How to Financially Sustain Behavioral Health Integration in Your Practice

Featured topic and speakers

Experts share real-world experience implementing behavioral health integration (BHI) into their practices to enhance patient access to quality and whole-person care. The panelists examine how physician practices and health systems can financially sustain these models and offer some actionable strategies. This webinar is part of the BHI Collaborative's Overcoming Obstacles webinar series.

Moderator

- **Anna Ratzliff, MD, PhD,** co-director, University of Washington AIMS Center; director, UW Integrated Care Training Program

Panelists

- **Nelson Branco, MD, FAAP,** primary care physician, Tamalpais Pediatrics; assistant clinical professor of pediatrics, University of California San Francisco
- **William Beecroft, MD, DLFAPA,** medical director, behavioral health, Blue Cross and Blue Shield of Michigan
- **Julie Geiler, MA,** technical assistance associate and policy coordinator, Collaborative Family Healthcare Association
- **Sandra Bond Chapman, PhD,** chief director, Center for BrainHealth, University of Texas at Dallas; Dee Wyly Distinguished University Professor, School of Behavioral and Brain Sciences

Host

- Samantha Lewin-Smith, program manager, professional satisfaction and practice sustainability, AMA

Webinar resource: FAQs

- Frequently asked questions: How to financially sustain behavioral health integration in your practice (PDF)

Transcript

Lewin-Smith: Hello, everyone. Before we get started today, just a few quick housekeeping items to go over. Please note this discussion is for informational purposes only, and you should consult a professional advisor for specific medical, legal, financial or other advice. You can also find relevant resources to today's discussion in the related content box on your screen.

Lastly, if you have any general questions or concerns, you may send them to practice.sustainability@ama-assn.org.

Welcome to today's live discussion, "How to Financially Sustain Behavioral Health in Your Practice," which is part of the BHI Collaborative's Overcoming Obstacle Series. Financial sustainability continues to be a pervasive concern for many health care organizations, particularly as it relates to adequate reimbursement, particularly when considering upfront startup costs such as staffing and IT infrastructure, along with complex and burdensome billing requirements.

While many practices continue to combat these obstacles, there are actions that physicians and their care teams can take today to enhance the financial sustainability of these models.

Moderating today's session, we have Dr. Anna Ratzliff, co-director of the University of Washington AIMS Center. And joining today's conversation, we have Dr. William Beecroft, medical director of behavioral health at Blue Cross Blue Shield of Michigan. Dr. Nelson Branco, physician partner at Tamalpais Pediatrics. Dr. Sandra Bond Chapman, chief director for the Center for BrainHealth and distinguished professor at the University of Texas Dallas. And Julie Geiler, technical assistance associate and policy coordinator at the Collaborative Family Healthcare Association.

This panel will explore real-world, evidence-based solutions and best practices on how health care organizations can practically make BHI financially viable for their practices and ultimately their patients. And with that, I will turn the conversation over to our moderator, Dr. Ratzliff.

Dr. Ratzliff: Alright. Hi, everyone. Welcome. We're really excited to be here today and share some of our experiences and our perspectives that hopefully will help you and your practice be able to be sustainable for your integrated behavioral health efforts. So I am going to talk a little bit about just

some perspectives, and then I'm going to ask each of our panelists a question to get the conversation started. As a reminder, we welcome your questions too, and you can type them into the Q&A.

I think one of the things that as we enter into talking about financial sustainability, it's important to acknowledge that there is going to be, also, a lot of important considerations related to the workforce that's involved in your behavioral health efforts. And of course, how we balance financial sustainability with high-quality care and monitoring that quality is a really important part of long-term sustainability for your practice. So with that, I'm going to start the conversation off, and I'd like to start with a question for Julie.

Integrating behavioral health sustainably

So starting with the financial side of things, what key items should physicians be looking for when integrating behavioral health into their practice in a sustainable way? Are there key resources that physicians and their care teams should lean into to ensure reimbursement services rendered, for example, particular codes?

Geiler: Yes, thank you. So when I think about behavioral health integration, one of the first things I think about is really getting key buy-in from your systems. You need IT, you need billing, you need your providers because they provide the referrals, and then your behavioral health providers, who may not be trained in any of these models.

So looking for an evidence-based model, knowing what problem that you're trying to solve. That will help you determine which model you use, what your outcomes are, and then making sure that everyone in your system is on board, knowing what your goals and your outcomes are. Neither of these models are really psychotherapy in the sense that most of us think about therapy.

And then when you think about defining what reimbursement is, think about not only the billing codes, because each model has particular billing codes that they use, but also think about other payment streams that you have that will help support behavioral health integration.

And then when you're looking at the models, we generally talk about the collaborative care model or the primary care behavioral health model. Those are two very different models that solve very different problems. And COCM has codes that are used. Those are billed through the primary care physician. The psychiatrist and behavioral health care manager are billed incident two, whereas the primary care behavioral health model, they traditionally use psychotherapy codes, health and behavior codes, and then the general BHI codes. So really starting at the codes and working backwards is really the opposite way you need to think about it. You need to get your buy-in, determine what problem you're trying to solve, and that will lead you to the best model in the codes that you would use to bill that.

