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Session #B1

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Track 2. Clinical Skills and Innovations in Team-Based Care

It Takes a Village to Battle Opiate Addiction: Medication-Assisted Treatment (MAT) for Opioid Addiction through a Team-based Patient Centered Approach

Aimee Valeras, PhD, LICSW, Faculty, NH Dartmouth Family Medicine Residency

Dominic Geffken, MD MPH Faculty, NH Dartmouth Family Medicine Residency

Karen Decker-Gendron, RN Clinical Nurse Leader, Concord Hospital Family Health Center

Jeannine Ouelette, LICSW, Integrated Behavioral Health Clinician, Concord Hospital Family Health Center

Medication-assisted treatment (MAT) for opioid addiction/dependence using buprenorphine is well suited to the primary care practice (Donaher and Welsh, 2006). The premise of MAT is to utilize behavioral and pharmacological therapy in combination to address the cognitive and physical aspects of addiction (Mattick, Breen, Kimber & Davoli, 2014; SAMHSA). This presentation, co-authored by a physician, nurse, behavioral health clinician and the patient, will provide a case example in providing integrated care to a patient receiving buprenorphine to illustrate the key tenets including: a) communication; b) coordination; c) accountability; d) flexibility; e) advocacy.

At the conclusion of this presentation, participants will be able to:

- Emphasize integrated care as the essential ingredient to successful buprenorphine-aided recovery
- Describe how a residency-based community health center initiated a buprenorphine treatment program
- Illustrate, through a case example, the key elements to approaching a patient population utilizing buprenorphine treatment

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Track 2. Clinical Skills and Innovations in Team-Based Care

A Promising Approach: Integrated Health Care with Foster Care Children

Children in foster care have much higher rates of emotional and behavioral problems, physical health concerns, and developmental delays than children from similar socioeconomic circumstances. The evidence base for pediatric IHC programs is limited; there are no studies of children in State custody (foster children) served by an integrated care model or program. In 2012, Harris County Protective Services (HCPS) launched an integrated behavioral health program for children in State custody with an external evaluation of the program. This presentation will highlight the components of the HCPS IHC program, implementation, program evaluation outcomes and recommendations for future replication and implementation of this promising approach.

At the conclusion of this presentation, participants will be able to:

- Identify three aspects of how the care delivery system is structured in foster care settings.
- Describe three characteristics of the HCPS IHC program for children in State custody that differ from usual.
- List three recommendations for future design and implementation of practice, program and policy considerations of IHC with foster care children.

Rick Ybarra, MA, Program Officer, Hogg Foundation for Mental Health

Alejandra Posada, MEd, Director of Education and Training, Mental Health America of Greater Houston

Toni Terling Watt, PhD, Professor, Sociology Department, Texas State University (project evaluator)

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Track 4. Financial Sustainability and Cost Control

Making a Behavioral Health Program Financially Sustainable: A Look at Costs and Revenue Generation at a Fully Integrated Federally Qualified Health Center

The benefits of integrated primary care are well delineated in the literature, but how do we pay for a behavioral health team once the grant money runs out? In this presentation, the CEO, Behavioral Health Director, a PMHNP, and a Licensed Psychologist from a Federally Qualified Health Center will offer their perspectives on how they have built and maintained a financially sustainable large-scale behavioral health team in a mental health professional shortage area.

At the conclusion of this presentation, participants will be able to:

- Identify strategies for overcoming financial barriers to implementing integrated primary care.
- Discuss ways that an organization can maintain a financially sustainable model of integrated care.
- Define the "hybrid" model of integrated primary care.

Alysia Hoover-Thompson, PsyD, Staff Psychologist, Stone Mountain Health Services

Malcolm Perdue, Chief Executive Officer, Stone Mountain Health Services

James L Werth, Jr, PhD, ABPP, Behavioral Health and Wellness Services Director, Stone Mountain Health Services

Emily C Stacy, PMHNP-BC, Stone Mountain Health Services

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Track 3. Population and Public Health

Champion Teams as a Mechanism for Developing Team Care Capacity

"Practice transformation" toward team care as a singular undertaking can be daunting. In this presentation, we describe the development of a mechanism for small, iterative and sustainable practice changes toward team care known as "Champion Teams." Champion Teams are based on the Institute of Medicine's "learning health care system" approach in which practitioners develop an internal mechanism for and culture around digesting and implementing new evidence based practices on an ongoing basis. In addition to presenting the Champion Team concept as a strategy for implementing new team care initiatives, interprofessional providers will present two case examples from each adult and pediatric primary care.

At the conclusion of this presentation, participants will be able to:

- Define the term "learning healthcare system" and its application to Champion Teams.
- Describe the utility of and keys to implementing Champion Teams.
- Describe two examples of Champion Teams and the application of this mechanism to making data-informed changes toward team-based care in their own setting.

