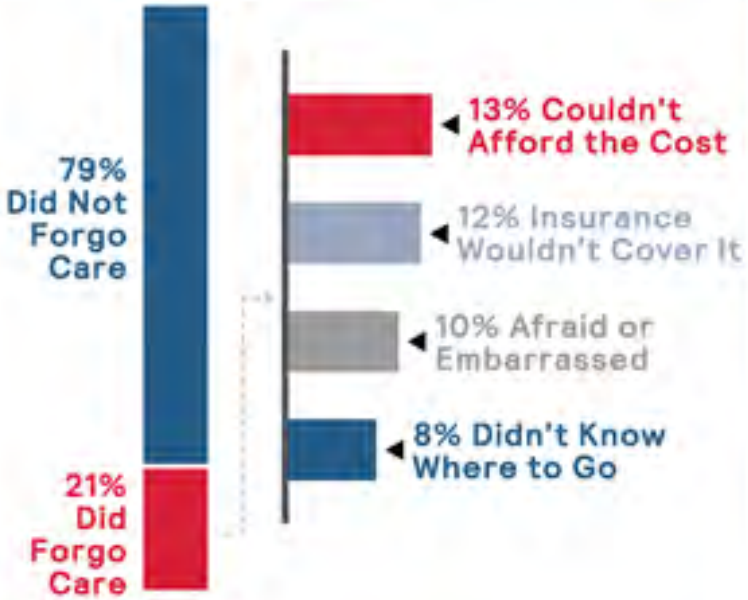
- Understand the magnitude of unmet mental health needs and its impact on physical health burden, especially cardiometabolic health
- Understand the rationale, evidence, and outcomes for integrated care to address unmet mental and physical health needs, especially cardiometabolic health
- Gain familiarity with the practical, stepwise application of integrated care into existing Ohio practices serving disadvantaged populations

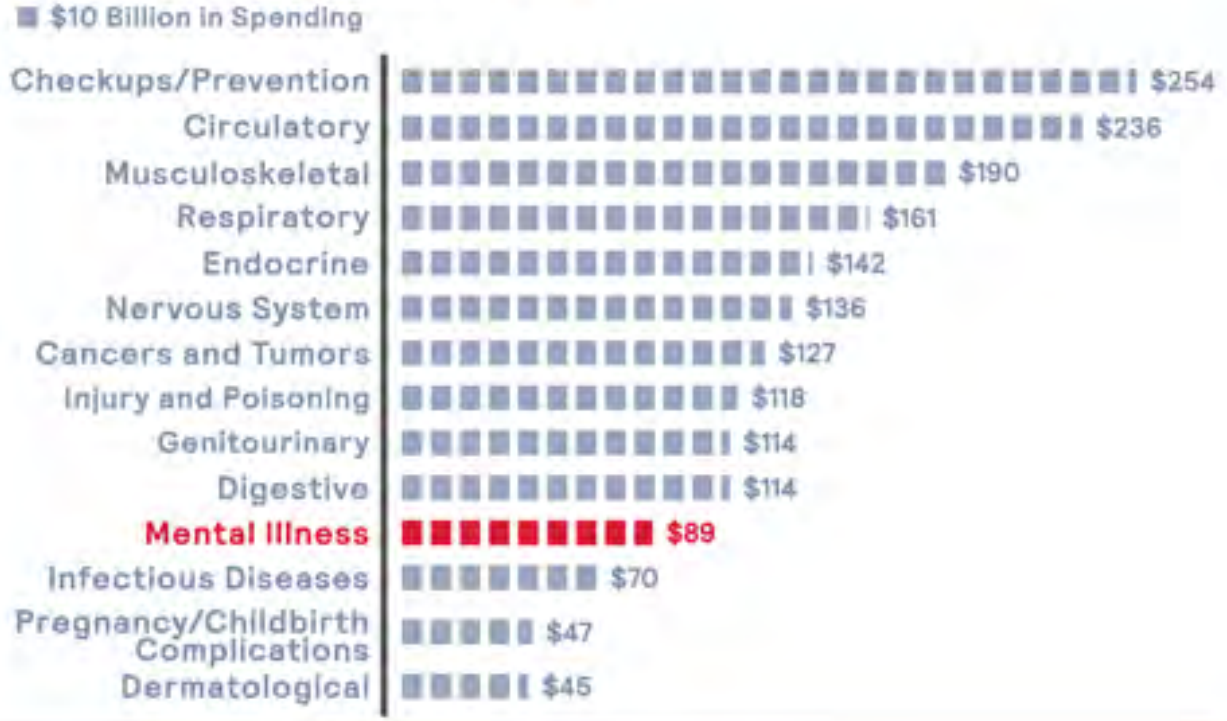
Mental Health and Substance Use Disorders Were the Leading Cause of Disease Burden in the US in 2015

Disability adjusted life years (DALYs) rate per 100,000 population

1 in 5 Reported That They or a Family Member Had to Forgo Needed Mental Health Services in 2016



Mental Illness Treatment Accounted for $89 Billion (5%) of Total Medical Services Spending in the US in 2013



Kamal R, Cox C, Rousseau D, for the Kaiser Family Foundation. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. JAMA. 2017;318(5):415. doi:10.1001/jama.2017.8558.