Dr. Ratzliff: Thank you. I think it's such an important consideration to be really clear on your goals, because I really appreciate you highlighting different approaches will have different potential targets or solutions that they offer, and so making sure that everyone is really on board with what are the priorities for the organization, and then really building a model and then a financial sustainment plan to support that is such an important way to get started, I think, as you think about financial sustainability. And it means, I think, then, that you're really having to think about that from the very beginning of as you're building this care, which I just want to highlight some of that perspective. So thank you so much.

How to financially evaluate success

I'm going to move next to Dr. Branco. And in your experience as a managing partner, how did your practice financially evaluate the success of your practice? Did you look beyond code reimbursement? What other factors should people be looking at with regard to return on investment?

Dr. Branco: Thank you. Thanks for the question. I just want to start by commenting on the two comments about setting the goals, which is to say that your goals may change. And that's something that we saw in our practice and our behavioral health integration started with one model and ramped up from there. And that ties into financial success because you can, you know, you don't need to do everything all at once. You can have some small success and build on that.

But the pro coordination and maybe some case management and then eventually providing you provide primary care behavioral health. I think that the challenge for many of us is when we're evaluating the financial viability, we have overhead versus revenue evaluation. And that can be very difficult. In a typical primary care practice or pediatric practice in my case, we know how much overhead we can attribute to our medical, but we don't have a good sense of incremental or too much more than we need to spend to bring in the challenge of kind of choice in the therapists. And so we can't use the same number, the same percentages. So that is a challenge. But in general, there's less overhead than what we've seen in these last few days, as many support staff.

The other thing is maximizing billing and coding and reimbursement for payments, as Julie mentioned. Making a case for value to your payers when you're negotiating your contracts, not only in the people service contracts, but in the value based contracts, there will be fewer referrals to be reduced in your visits to urgent care. Not that there's a great deal of data of how valuable behavioral health management is to help out. There will be increased productivity of your medical providers. You can only really take advantage of that if you take advantage of it. … well, care, and the benefit of care.

And so I encourage practices to take a good look. Other templates are set up, if you're not spending time talking to the … team, you have the ability to get, in many cases, better care with your behavioral health colleagues, and you can move on knowing that that patient is taken care of and do another checkup and keep a child up to date with their immunizations … And then the other side of that is I am more efficient and my longevity as a clinician was enhanced by the fact that I have resources I can offer to patients, not only a visit with my behavioral health colleagues, but books and websites and other resources that they provided to me.

So the value of integrated behavioral health is beyond the financial, but when you're looking at the financial, the bottom line is you have to look at your ability as a primary care clinician to be more efficient, to be more effective. And I will stop there. I could go on, but I think that's plenty to talk about for now.

Dr. Ratzliff: Thank you so much. I think I really appreciate some of the things that you're talking about because I think they are the things that go beyond the dollar and cents, right? What are those other values that you're really hoping to accomplish? And it also sounds like having some way to tell the story of how integrated behavioral health may be helping you accomplish those things can be really valuable.

It sounds like maybe thinking about some of those measures like can you measure in some ways productivity or some of these other dimensions of your practice and really make that value argument. I also will just speak from personal experience that I think some of the patient stories are another really complimentary way to be able to tell that story of the value. And that can be really helpful, I think, as you are advocating with your payers and other, even engaging your practice and making and strengthening that commitment to integrated behavioral health. So really appreciate those perspectives.

What do payers need to understand?

I'm going to transition to Dr. Beecroft. He is joining us by audio. And working for a payer, what do payers need to understand about the importance of supporting sustainment of behavioral health integration? Why should they partner with physicians to integrate behavioral health? And I think a lot

of the people who are practices on here sort of how do we make a compelling argument to payers about this work? So I'd love to hear your thoughts about that.

Dr. Beecroft: Contrary to popular belief, Blue Cross Blue Shield of Michigan really has a fiduciary responsibility to its members to really try to look at total health care. And we're looking at total health care dollars when it comes to being a financial institution, which is true, insurance companies are, but they're founded by physicians and physicians have a big part of that.

What was really compelling for making the argument to pay for collaborative care was the issue of, and Milliman brought this out in their 2014 and later editions as well, that about anywhere from 13, 14% of the population to, in our case, was about 26% of the population, has both behavioral health and medical needs simultaneous in the primary care setting. As a internist in the past, you know, I know about 30% of my patients were, the primary reason that they came to the office was a behavioral health condition. And you see that in primary care quite a bit. So when you start looking at that total medical spend, it's about double that. So that's where the two to one ratio that you see that's brought up over and over and over again with collaborative care, it really does exist.

We just started a preliminary analysis of our four years experience in this, and we're starting to see that signal actually coming through that we're starting to see a separation of the people that are in collaborative care, actually having a lower total medical spend than the people that aren't in collaborative care with age match and disease match criteria.

