NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

Integrated Care Requirement Overview

March 26, 2025

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National Training and Technical Assistance Center
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Acknowledgements and Disclaimer

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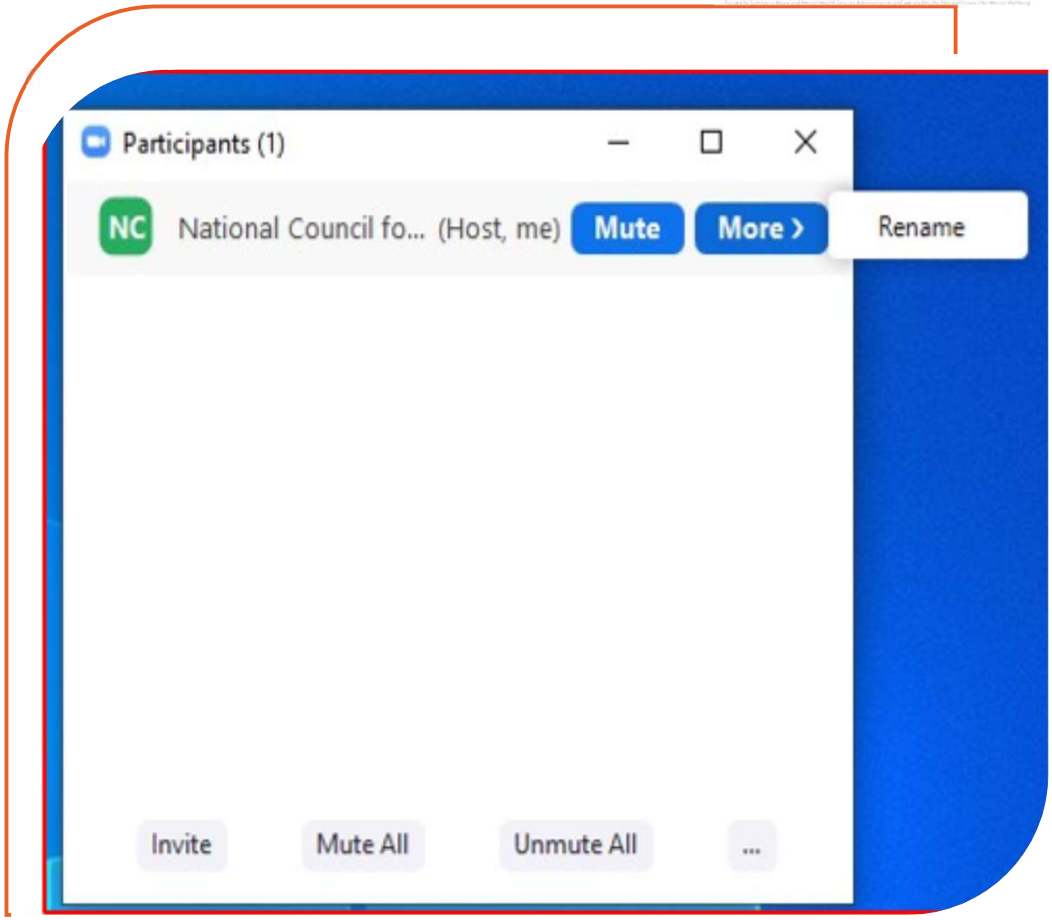
Logistics

- Please rename yourself so your name includes your organization
  - *For example:*
    - **Roara Michael, National Council**
  - *To rename yourself:*
    - Click on the **Participants** icon at the bottom of the screen
    - Find your name and hover your mouse over it
    - Click **Rename**
  - If you are having any issues, please send a Zoom chat message to **Danielle Foster, National Council**