Neglected Mental Health is Expensive

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- The average delay between onset of mental illness symptoms and treatment is **11 years**
- People with depression have a **40% higher risk** of developing cardiovascular and metabolic diseases
- Mental illness and substance use disorders are involved in **1 out of every 8 emergency department visits** by a US adult
- Across the US economy, serious mental illness causes **$193.2 billion in lost earnings** each year
- 2014 APA Milliman Report: Patients with MH/SUD cost 2-3 times more due to increased medical ED and inpatient encounters

Mental Health By The Numbers. (2019, October 20). Retrieved from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers.

Mental and Physical Health are Associated

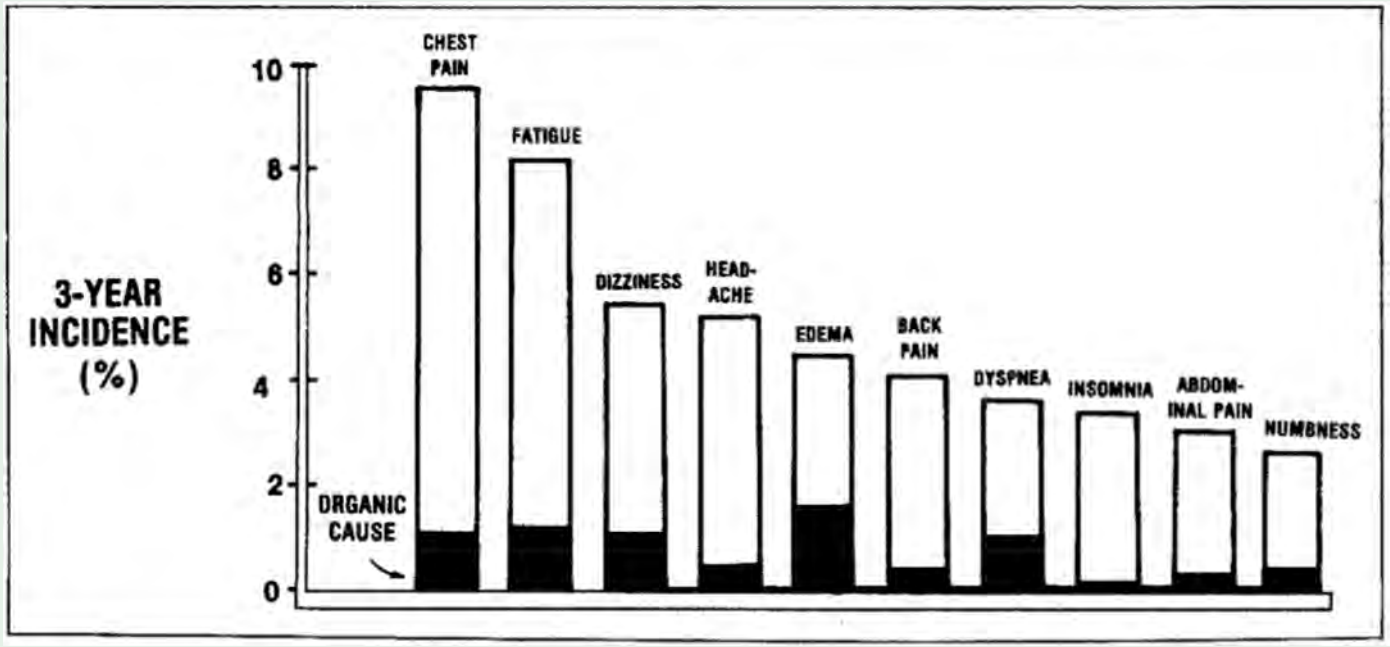


Table 3. Number of Physical Symptoms and Association With Psychiatric Disorders

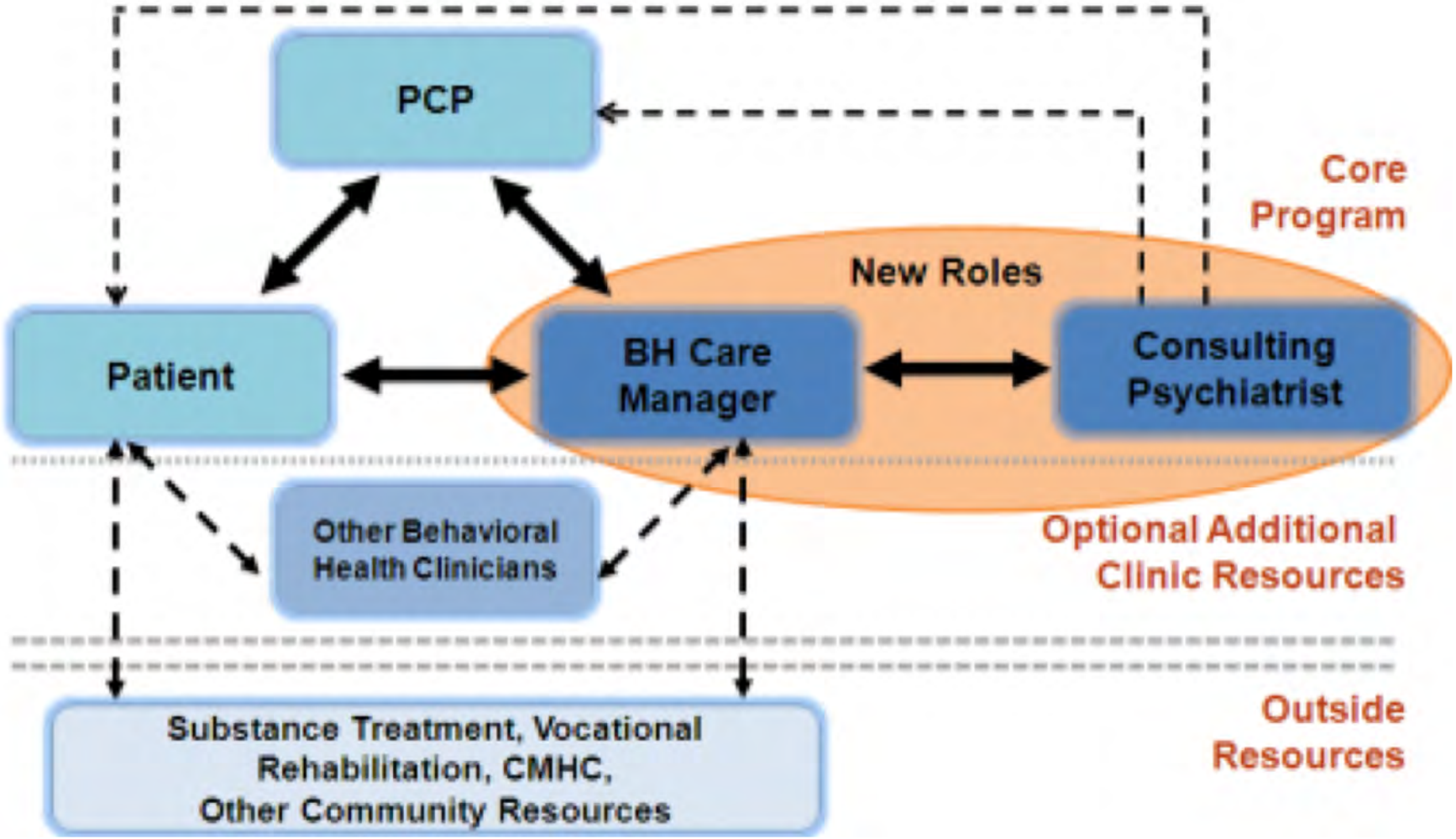
No. of Symptoms	No. of Patients	No. (%) With Psychiatric Disorder		
		Anxiety	Mood	Any
Physical (n=1000)				
0-1	215	2 (1)	5 (2)	16 (7)
2-3	225	17 (7)	27 (12)	50 (22)
4-5	191	25 (13)	44 (23)	67 (35)
6-8	230	68 (30)	100 (44)	140 (61)
≥9	139	66 (48)	84 (60)	113 (81)
Somatoform (n=933)				
0	654	68 (10)	107 (16)	162 (25)
1-2	143	42 (29)	60 (42)	74 (52)
3-5	87	35 (40)	40 (46)	77 (89)
≥6	49	27 (55)	34 (69)	46 (94)

Kroenke K, Spitzer RL, Williams JBW, et al. Physical Symptoms in Primary Care: Predictors of Psychiatric Disorders and Functional Impairment. Arch Fam Med. 1994;3(9):774-779.
Kroenke K, Mangelsdorff AD. Common symptoms in ambulatory care: Incidence, evaluation, therapy, and outcome. Am J Med. 1989;86(3 C):262-266.

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 System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

https://www.thenationalcouncil.org/integrated-health-coe/resources/

Collaborative Care



Retrieved from https://aims.uw.edu.