We'll get into more of that, you know, as we get deeper into this and get into all those details, but that I think was really the key point to be able to make the decision of helping them to recognize the people, if you don't address the behavioral health needs of individuals with diabetes, with heart disease, with COPD, you're never going to get those medical illnesses under control. And very frankly, that's 95% of the of the spend. Behavioral health conditions only are about 5, 10% of the spend when you look at it on overall spend. So it's like the tail wagging the dog here, if you don't take care of the behavioral health, you're not going to get the ER visits down, the ICU visits down, the hospitalizations, the disability, all of those kinds of things.

So that's the financial argument. And the fiduciary argument is you're really doing good things for your members. There's other things that play into that. We have in our system, a lot of our first adopters were practices that were capitated. And we have a very strong risk value-based reimbursement program in our primary care and surgical space. So they're responsible for that overall medical spend. And they recognize very quickly that this is the way to be able to actually get more money in their pocket, to be able to take care of a … defined population. And that has also been extremely helpful to be able to get us kind of moving in sync with our providers to be able to move forward with that.

Kind of addresses the issue also looking at your funding streams. It's not just the fees that you get from collaborative care. But it's the other fees that you may get in any kind of value-based

reimbursement for HEDIS measures. Or for plans, it turns into stars ratings, which are a Medicare specific, but also play a factor in your commercial products, which you actually get money from the government for being a better quality provider. So having a higher stars rating is going to be able to get you indirect funding for that. But the way you do that is by improving your A1C, your FEV1s, you know, all of those kinds of things really help to be able to get you more dollars in the bucket.

So in this way, it really does add value not only to the primary care doctor in the trenches doing the work, but for the plans themselves to be able to see that health care delivery. And we know that increasing outpatient services decreases your inpatient utilization, which is where the money is. So if you get that decreased to a lower level or to a normal level of utilization, that also is going to be able to help the plans recognize that this is in their best interest to do. It's in their members' best interest. It's in the primary care doctors' best interest. I'll get going on my burnout issues as well, but it decreases burnout for the practitioners and for the psychiatrist as well. So with that, I'll stop. I could go on all day about this stuff as well.

Dr. Ratzliff: I appreciate a couple of things that I want to highlight. I mean, I think one of the things I heard is, it's important to have kind of a longer view, right? That some of these things that we're imagining we're going to … that we anticipate being able to see as terms of benefits to the patients may take a little time to show up on that dollars and cents page, right?

And so I really appreciate that reminder, because I think that's something that's often a really important part of that conversation with people who you're advocating to is that, don't expect three months turnaround, right? Like, this is going to take a little bit longer to start to see some of those benefits, but they will be real, and there are good data that support that making that investment will result in those better outcomes.

So I so appreciate some of those comments. And I do think we should come back later to the piece about burnout and the importance of also providers really feeling that they can take care of patients in the way that they feel like they need to, because I do think we haven't talked about this, but turnover of providers is very expensive, right? I think we all probably appreciate that on this conference. And I think it is really important to think about how do we help people also be able to provide the care that they feel like their patients need to not experience that moral distress that can lead to burnout. So thank you for highlighting that. And maybe something we can come back to in our broader conversation. Great.

How is brain health being integrated into behavioral health care?

So I'm going to move to Dr. Chapman. While many folks may present in a physician's office with a mental or behavioral health condition, tell us how you see brain health being integrated into behavioral health care. Maybe start with how you define brain health and its relationship with mental health disorders. And what would the value add for brain health assessments and actions for patients and physicians really, how does that fit into this conversation?

Dr. Chapman: Thanks so much. You know, when I was first asked to be on this, I thought, why am I doing, why am I on this? Because I have a very different career path. For the last 30 years, I have been focused as a neuroscientist, understanding what is brain health and trying to move the conversation for us not to wait until something happens before we start treating people proactively. Unlike heart health, brain health has been largely neglected. And it's only when something goes wrong that we do it.

So in the last three decades, showing that if we find ways for people to thrive, whatever they're dealing with, then a lot can change. And I wonder if we pose the question in a different way of how can my practice bottom line increase if my patients were able to find ways to flourish? And sort of this came out of I've worked a lot with military—and looking at how we define brain health, I'm going to get back to that in a minute. But it surprised me when we began not to label them so much, but really to empower them and do self-agency, we showed not only that their brain health got better holistically, but their depression and stress got better.

And also working with patients with bipolar. No one had really ever taken the approach of looking, can you make their ability to take small steps cognitively to build their cognitive health, as well as their connectedness. And we showed the psychiatrist that we worked with said, I've never seen gains in my patient, when someone began to give them proactive steps beyond what they were dealing with.

So back to your first question, how do we define brain health? So we really use it working off of the World Health Organization that says brain health is the continual promotion of optimal brain development, cognitive health, psychological well-being—and we added connectedness to people and to purpose.

And the reason this definition is so important is it takes into account the neuroplasticity that we know exists, even when we're dealing with mental health disorders. So brain health is a higher category of health. And what we've been able to show that, really, our health is driven by that. And I think behavioral health integration specialists are really kind of primed to take this whole mantra of what can be done to help our patients flourish.