Jodi Polaha, PhD; Associate Professor, Department of Family Medicine, Quillen College of Medicine, East Tennessee State University

Reid Blackwelder, MD; Professor, Department of Family Medicine, Quillen College of Medicine, East Tennessee State University

Tom Bishop, PhD Assistant Professor, Department of Family Medicine, Quillen College of Medicine, East Tennessee State University

Leigh Johnson, MD; Assistant Professor, Department of Family Medicine, Quillen College of Medicine, East Tennessee State University

Diana Heiman, MD; Associate Professor, Residency Program Director, Department of Family Medicine, Quillen College of Medicine, East Tennessee State University

Gayatri Jaishankar, MD; Associate Professor, Department of Pediatrics, Quillen College of Medicine, East Tennessee State University

Deborah Thibeault, MSW; Assistant Professor, Departments of Pediatrics and Social Work, East Tennessee State University

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Track 3. Population and Public Health

The Integration Metrics Project

Rodger Kessler, PhD, ABPP, Associate Professor, University of Vermont College of Medicine

Parinda Khatri, PhD, Clinical Director, Cherokee Health Systems

This presentation will report on the work of a national expert panel convened to refine, test and implement a set of clinical, operational and financial metrics evaluating integration effectiveness. One set of measures will be drawn from the administration of the Kansas Integration Profile, an assessment of level of practice integration. We will request participants to serve as a focus group, discussing and critiquing all aspects of the work. the feedback will be used for further refinement of the effort. This panel includes experts from psychiatry, family medicine, psychology, integration clinical and administrative practice, national certification organizations and health economics, and will raise important questions about the relation of integration efforts to the larger challenges of health care reform.

At the conclusion of this presentation, participants will be able to:

- State the 3 core justifications for integration methods development
- Critique the method of methods development and implementation
- Offer at least two suggested improvements to the proposed metrics and implementation

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Track 2. Clinical Skills and Innovations in Team-Based Care

"Integrated Care Clinic": Full Integration of Behavioral Health in a Family Medicine Residency Clinic

The process of developing a behavioral health "Integrated Care Clinic" (ICC) across several domains of the clinic will be presented, including: (1) clinic management buy-in and logistical issues (e.g., transitioning to 30 min. appointments); (2) medical provider buy-in and involvement (e.g., team and group visits); and (3) partnering with clinical staff (e.g., nursing and front desk). ICC components to be presented include: paired visits with MDs, behavioral health and pharmacy, conducting point-of-care interventions, team visits to decrease hospital readmission, co-facilitating group prenatal visits and delivering obesity-prevention messages during well-child visits. Feasibility, process data and initial outcome data regarding the transformation will be presented. A behavioral health faculty, MD faculty, and pharmacy faculty will co-present this session.

At the conclusion of this presentation, participants will be able to:

- Describe how the ICC was strategically planned and carried out in a family medicine residency program from the perspective of a behavioral health faculty, family medicine faculty, and pharmacy faculty.
- Describe the specific components of the Integrated Care Clinic, how components were measured and initial feasibility results and financial data related to the utilization of the ICC.
- Discuss how integration of behavioral health is occurring at their respective clinics, lessons learned from the process, and next steps in their respective transformations.

Jerica Berge, PhD, MPH, LMFT, Behavioral Health Faculty, University of Minnesota Department of Family Medicine and Community Health

Alexander Hubbell, MD, Medical Resident, University of Minnesota Department of Family Medicine and Community Health

Stephanie Trudeau-Hern, MS, Behavioral Health Intern, University of Minnesota Department of Family Medicine and Community Health

Lisa Trump, MS, Behavioral Health Intern, University of Minnesota Department of Family Medicine and Community Health

Jean Moon, PharmD, Pharmacy Faculty, University of Minnesota Department of Family Medicine and Community Health

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Track 1. Focus on a Patient and Family-Centered Approach to Care

Characteristics of Latinos Seen In A PCBH Model And Differences In Utilization and Outcomes From Other Racial/Ethnic Groups.

Analyze and describe PHQ-9 and ACE scores reported by Latinos versus other racial/ethnic groups from 2015 data at a Midwestern Community Health Center. Analyze and describe utilization data (behavioral health encounters) for this subset of patients. Describe the type of issues that this subset presents with in contrast to other racial/ethnic groups.

At the conclusion of this presentation, participants will be able to:

- Identify diagnosis data trend differences between Latino families and other ethnic families in the primary care setting.
- Describe differences in PHQ-9 and ACE scores by racial/ethnic categories and utilization pattern differences by racial/ethnic categories.
- Describe the impact of familism on patient response to and engagement with the PCBH model and healthcare in general.

Martha Saucedo, LCSW, Latino Engagement Lead, Access Community Health Centers

Neftali Serrano, PsyD, Director of Clinical Training, The Center of Excellence for Integrated Care

Catie Beck, LCSW, Behavioral Health Consultant, Access Community Health Centers

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Track 6. Training in Research and Evaluation

Let's Talk! Identifying Ways to Improve the Quality and Generalizability of Program Evaluation or Quality Improvement Data (Part 2)

It can be challenging to design program evaluation or quality improvement efforts that can provide generalizable knowledge to the integrated healthcare field. An overview of ways to improve these projects quality and generalizability will include examples of how changes to the designs and methods of actual projects could have strengthened results to inform the field. Presenters will then lead small groups to discuss their own current or upcoming program evaluation or quality improvement efforts.

At the conclusion of this presentation, participants will be able to:

- Describe how to determine the quality and rigor of a quality improvement/program evaluation project
- Identify general strategies for improving the quality and generalizability of quality improvement/program evaluation efforts
- Describe how you can improve the quality and/or generalizability of a project that you are planning or currently implementing

Jennifer S Funderburk Clinical Research Psychologist VA Center for Integrated Healthcare

Christina Studts, PhD Assistant Professor University of Kentucky College of Public Health

William Lusenhop, PhD Assistant Professor University of New Hampshire

Mary Peterson, PhD Department Chairperson George Fox University

Jennifer Wray, PhD Postdoctoral Fellow VA Center for Integrated Healthcare