Collaborative Care: Outcomes

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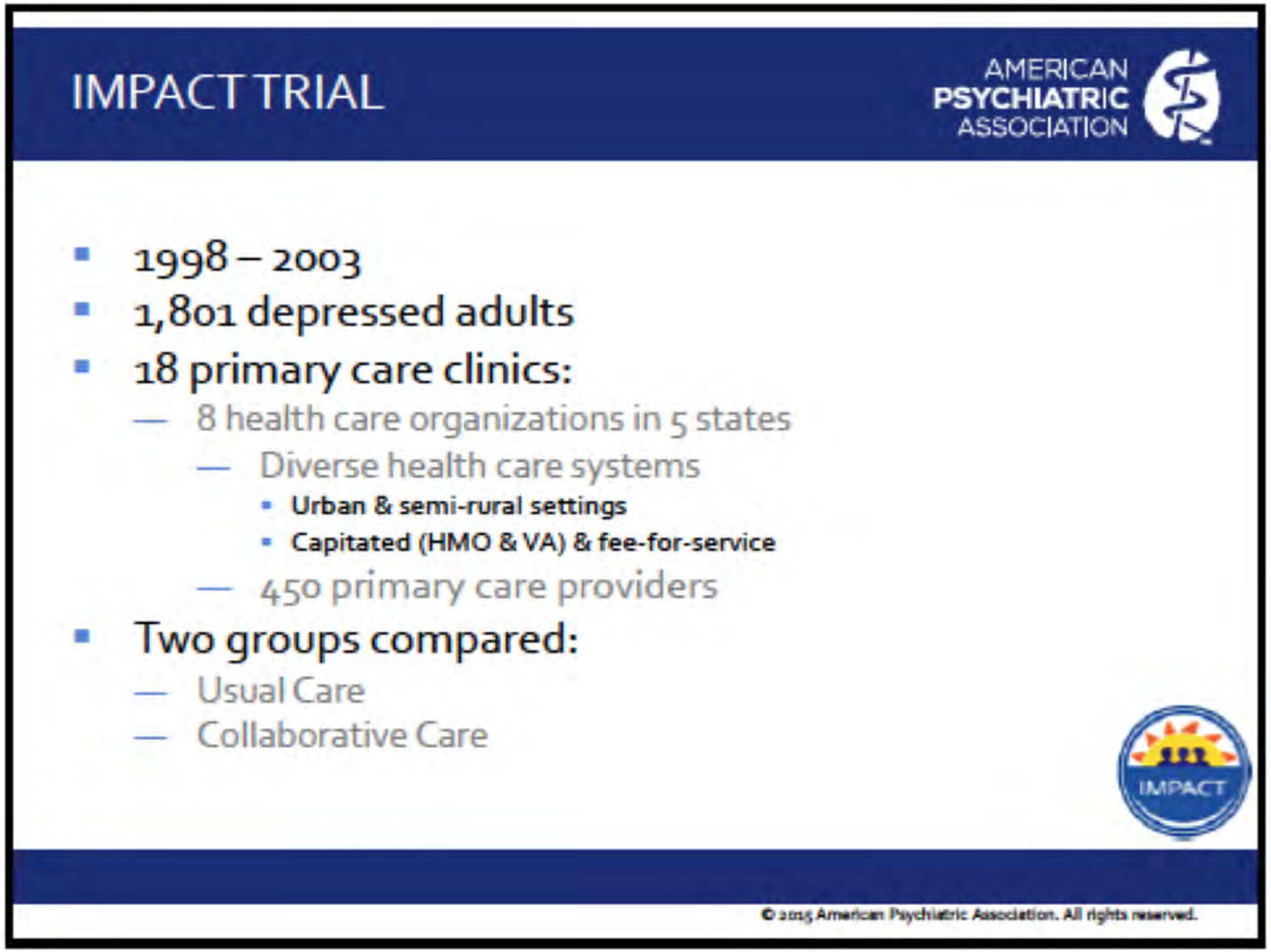
- Over 80 Randomized Controlled Trials demonstrating effectiveness of Collaborative Care Model (CCM) over Care as Usual
- Meta-analysis (2006) and Cochrane Review (2012) also strongly in favor of CCM over Care as Usual
- Benefits for wide range of Behavioral Health, Physical Health Outcomes/Diseases
  - Depression, Anxiety, Substance Use Disorders, Post Traumatic Stress Disorder
  - Hypertension, Diabetes, Smoking
- TEAMCare: tracked A1C, systolic blood pressure, LDL cholesterol; saved $600-$1.1k/patient

Gilbody S, Bower P, Fletcher J, et al. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med. 2006;166(21):2314-21.
Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525.
Katon W, Lin EHB, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. N Engl J Med. 2010;27:2611-2620.
Katon W, Russo J, Lin EHB, et al. Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial. Arch Gen Psychiatry. 2012;69(5):506–514.

IMPACT Trial



Unutzer, J., Katon, W., Callahan, C. M., at al. (2002). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA, 288(22), 2836-2845.