And I want to just share real quickly three breakthroughs that we'd love to partner with some of you with. One is that we have developed a holistic measure of brain health that looks not only at your mental health, your cognitive clarity, possibility thinking, but also connectedness to people and to purpose. And as those get better, when someone has a little depression, if they start to work on

maybe their possibility thinking, we see that they're able to flourish in their context.

The second big breakthrough that we've shown is that as we track people over time, and they began to really take steps, their self-agency, that can really take the total health care, they make better health choices. They are much more proactive about the things that they do, that we've shown 75% of the people, regardless of what they're dealing with, continue to improve.

And the third big breakthrough is that we're showing neural changes, neural markers of their brain getting better, whether someone's dealing with post-traumatic stress disorder, depression, to show that the brain, regardless of where you are … so what I want to say is that brain health, and it's kind of a new category of health, but working with experts like you and the behavioral health integration can see sort of this holistic perspective. And we'd love to partner with you all in different ways to show what could happen as a result of putting brain health complementary into what you're already doing as you're dealing with different issues. So when you talk about high-quality care, holistic care, and helping the patients to be part of the solutions, that's where brain health comes in.

Dr. Ratzliff: Great. Thank you so much. I mean, I think that that's such an important concept that being in primary medical settings, there is such an opportunity to move upstream and really be addressing behavioral health, brain health as part of overall health. So I appreciate you highlighting that opportunity. And as we're thinking about building this capacity, really making sure we're thinking holistically around that whole spectrum from prevention to addressing diagnosable mental health conditions. So thank you for those, that perspective.

Policy changes to BHI coming in 2024

I'm going to start now and transition to kind of open up questions to the whole panel. The first question that I'd like to focus on is, are there any things that you see coming down in terms of policy or other opportunities in 2024 that would really, you think might be helpful to support sustainability of behavioral health integration, things you're excited about, things you're hearing about?

So I'll kind of open it up to everyone and see if there's any responses to that question.

Geiler: I can share that beginning in 2024, that being able to hire licensed professional counselors, as well as marriage and family therapists, will expand the workforce who is able to bill for behavioral health services and provide these services in primary care. So that's pretty exciting. It's been a very long journey to consider those two disciplines as well, but that should allow practices to hire more individuals to provide the services that they need.

Dr. Ratzliff: So that change with Medicare is a big deal. It's a big deal that we're opening up to a broader range of professionals that have pretty equivalent training, or comparable training to be able to bill for similar services in our setting. So that is a very exciting thing. And I think that that's helpful for a range of billing strategies, so I really appreciate you sharing that perspective.

Anything else anyone wants to add around this question?

Dr. Chapman: Let me add something that I think is interesting. I think, and you kind of pointed it out earlier, is getting individuals to think about things way before they become clinically significant. I think the military preventing suicidality is going to be way before someone gets suicidal. So that's why I think this promotion of removing the stigma to empower people to get help sooner and to see actions is making a big difference that we hadn't really realized, that people just tend to wait too long in our patients. And if we could tell them, you know, an ounce of prevention is worth a pound of cure, that we can really help them more. And I think that changes in our society is also in the workplace for people to be much more preemptive and preventive to make a difference sooner.

Dr. Ratzliff: So maybe some opportunities to think about how can we move upstream.

Dr. Beecroft, I see you coming back on. Did you want to add in?

Dr. Beecroft: Yeah, just the issue of doing universal screenings in your whole population is going to be very helpful, too. At some frequency in collaborative care, it's done all the time. But in other VHI mechanisms, that's one thing that sometimes is forgotten about. But being able to do screening of, you know, PHU 9s or the GAD 7s or whatever other tool you want to be able to use in your practice, to be able to pick up those cases that go into the radar otherwise. So being able to do that I think is really important.

Dr. Ratzliff: You had some of that preventative work that is recommended now, because there's good evidence that it's going to yield better outcomes for patients, so appreciate that.

One thing that I'm excited about is that there are some efforts. For example, the American Psychiatric Association has put a bill forth to try to increase the reimbursement for practices that are just getting started with the collaborative care model, for example. And that is actually a really important strategy, because I think we haven't talked about this a lot, but there are some upfront costs. And I think Dr. Branco, you did a nice job of sort of highlighting that you may have to start small and get those early gains to really build. There is some upfront costs that often comes from an organization as you hire people, and then may take a little while to build enough, you know, billing to start to make that a more financially sustainable approach.

Advice for practices getting started with BHI

So there are some innovative strategies trying to look at, like, how can we support practices that are in those early phases of building out their integrated behavioral health capacity?

Great. Does anyone want to add anything?

Dr. Branco: So sorry, I'm hoping that people can hear me a little better now. Please let me know.

Dr. Ratzliff: We can!

Dr. Branco: Great. Just add a couple of comments that you brought up the issue of startup costs. And that is a huge issue. And there are lots of places that are leveraging grants and other funding too for startup costs until the behavioral health program is sustainable. I know that for FQHCs, that's a very popular way of starting a behavioral health integration program.

I just got back from the American Academy of Pediatrics conference in D.C. where there is a lot of advocacy being done for mental health parity and integrating behavioral health and policies and, you know, legislate, the advocating for legislators for that.