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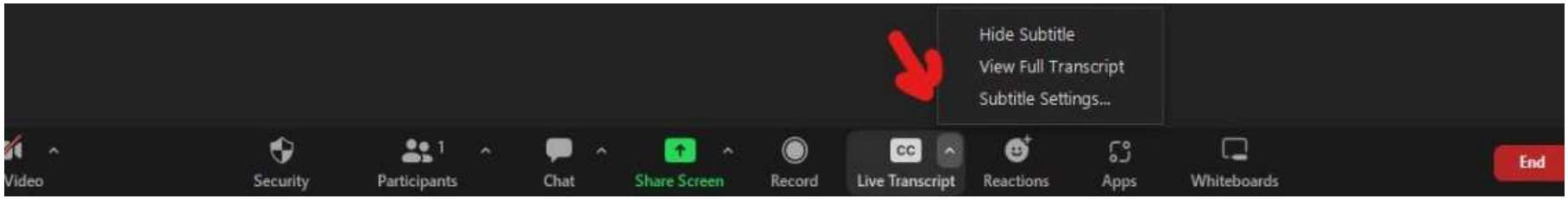

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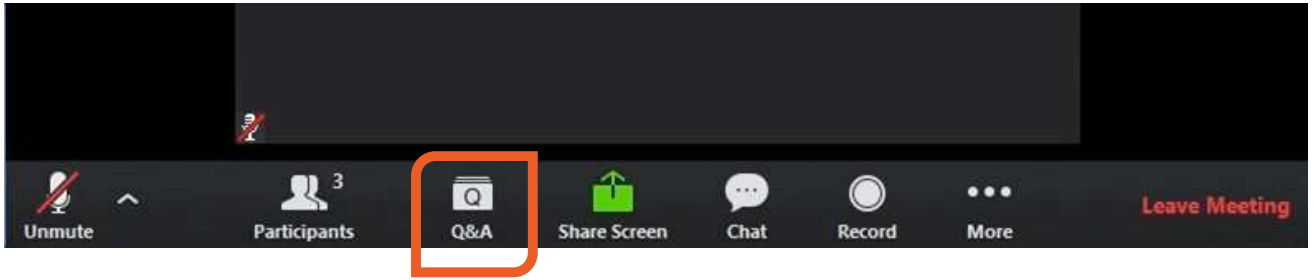
Asking a question



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Session Presenters

Katie Lipp, LICSW, PMP
Principal, Bowling Business Strategies

Lauren Moyer, LSCSW, LCSW
Executive VP of Clinical Innovation, Compass Health Network

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Learning Series Curriculum

Date	Topic
March 26th	Overview of Integrated Care Services Requirement
April 23rd	Care Coordination
May 28th	Data Points & Metrics

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Learning Objectives

Participants will learn:

- SAMHSA requirements for primary care screening and monitoring.
- Strategies for communication about and operationalizing the requirements across teams.
- Strategies for integrating screening and monitoring into workflows.

Integrated Care Session 1: Polling Questions

- How does your organization collect data to meet the primary care screening and monitoring requirements?
  - In house
  - Through an FQHC partnership
  - Both
- How is your primary care screening and monitoring data captured and documented in your EHR?
  - Data is included in progress note (unable to pull for reports)
  - Data is captured in a field in EHR (able to pull reports)
  - FQHC partner sends us a report with this information
  - Data is not currently available in CCBHC's EHR
  - Other
- Does your organization partner with a lab(s) to process biologic samples?
  - Yes
  - No
- Does your organization collect information on physical health/chronic health conditions?
  - Yes
  - No