IMPACT Trial Outcomes

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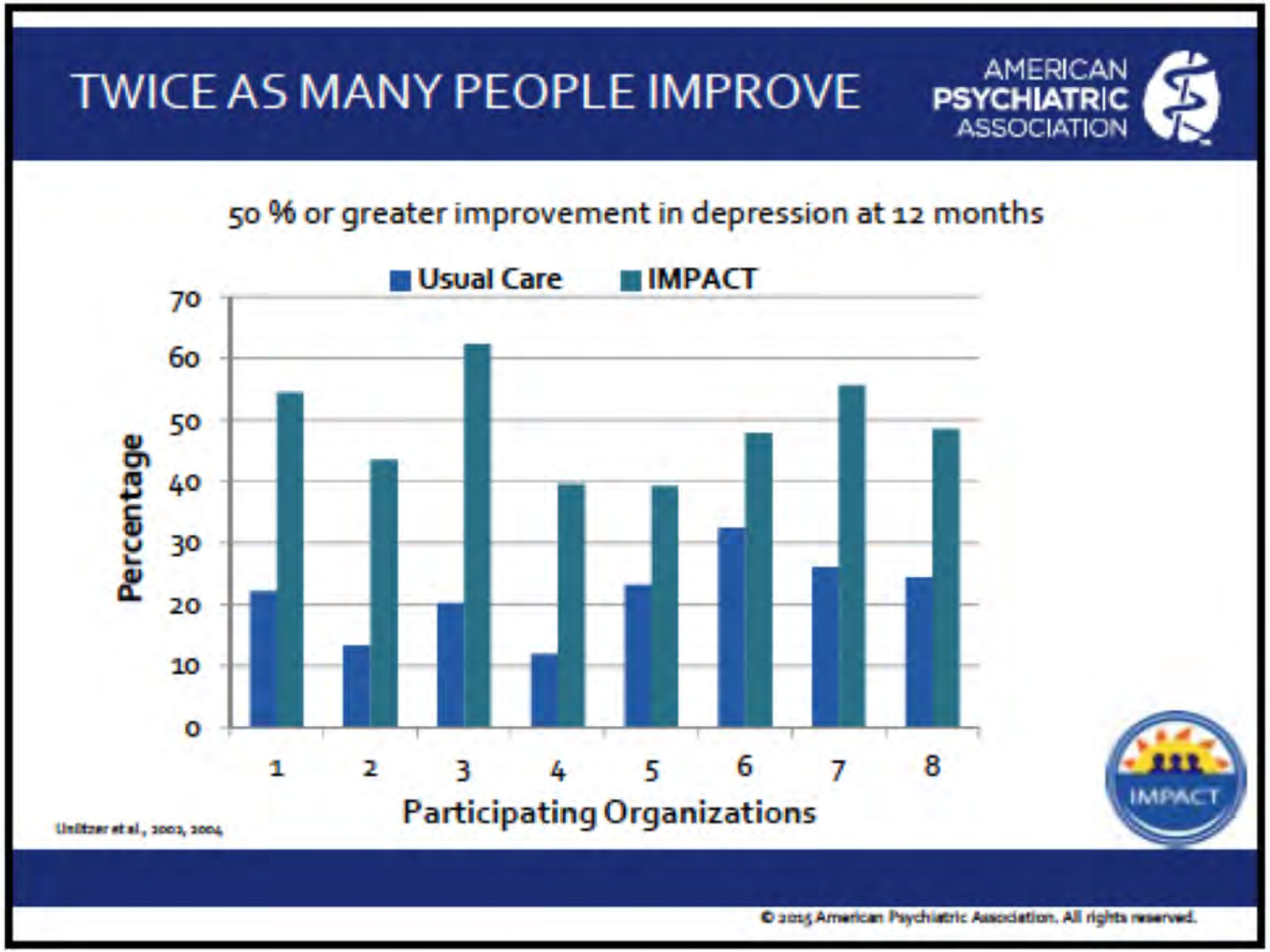

Collaborative Care: Framework

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Principles

- Population-Based Care
- Measurement-Based Treatment to Target
- Accountable Care
- Patient-Centered Collaboration
- Evidence-Based Care

Key Elements

- Universal Screening
- Registry
- Minimize Specialty Referrals
  - PCP Remains Primary
- Education
- Shared Documentation/Communication
- Case Management

Collaborative Care: Practicalities

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- Common consult questions:
  - Clarifying diagnosis
  - Addressing treatment resistance
  - Recommendations for difficult patients
- Screening: United States Preventive Services Task Force recommends depression screening only when there are accessible resources
- Duration:
  - Active treatment until PHQ<10 or 50% decrease in symptoms, usually first 3-6 months.
  - After that, move to “monitoring” or “relapse prevention,” patient is seen less frequently.
  - Total amount of time engaged is usually 6-10 months.
  - Patient will usually need at least one medication change.

Collaborative Care: Billing

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- Based on time
- Behavioral Healthcare Management (BHM) keeps track
  - Time with patient (phone, in person)
  - Time discussing patient with Primary Care Provider (PCP)
  - Time discussing patient with psychiatrist
  - Time discussing patient with anyone else relevant (family, pharmacy, agency)
- Billing goes through the PCP practice

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Clinic Site #1: University of Cincinnati

Hilja Ruegg, MD
Director of Integrated Mental Health Services
Departments of Family Medicine and Psychiatry