And then I just want to touch on the credentialing issue. I don't want to forget to mention that credentialing can be a roadblock to billing. And so as soon as you have identified someone that you're hiring to start the credentialing ASAP, because that can take some time and you'll be limited in your ability to bill until they are fully credentialed. So just a reminder to do that.

Dr. Ratzliff: I appreciate that. Very practical advice, right? We're talking a little bit about building capacity and some of the challenges that can come up. I also have seen payers make investments, either in supporting training and technical assistance to build implementation. I think, in fact, Dr. Beecroft, you guys have offered quite a bit of that in Michigan, and also, sometimes, you know, going to payers and really partnering with them to help cover some of those costs is another strategy that I've seen some practices have success with.

And Dr. Beecroft, did you want to add in a little bit more?

Dr. Beecroft: Yeah, that's what I was going to talk about is the issue of what we've done. And it is a fair and steep climb to be able to get the practice closed, everybody trained up on the same kind of thing. We partnered with a couple different groups to be able to do our educational programming and analysis of the practices before they even started the education part. We paid for them to close the practice for two days to be able to get the training. So everybody in the practice was ready to go the day that they started opening up the doors again.

And then really supporting the issue of the tools that are necessary for collaborative care—you've got the routine patient evaluation tool that you have to do, templates of contracts, those sorts of things to be able to get the infrastructure put together.

We were fortunate in the sense of having practice transformation funds from this VBR pool that we've had, a base reimbursement pool. But we also trained up practices that just don't take care of Blue Cross patients. They take care of all the other insurers and Medicaid patients in Michigan as well. So it, I think, was really a good way to kind of pay back to the community what they've been giving us.

And we've had like 1,300 providers that we've trained up, 230 practices now that are doing this and pediatrics and an OB-GYN and primary care. So it is a big step. And the government actually coming along with paying for some of these things, that is remarkable. We've been advocating for that for a while, and it now has come to fruition. So that's where you can tap into some monies doing this to be able to get started up.

Dr. Ratzliff: So it's great. I appreciate everybody covering a little bit about startup costs, because I do think that that's a big consideration for people building out this capacity or trying to grow it, right? A lot of times we start, we may start small, but we want to grow that opportunity.

I think I'm going to kind of transition and talk about sort of big picture and say a little bit of, I'd love for people to share their key advice that they might give a physician or their care team who are working to financially sustain their practices today. I mean, we've talked a little bit about how to think about startup costs, but, you know, are there strategies that have really helped you cover, get your insurance partners to really fully cover the cost of some of those services?

Are there things—I know you guys have kind of sprinkled those throughout the conversation so far—but there are a couple of key things that you would want to highlight to people listening about how to how to cover some of those things when you get started?

I toss that to the whole panel so anyone can jump in. Dr. Branco.

Dr. Branco: I'll start with that, which is, again, coming back to that there were a lot of questions in the pre-event questionnaire about value-based care and how to integrate this into value-based care or capitated models. And Dr. Beecroft, I think talked a little bit about capitation and the insurers. If you can increase your screenings, then you will do better on the HEDIS measure for screening. If you can create more spots for checkups and immunizations, you will increase your HEDIS numbers on immunization. I'm speaking, of course, as a pediatrician, so I'm going to use those examples. And so you can get more pay for performance dollars or pay for quality dollars or however we're categorizing those.

The other is when you sit down with insurers to renegotiate contracts, and this is something that I think most practices do infrequently, but it's important to point out all of the things that you're doing to keep that particular patient out of the emergency room, whether that's by providing excellent asthma care or providing behavioral health integration. All of the things you're doing to save them on psychiatry referrals because you've increased your capacity to care for patients with these behavioral health issues. And we haven't touched on that very much, but another big benefit of integrated behavioral health is to increase our own knowledge and ability to take care of these kids and adults and not refer as often. I'll stop there, but just a few ideas about how to make that happen.

Dr. Ratzliff: Yeah, it sounds like really thinking about strategizing where is going to be the highest value place to start, right? Really trying to pick a couple of those areas as a way to get started. So I appreciate that. Other panelists' thoughts on sort of how do we help people in this early, maybe giving some advice to our group, our audience listening today, things that you'd want to make sure they took away from this conversation.

Geiler: So I can add that one thing that's really important is to have some fidelity to the model that you're choosing and to measure those outcomes. People tend to, not a lot of behavioral health providers are trained in these models in school. So when they come out, the team has to develop their own processes, but without measuring those, making sure that they're not slipping into one-hour therapy, psychotherapy sessions with a behavioral health PCVH model. So again, looking at the outcomes of what they're doing and following those process, maybe do some PDSAs to make sure that you're going to get the outcomes that you're hoping to get.

Dr. Ratzliff: So another really important piece of advice, picking some measures, processes of care may be very important, especially early in practice when you may not have enough patients to start looking at like outcomes and things like that. I think that that can be really valuable to focus on that.

Think about those measures ahead of time a little bit, because I do also think about building the capacity to measure things as you're building the capacity to deliver care could really help you be able to engage in that monitoring process and be able to really tell that story, right? I mean, those things can be helpful too, as you try to tell that story to payers around what you're able to accomplish. So appreciate that.