SAMHSA Requirements

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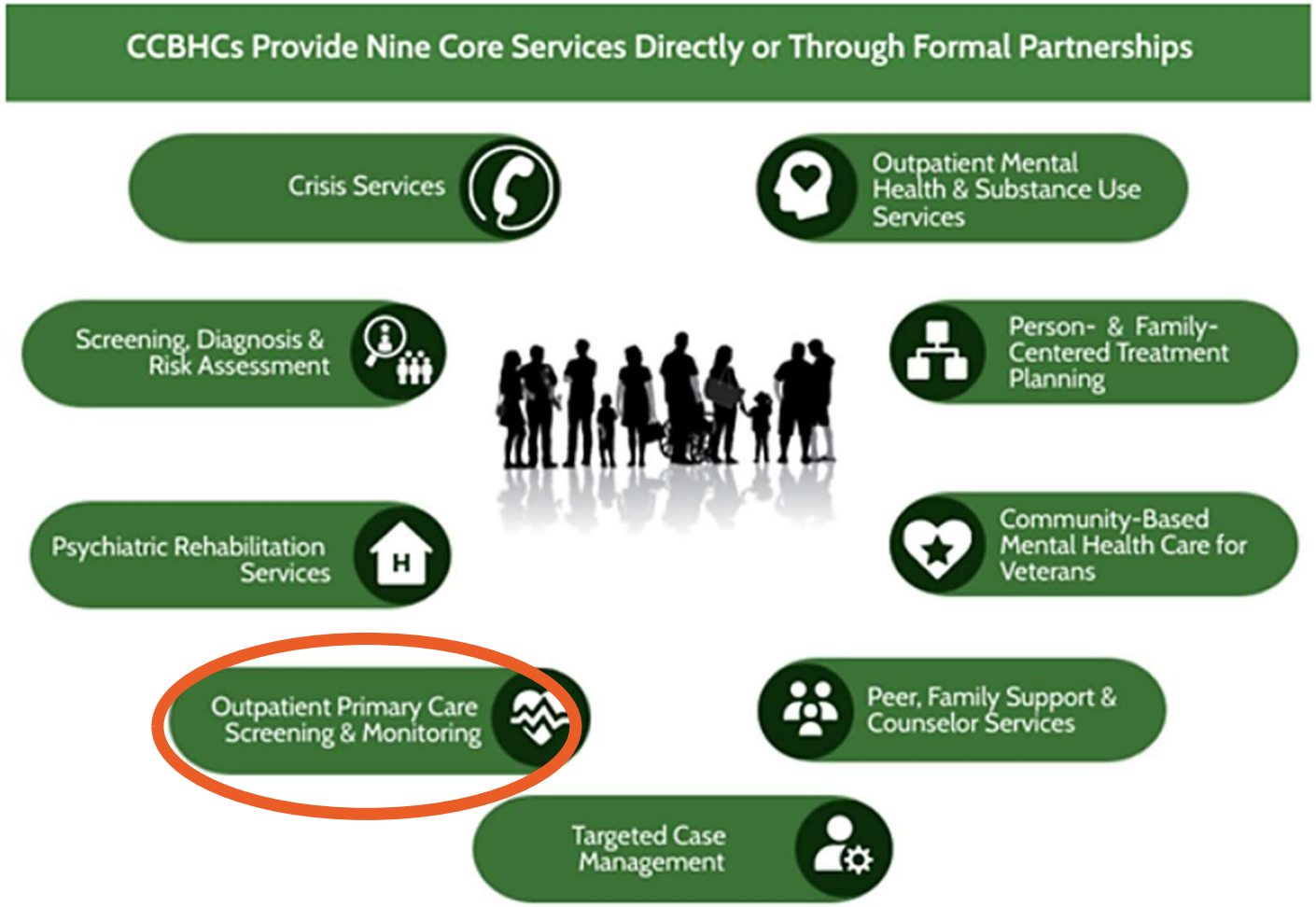
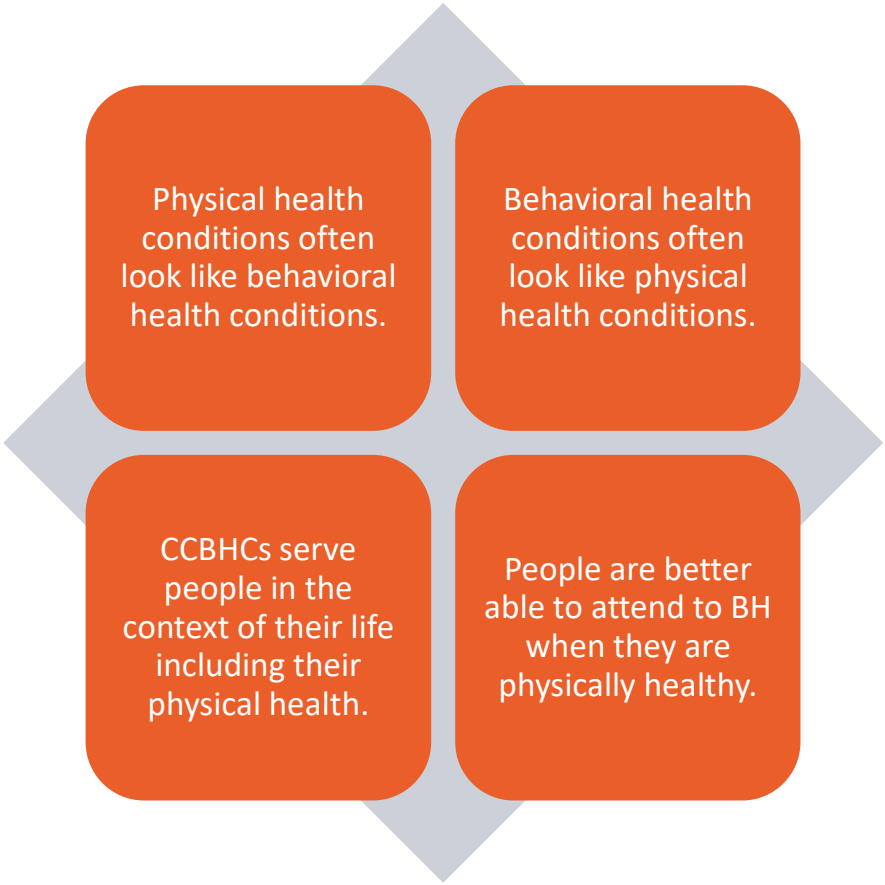