Other Team Members:
Corey Keeton, MD
Lauren Wang, MD

Mental Health Integration at the University of Cincinnati

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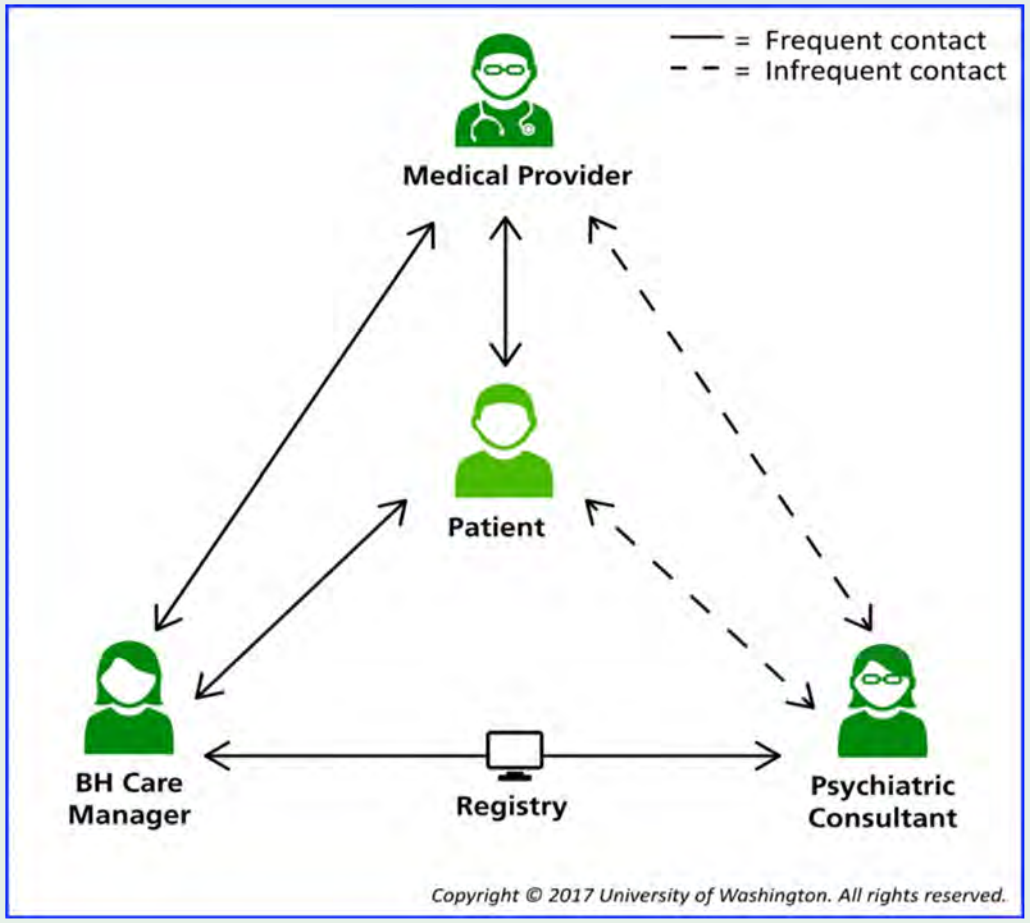

1. Patient Centered
2. Population Based
3. Measurement Based
4. Evidence Based
5. Accountable Care

Collaborative Care Site Process

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- Primary Care Network – addressing patients with hypertension (HTN), diabetes (DM) and comorbid depression and anxiety
  - Patients are screened regularly with PHQ9 and GAD7
  - Clinicians refer patients with positive screen to the Behavioral Care Manager who then assesses patient and drafts treatment plan, starts providing brief psychotherapy services and reviews with consulting psychiatrist
  - Psychiatrist reviews panel of patients and makes treatment recommendations to the PCP, usual through an Electronic Medical Record (EMR) note
  - Patients achieving remission are returned to PCP for maintenance care
- Subspecialty adaptations; HIV, intellectual disability/developmental disability, growing into oncology and perinatal populations
  - Teams of consulting psychiatrists and behavioral health specialists

Patient Case

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- 67 year-old female with Type 2 DM, HTN and recurrent major depressive disorder (MDD)
- Baseline: A1C 13.3%, PHQ9: 11, GAD7: 10
- Engagement: Problem solving therapy focused on barriers to DM control, cognitive behavioral therapy (CBT) skills, motivational interviewing around behavior change, goal setting around diet changes, managing family stressors, monitoring use of medications
- At 3 Months: A1C 7.4%, PHQ9: 4, GAD7:0
- Behavioral Health relationship facilitated communication with PCP when patients became will with an acute gastrointestinal illness that patient had not reported to PCP; patient then called patient and patient required ED care

Challenges and Opportunities

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- Getting buy-in from the institution
  - Identifying that this model of care does not make money but saves money for the system (there typically is an upfront cost to the institution or department)
  - Important to solidify institutional support for appropriate staffing (care mangers) early
- Payment models for sustainability
  - Collaborative Care Management (CoCM) codes can be billed by primary care provider to support time of behavioral consultant and care manager
  - As of September 2020 Ohio Medicaid was not reimbursing CoCM codes
  - Medicare is currently reimbursing CoCM codes
  - Billing CoCM codes may be limited if clinics/providers are getting other state or federal funding
- Subspecialty populations
  - Model can be adapted to specialty populations to monitor symptoms other than depression
  - Ensure there is a screening tool validated for a specific population to monitor symptoms