Q&A

OK. Well, I want to make sure we get a chance to address some of the questions that are coming in through the Q&A and some of the questions that were submitted ahead of time. We've had some opportunity to address some of those, but I'm going to transition and try to kind of organize that a little bit.

I really liked this question that came in, and I think it's the one that many of us think about, and it sort of speaks a little to what you were just mentioning, Julie, that, you know, most people are not trained in these models, may not have seen these models in training because they're still being built, I think, in a lot of places where our workforce is being trained.

So I would love to have people talk about things that have been helpful to engage and gain commitment from both primary care and practices, getting that buy-in from primary care providers. And I would also add in, although it's not in the question, but I think it's really important also behavioral health providers to work in really new and different ways to make that transition from longer term care to maybe shorter, more intensive kinds of ways of connecting with patients different than maybe what they were trained in. So, I'd love to hear people's ideas about what they've seen to be helpful as they're trying to really engage their whole care team in this work. So, I'll open it up.

Geiler: Well, when we built our program, we used technical assistance, which I would highly recommend to anyone that's thinking about this work, and there are ways that you can get it online. There are webinars that you can access as well as hiring individuals to come in and help you. But being able to train up, you're taking that time to build up your whole team and to train them and to help individuals talk to patients in ways they may not have been able to talk to them before, describing your behavioral health services as part of your team, so you're not referring them out to someone, that it's really part of the services that you provide in your practice. So, kind of changing the culture and the language is really important to be able to get everyone on the same page and to present something to the patient that makes sense to them as well.

Dr. Ratzliff: Great.

Dr. Branco: I mentioned earlier that we had started small and built our practice. And again, speaking as a pediatrician, what was very helpful was to look around at local schools and school counselors who are looking for a change. The school counselors for us have been, we've hired three now, and they come from that background of working as part of a team. They're used to collaborating across disciplines.

And so, looking at, you know, in the adult world, there's got to be some corollary, something like that. We started with a school counselor who was able to do referral management for us and help us with meeting with patients. And this is a code that is not billed incident-to, it's billed under the provider, the clinician, that they were able to curate referrals and help parents to navigate the many options for getting behavioral health care.

And then we built on that and had someone who was integrated into our practice and providing some psychotherapy. And, you know, as I mentioned, we have kind of built the program from the ground up and added a little bit as we needed more. And it's allowed us to do more. And then again, to echo, we talk about the behavioral health providers as clinicians in our office. They are part of our team. They're

on our website, just like the physicians and the nurse practitioners. And at our morning huddle, we announced which behavioral health providers are in the office that day and where they are so that they can be consulted and we can do warm handoffs and make sure that our patients see them as part of our practice. And that's really helped us quite a bit.

Dr. Ratzliff: That's great. So I hear a couple of themes there. I think one is sort of engaging people, especially if you're making new hires that are open and kind of excited about working in a different way. I would say some of the adult corollaries that I've heard around that are people who've worked in emergency departments, I think there's a lot of parallels between sort of the intensity and energy that you might have.

And then I think good training and technical assistance. Really appreciate Julie weighing in on that.

And then I would add the other thing around, especially primary care provider buy-in, that one of the things that I've seen is that really making sure you get their input on one of the things that they are feeling like they need support on and making sure that there's some way that this program is helping them address those needs. And I think that takes some conversations. I think that that's been a theme throughout what people have shared today is that having some conversations and making sure that there is that buy-in may take some time, but it's really valuable as you move forward and try to build out and do some of the hard work of practice change, right? I mean, most of this work is working in new and different ways than maybe we were trained in.

Dr. Beecroft, I saw you come back on. I wanted to see if you had some additional thoughts.

Dr. Beecroft: Yeah, what really has been our experience has been that you really have to have the medical needs all on the same page.

That all the practitioners that are running the practice have a belief that moving in this direction is in their best interest, not only personally, but in the practice's best interest and their members' best interest, the patients' best interest. And if you have one doc or one nurse practitioner that is a naysayer, it will destroy the rest of the team moving forward.

The other thing is that most medical practitioners don't get trained in team medicine. As a psychiatrist, we do that all the time. Psychotherapists do that all the time. Psychologists do that all the time in our training. So we're kind of used to that. But it's only people that are dealing with, say, nephrologists in a dialysis center or oncologists or chronic pain clinics that do team medicine. The rest of it is pretty solitary. So it's a different way of doing practice.

But on the other hand, if you worked in teams, it really starts looking at using multiple eyes to get a lot of gathered information, multiple brains, thinking about solutions to problems, and people that can do specialty work that are specialists in case management and do that very, very well.

So those are things that probably a primary care doc doesn't need to be figuring out how to get gas money for getting this person to the pharmacy to get the prescription for Abilify that they just wrote for them. That kind of stuff. The doctor wants to do that, but they don't have the time. They don't have the skill sets to do that. So that's where working in a team, you have everybody working on top of their skill set, and people feel really much better at the end of the day that they got a lot of work done.