Why does it matter?

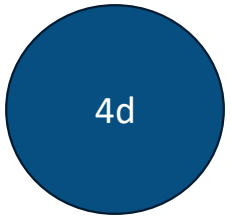


Primary Care Screening

4g1

- The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk.
- Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion.
- Prevention is a key component of primary care screening and monitoring services provided by the CCBHC.

Universal Primary Care Screening



- Pregnancy status
- Relevant medical history and major health conditions that impact current psychological status
- Substance use
- Medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medication
- An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up)

Conditional Primary Care Screening

4g2

- Screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan.
- Protocols, developed by Medical Director, will include:
  - Identifying people receiving services with chronic diseases;
  - Ensuring that people receiving services are asked about physical health symptoms; and
  - Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g.

Conditional Primary Care Screening

Apx B

Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)

- Assesses the percentage of members 18–75 years of age with diabetes (type 1 or type 2) whose HbA1c was at the following levels:
  - HbA1c control (<8.0%).
  - HbA1c poor control (>9.0%).
- Symptoms of poor glycemic regulation often look like mental health symptoms
- Only required once/yr; Medical Director may elect more frequent screening such as when there is a triggering event

Although this is a state-collected measure,
CCBHCs need to collect the levels.
CCBHCs do **NOT** need to calculate percentages

KL0

Slide 17

KL0 Flag for National Council: Is this required by this cohort of grantees?
Katie Lipp, 2025-02-13T19:42:10.547

Collection of Biologic Samples

4g2

- The CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization.
- Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC.
- The CCBHC must also coordinate with the PCP to ensure that screenings occur for the identified conditions.
  - If the person's PCP conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.

Compass Biological Sample

- Recurring orders will be used.
- If a client is in psychiatry services, the treating provider will order/review the labs. (Clinical Staff must check the lab order note to know which order set has been approved prior to sending to the lab)
- If a client is not in psychiatry services, a specified psychiatric consultant will order/review the labs.
- There will be dedicated providers as part of the treatment team process to assess need for labs, and order and review labs.

Primary Care Monitoring

- Provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual.
- Monitoring includes:
  - ensuring individuals have access to primary care services;
  - ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions;
  - coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and
  - promoting a healthy behavior lifestyle.

Note: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services.

CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS.

Operationalizing the Requirements

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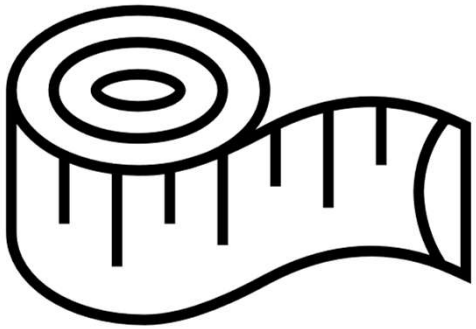
Tailoring Communication Across the Team

- Not everyone needs to know everything!
- Team members require a varying level of knowledge of the requirements, based on their specific roles
- Tailoring (and limiting) verbal and written communication to each role will support their understanding and the change management process



Compass Examples of Team Communication

- Huddles each morning with NCM, case managers, peer specialists, and other team members as needed/able
- Integrated team staffing meetings monthly
- PCP consult meetings
- Utilization of data to share trends and areas to focus on improvement

D(0

Medical Director: Reporting Requirements

Needs to Know

- CCBHC reporting requirements in full
- Data identified in the CNA that highlights key areas of increased risk or need

Ex: Heart disease is highest cause of death in NM. Medical Director may determine that blood pressure should be taken at every appointment for at risk patients and monthly for lower risk patients.