Resource

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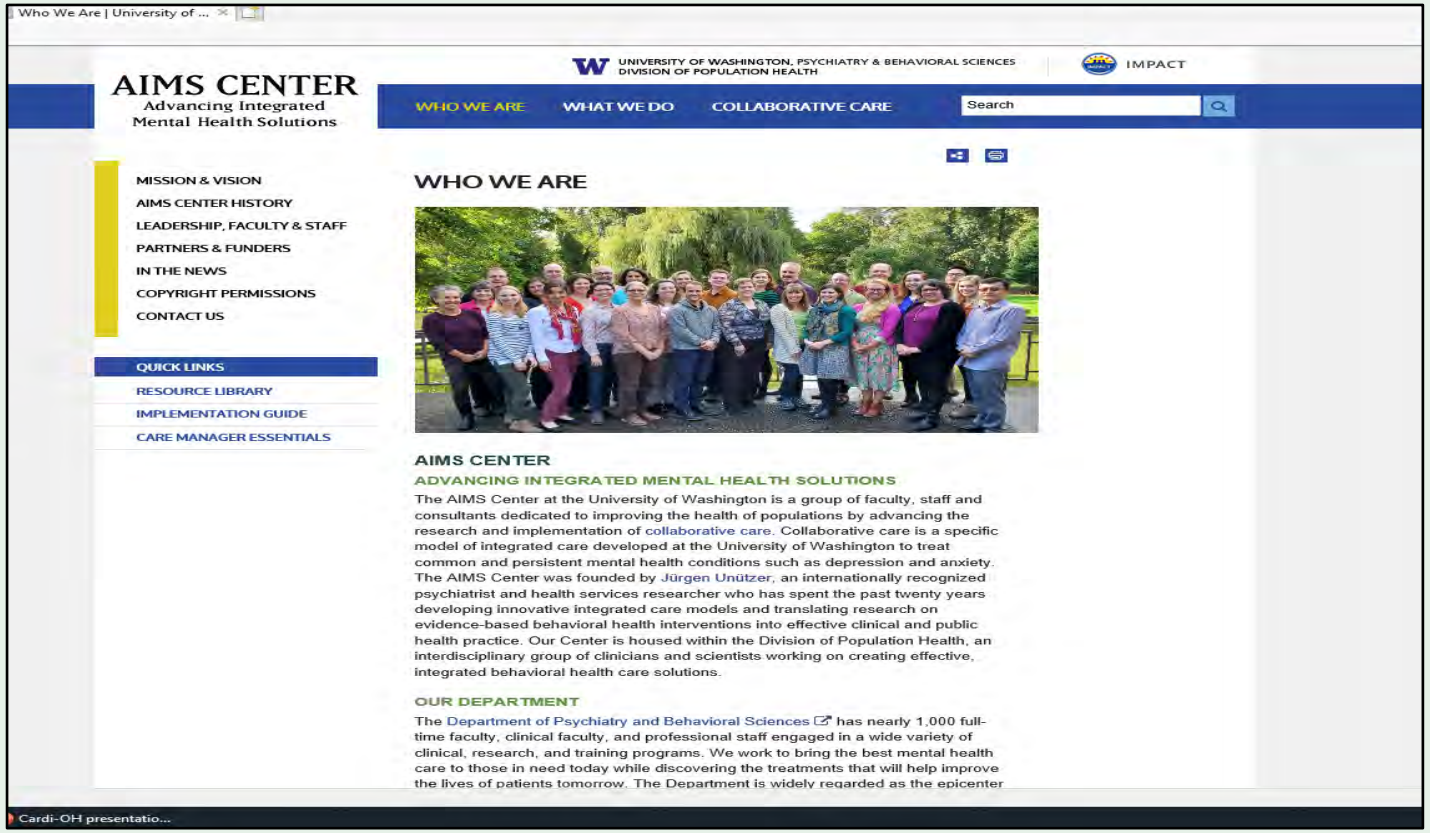
http://aims.uw.edu/



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Clinic Site #2: The Ohio State University

Laurie Greco, PhD
Vice Chair for Behavioral Health and Assistant Professor - Clinical
Director of Psychology Fellowship Training Program
Department of Family and Community Medicine

Mark Rastetter, MD
Vice Chair for Community Health and Assistant Professor - Clinical
Associate Program Director of the Family Medicine Residency
Department of Family and Community Medicine

Behavioral Health Services

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- **Outpatient Behavioral Health Clinic**
- **Primary Care Behavioral Health (PCBH)**
- **Interdisciplinary Specialty Care Clinics**

Integrated Behavioral Health Services

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Primary Care Behavioral Health (PCBH) Model of Integrated Care

PCBH: Key Components

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Team-based primary care

Fully integrated, brief visits, evidence-based interventions

Improve efficiency and effectiveness of PC visits

PCBH Implementation

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- Psychology trainees embedded in primary care clinic
  - Part of primary care team
  - Curbside consultation, team education
  - Warm handoffs, same-day visits
  - Joint visits and tag-team visits
  - Care coordination, resource connection, referrals

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Clinical Pathways to Improve Access and Augment Care

Clinical Pathways Programs

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- Education and Self-Management Groups
  - Chronic Pain (2017-Present)
  - Diabetes (2019-2020)
  - Insomnia (2018-2019)
  - Health and Wellness (2017-2018)

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Interdisciplinary Specialty Care Clinics
Refugee Health and Pain Team Clinics

Refugee Health Clinic
(Behavioral Health Integration 2017-present)

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- Interdisciplinary team approach
- Behavioral Health Role:
  - Education (US healthcare system, healthy literacy)
  - Integrated BH assessment and intervention
  - Office-based visits as needed
  - N648 Evaluations
  - Community partnerships

Primary Care Pain Team Clinic
(Sept 2020 – Present)

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- Interdisciplinary team-based care, coordinated bio-psycho-social services

- Behavioral Health Role:
  - Pain psychology evaluations (part of larger team evaluation)
  - Education and evidence-based psychotherapy (ACT)
  - Self-management and lifestyle modification skills
  - Interdisciplinary pain programs

“Pema”