So those are the kinds of things to really get that team going in the first place. And it takes a team to be able to figure that out and move forward.

Dr. Ratzliff: Great. Thank you for those additional thoughts. All right. Well, I see some really specific questions in our Q&A. So maybe I'll run through those pretty quickly, and whoever feels like they have a good answer can jump in. And I also will just highlight that there are a lot of resources that have been curated, which have a lot of, I think, some of these specific nitty-gritty details in them. So a reminder to anyone participating on the call today to look at those resources.

There's a question, and I think, Julie, maybe I'll direct this one to you. Will LACs be able to bill in primary care in 2024, or will the additional licenses only be LPCs and LMFTs?

Geiler: So I had to look up LACs. My understanding that's an unlicensed counselor or someone in training, if that's the question I'm answering. In the primary care behavioral health model, those individuals typically have to be independently licensed, and that is because that's what the payers want. On the COCM model, typically those individuals serving as care managers do not have to have a license. They must be trained, but they don't have to have a license. So again, it depends on your model and what that individual is actually doing in the practice and your state. Each state is different.

Dr. Ratzliff: Yeah, thank you for that I don't know if anybody else has any additions … all right.

I'm going to move to another one. When evaluating expenses, is the cost of a psychiatry time pay considered in the calculation of expense?

And maybe I'll take this one on as somebody who does a lot of work around this, and then Julie, it'd be great if you have anything to add. In general, I think any of the team-based, any of the team members, their cost of the time that they're spending devoted to that resource should be included in what you think of as sort of some of the expenses.

I think there are different models of how you attribute that time or compensate for that time. So I'll just highlight that I've seen different models of that. I've seen primary care practices that hire that person and pay their salary and benefits as part of their work. I've seen people contract for a few hours of time or pay for part of the FTE of a person to be able to pay those costs. Because a lot of times, if you're doing more team-based approaches, that cost may not be, for example, like collaborative care. That psychiatric consultant is typically not seeing patients directly. I think most organizations do direct

billing for any direct services that psychiatric providers provide. Anybody else have anything they want to add to that?

OK. I think it brings up a really interesting question, though, about RVUs and a productivity-based environment. How does that really work with some of the time that providers are often spending in integrated behavioral health really on team-based activities that may or may not have a way to capture that contribution in our traditional RVU-based models? So I'm curious if anyone would like to speak to that. I have a few thoughts on that as well. I don't know if Julie or Dr. Branco, like if you have thoughts about that.

Geiler: There are some general BHI codes that can help to cover some of the non-typical, you know, you're not enrolled in COCM necessarily, or PCVH is doing some of that care coordination. But as far as RVUs, I think that that's probably challenging. I have not seen that done. So I really can't speak to that. But there are ways to get some of that typically unbillable work billed now with the new general BHI codes.

Dr. Ratzliff: So that might be a strategy. Great. Other thoughts from that team?

Dr. Branco: Yeah, I think this is just another place where the RVU system fails to adequately demonstrate the work that's being done. Again, I always come back to talking about, have we made the whole pot bigger? Have we gotten better at doing screening because we've taken away the reluctance to screen because we don't have anything to do with a positive screen? You can't attribute that to a particular behavioral health practitioner.

But again, using some of the collaborative care codes, using the case management codes, the telephone care codes, those are all ways to appropriately attribute RVUs to the behavioral health practitioner.

Dr. Ratzliff: Yeah, I'll just add in that I've seen a few different examples of how people have done this. I think one of the ways that people think about this is perhaps that whole FTE of a person is not actually devoted to productivity-based activities. So perhaps if you are in a productivity environment, having a lower sort of FTE that is being used as you do those calculations to acknowledge that some of that work is not going to make sense in that environment. And so we've definitely seen that.

I've seen … for example, that's actually how it works with psychiatric consultants at the University of Washington. Their clinical FTE devoted to collaborative care is not included in their baseline clinical FTE that's used in their productivity calculation. So I'm just naming that because I think these are some of the things that you do have to anticipate and plan for. And then really articulating are there other ways you might assess people's contribution?

So are there process-based measures that maybe there's incentive pay tied to or things like that are things to think about as we move to maybe a world that isn't just fee for service. So some ideas to see that process.

All right. The next one that I have, and I'd love to hear maybe a little bit from Dr. Chapman if she has thoughts about this one, which is, the question is really around digital intake processes, but I'm actually curious too about what are some of the things we should be trying to assess as we're bringing people into the practices? What are some questions or ways we might be trying to gather that information that's efficient because I think that is one of the challenges, right? There's just never enough time for everything you want to do. So I don't know if Dr. Chapman, you have any thoughts about a briefer ways to get involved? And then I'd love for other people to talk about if they've seen any use of sort of digital assessments to try to facilitate that intake process.

Dr. Chapman: Yes. So, and I love hearing all these comments. It's such a different feel for me. And absolutely, as I mentioned, one of the things that we have validated is this BrainHealth Index that people can do online now. And there is a link to the BrainHealth Project that's offered for free for people to do. And the intake process allows you to really see where you are as an individual to think about capacity building. As you're looking for improving positive outcomes, the more doctors that take to account where the individual is and the gains that they make, I think it's going to make a really big change on sort of the self-agency of their role in their better care, so that they can begin to partner. So I think the intake of where do you see the patient's role in making themselves better, along with you as the doctor.