Needs to Do

- Establish protocols that conform to screening requirements, including “other clinically indicated primary care key health indicators as determined by CCBHC Medical Director and based on environmental factors, SDoH, and common physical health conditions experienced by the population"

Slide 25

D(0 Need to close quotes on the second part of this slide.
De Voursney, David (SAMHSA/CMHS, 2025-03-19T11:17:23.835

Medical Director: UPSTF Recommendations

4g1

D(0

Needs to Know:

Population	Recommendation(s)
Pregnant persons	Screen for HIV Screen for HBV at first prenatal visit
Adolescents	Screen for HIV beginning at age 15; younger if at increased risk Screen for HBV
Adults	Screen for HIV until age 65; older if increased risk Screen for HCV until age 79; older if increased risk

Needs to Do:

- Review USPTF recommendations, needs assessment, and other data. Establish screening protocols based on what is clinically indicated.
- Determine how the CCBHC identifies individuals "at increased risk for infection."
  - Ex: People who currently or have previously injected drugs and shared needles, syringes, or other drug preparation equipment.

Slide 26

D(0

There is some nuance here about how the criteria require the USPSTF recommendations to be used. "The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions: • HIV and viral hepatitis • Primary care screening pursuant to CCBHC Program Requirement 5 Quality and Other Reporting and Appendix B "

The idea is not that they have to follow all recommendations "which wouldn't be feasible" but they should look at the recommendations for identified/required conditions to make sure that screening is being done in a way that makes sense.

De Voursney, David (SAMHSA/CMHS, 2025-03-19T11:21:06.117

Medical Director: CQI Reporting Requirements

Needs to Know

- CCBHC CQI Plan and related processes
- Relevant data

Needs to Do

- Medical Director is expected to help develop the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.

Primary Care

Needs to Know

- CCBHC responsibilities
  - Screening for key physical health conditions
  - Document medical history and major health conditions
  - Substance use care
  - Obtain medication list
  - An assessment of need for a physical health referral
- How information/records will be exchanged
- When CCBHC will outreach PCP
- How to reach CCBHC staff

Needs to Do

- Continue to provide full physical exam, well visits, sick visits, physical health treatment planning, chronic disease care, diagnostic testing, prescriptions and orders
- Respond to CCBHC outreach and data requests
- Communicate significant changes to CCBHC

D(0

Direct Care Staff

Needs to Know

- Why screening and monitoring matters
- Which screenings will be completed by whom
- Where they can find data
- What signs and symptoms they should look out for in the people they serve

Needs to Do

- Complete screenings as assigned
- Monitor the people they serve
- Coordinate care with other entities as needed