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- 65 year-old Nepali-speaking woman from Bhutan
  - Established care in 2017
  - 20+ years refugee camp, 5 years in US with husband, son, daughter-in-law, grandchildren
  - Non-English speaking, no formal education, does not drive, dependent on family, last worked 30+ years ago on farm in Bhutan

Biopsychosocial Assessment

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- Type 2 diabetes, hypertension, chronic pain
  - Chewing tobacco, low health literacy-adherence, high carb diet, sedentary
- Depression, anxiety, trauma history (RHS15, GDS, GAD)
  - Social isolation, no longer cooking, gardening or doing household chores, reliance on family
- Values Assessment: What matters? What brings you joy?
  - Children, grandchildren, cooking, gardening, taking care of family

PCBH Integrated Visits

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- **Involve family in care**
- Medication education, tobacco cessation
- Mindfulness and behavioral activation
- Chronic pain education and self-management
- Diabetes education and self-management

Re-Assessment

10 Integrated Visits + 2 BH Office Visits

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- Improvements: adherence, activities, mood
- Replaced tobacco with yak cheese (!)
- Living into values
  - Yoga with husband, family walks
  - Meditation-prayer group, gardening
  - Meal planning, cooking
  - Diet/nutrition: leafy greens, decrease carbs (rice, roti)

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Behavioral Health Integration Challenges

Challenges

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- Buy-in from leadership and other stakeholders
- Years of no identified BH leadership
- Workforce development – clinic leaders, PCPs, BH clinicians, other care team members, staff
- Staffing resources, space, billing/RVUs (improved with revised HBAI codes)

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Clinic Site #3: NEOMED

Alicia Bond, MD

Health Director, Student-Run Free Clinic

Department of Family and Community Medicine

Other team members:

John Boltri, MD (Medical Director)

Janet Raber, RN (Clinical Nurse Manager)

Ashley Loucek (Behavioral Health Coordinator)

Clinic Background

- Primarily student run free clinic
- All encompassing primary care clinic
- Medical student involvement:
  - Upper-levels serve as clinic managers
  - Clinic every Saturday with all levels of medical and pharmacy students

Integration of Behavioral Health

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- January 2020 behavioral health coordinator (BHC) joins team
- Students perform PHQ-2 on all patients
- If positive PHQ-2, PHQ-9 is performed
- PHQ-9 of 15+ automatic consultation with BHC
- BHC also included in visit per attending discretion

Adoption and Implementation of Behavioral Health…COVID-19

- March 2020 transitioned to virtual visits only AND electronic health record (EHR)
- One main zoom call on Saturday
- Individual break out rooms for different patients
- BHC placed into breakout rooms as deemed necessary
- August 2020 hybrid clinical model implementation


EXIT

Obstacles

- EHR implementation
- Behavioral health screenings not done and BHC not included in visit
- Virtual environment itself
- Junior medical students lack comfort and familiarity

Addressing Obstacles

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- April 2020 development of behavioral health training modules
- BHC began in-depth chart review
- Continued formalization and encouragement provided to students

Compelling Patient Case

- Adolescent patient with mom reporting self-injurious behavior
- BHC, attending and student were able to speak prior to calling the patient and develop plan
- Outcome – contract for safety, resources provided and referral made

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Question and Answer

Aleece Caron, PhD

Case Western Reserve University

Speakers

REMINDER: Submit questions using the 'Q&A' feature and specify which speaker should answer

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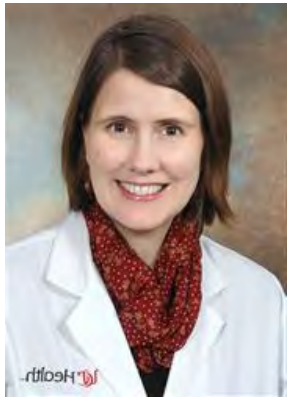
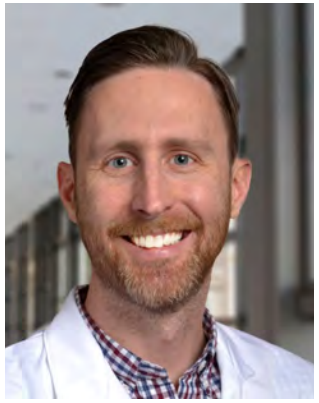
Donald Wharton, MD
Ohio Department of Medicaid

Trygve Dolber, MD
Case Western Reserve University



Hilja Ruegg, MD
University of Cincinnati



Mark Rastetter, MD
The Ohio State University

Laurie Greco, PhD

Alicia Bond, MD
Northeast Ohio Medical University

Aleece Caron, PhD
Case Western Reserve University

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Next Steps and Wrap Up

Shari Bolen, MD, MPH

Case Western Reserve University

We Want to Hear from You!

Please complete a brief evaluation of the webinar:

https://redcap.case.edu/surveys/?s=9FWAERPXPC

Note: Survey link will also be emailed to webinar attendees

THANK YOU!

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Learn More!

To learn more about the collaborative and read up on the latest best practices, visit cardi-oh.org and follow us on Twitter @cardi_OH and Facebook @cardiohio.

The Ohio Cardiovascular and Diabetes Health Collaborative is funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. The views expressed in this presentation are solely those of the authors and do not represent the views of the state of Ohio or federal Medicaid programs.