We've worked with a lot of pediatric brain injury with a lot of stress, depression, kids in underserved populations. And the more we do it to remove the stigma in our intake process from not what's wrong with you, but what are some capacities that you can build, they really kind of get around it and do a lot more to be part of the equation of being better. And so the intake process for technology is now there. And I think COVID really made that much more open where individuals were willing to do it and give their information and see where they were.

Dr. Ratzliff: Great. Anyone else using digital processes? Yeah, Dr. Branco.

Dr. Branco: Yeah, so we in our practice, we have actually been using a product called Jotform that allows us to create intake forms and not only collect, you know, demographic data and some history on, again, in our situation, school and school performance and other useful info. But then it just provides a way for our child psychiatrist and therapists to get a description of the concerns that the parent or the teen might have. And so that's been very effective. And we found a way to integrate that into our EHR. We also use a lot of portal messaging; we do a lot of televisits. And in order to connect with patients, and we've actually had to create a position in our organization of behavioral health assistant, who helps manage all that and helps make sure that during that intake visit with our child psychiatrist, one of our therapists, they have all the information that's necessary.

We chose Jotform because it's HIPAA compliant and we had been using it for other things in our practice. But there are lots of other solutions that will do the same thing.

Dr. Ratzliff: Thank you so much for sharing. I think the person who asked that question was saying they're thinking about that a lot, right? Because I do think as we try to get to that population health level, where are the efficiencies that we can have? If we can have some of that intake happen asynchronously, does that allow our providers during those practice hours to work in different ways?

And I think I really appreciate your examples because I think having the information you need probably makes that, you know, even a single or reduces it to a couple visits, maybe with a provider that needs to be leveraged in your practice to have the most impact, as opposed to them spending a lot of time trying to gather that information in real time, which may or may not be the most effective use of and efficient use of their time. So really appreciate all of these examples.

We're getting to the top of the hour and we probably should be wrapping up. I guess I'll just maybe give everybody a minute or 30 seconds to say, are there any final thoughts you have from this conversation today? I see the question came in and it was Jot, j-o-t-f-o-r-m.

OK. Great. So any final thoughts from our panelists?

Dr. Chapman: Well, I would like to close with I think the behavioral health integration specialists are really prime to tackle brain health where your patients and individuals begin to realize that there's so much that they can do to really promote their overall health and make better health choices and close the treatment gaps and remove stigma.

Dr. Ratzliff: Thank you. Any final thoughts from any of our other panelists?

Geiler: I'd just like to remind people that this takes a long time to really gel, to build a team, to change the culture. And I think as was previously said, you have to be flexible and it's individual. Each practice is very, very different and unique. So you need to find what works for you, but try to stay with one of the major models out there as you're building. Focus on one, once you get that down and you've got your outcomes and your processes, then think about bringing the other. But trying to do both is really a recipe for disaster.

Dr. Ratzliff: Yeah. I hear trying to think you have to be really strategic in what you're doing, right? And it's OK to maybe start a little smaller and build capacity over time. And I think that's something that maybe you were echoing, Dr. Branco, like about your practice too, right? Starting small and growing. Anything else you'd like to add?

Dr. Branco: Yeah, sorry. I would like to add, and this is in a way to answer one of the questions that came through about how to get buy-in. I will use our example. In our practice, we participate in a

hospitalist program. And so the hospitalists will go to the emergency room and see our patients who present during the day. They will go to the C-sections and the births that we used to get pulled from the office to see. We happily participate in that program and support it because it allows us to stay in the office and take care of our patients. Behavioral health integration is no different.

We also have advice nurses who do not generate revenue but help us take better care of our patients and help us provide access to our patients. And so in the same way, our behavioral health providers help us take much better care of our patients. They give us resources to take better care of our patients, and they make us more productive and allow us to do more screening and find these issues well before they become a problem. So that's how I get buy-in and that's how I like to think about the financial sustainability of behavioral health integration.

Dr. Ratzliff: Yeah, really this idea that this is part of whole health. And of course, we might have to absorb some of those costs just like that advice nurse or other things that we do in our practices to serve our patients well and really provide that holistic care.

So I think behavioral health is no different. I think it's interesting that sometimes there is that hesitation to extend payment for that in some systems without it being fully compensated. And I think maybe there's lots of types of care that aren't fully compensated and are still valuable and necessary to provide that holistic care. So really appreciate that.

All right, well with that, I'm going to hand it back to our host to close us out. And I just want to thank each of the panelists today for contributing and sharing your thoughts and helping the people who are participating really, hopefully, take away some pearls to get started or extend their ability to sustain their practices. So handing it back to you.

Lewin-Smith: Great. Thank you again, Dr. Ratzliff, Dr. Beecroft, Dr. Branco, Dr. Chapman and Julie for sharing your expertise and experience with our viewers today. And thank you to our audience for joining this discussion.