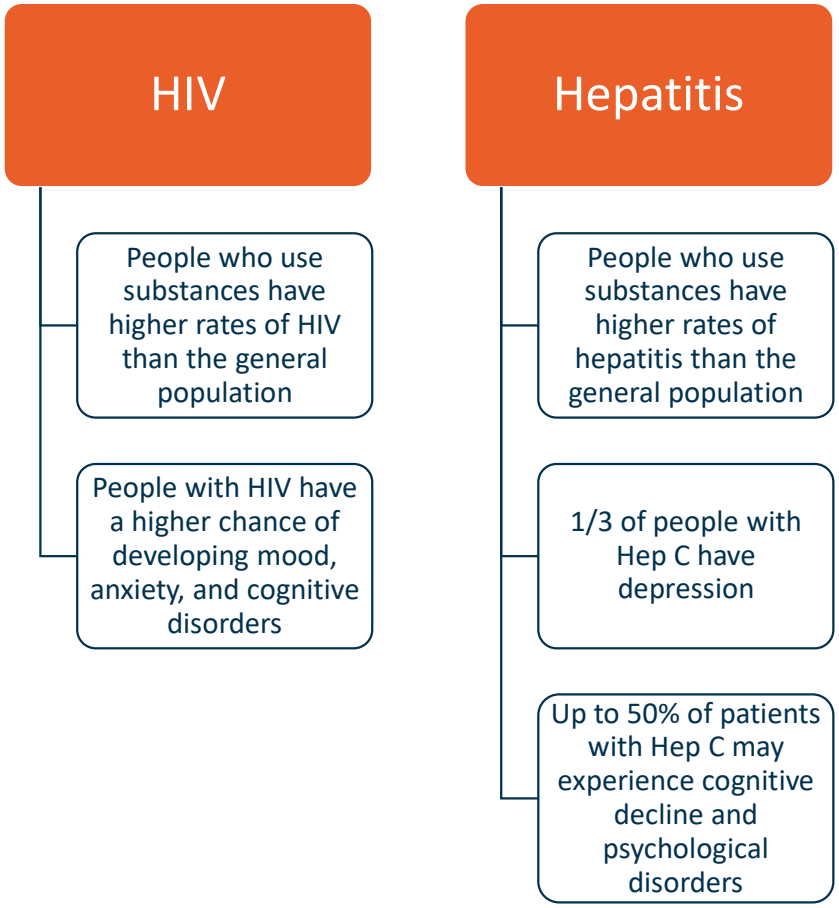
If another provider is conducting screenings, CCBHCs do not need to repeat the screenings, unless directed by Medical Director. CCBHCs *do* need to get a copy of the results and treatment plan if applicable to add to the CCBHC medical record.

Slide 29

D(0 May be helpful to confirm that they do not need a DCO for the screenings (but they should have some capacity to get screenings done if there is no other pathway).

De Voursney, David (SAMHSA/CMHS, 2025-03-19T11:22:16.007

CCBHC Screenings – Why?



Culture Change – Shared Care Approach

- Shared goal setting and team accountability
- Improve client outcomes by treating both mental and physical health holistically
- Enhance life expectancy and overall quality of life for those we serve
- Reduce hospitalizations and complications related to untreated physical conditions
- Foster a culture of whole-person care, reinforcing our commitment to comprehensive well-being

EHR Developers/Analysts

Needs to Know

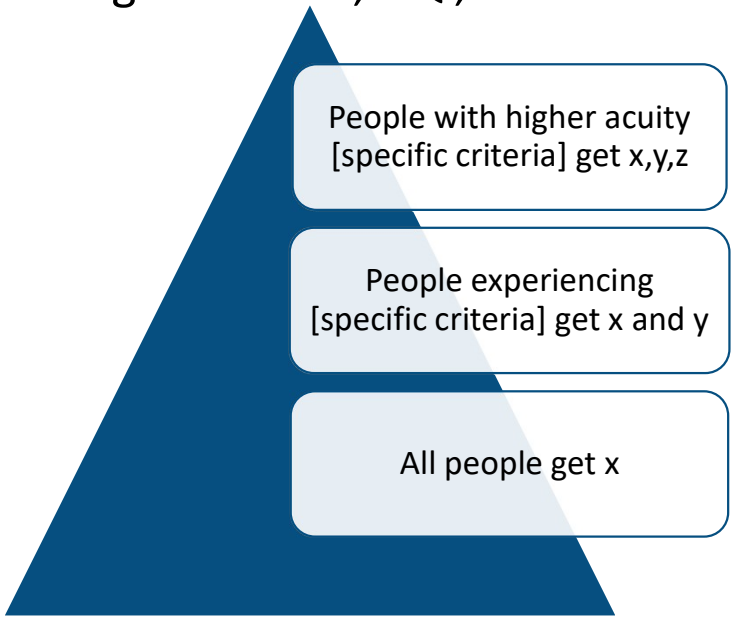
- Which screenings will be required of which populations
- Reporting requirements and data needed to support CQI
- Role types, encounter types, and codes associated with each screening

Needs to Do

- Build any needed decision support or prompts to ensure screening takes place
- Ensure all documentation is aligned with reporting requirements and CQI needs

Clinical Pathways

Under the direction of the Medical Director, CCBHCs can develop tailored protocols to meet needs identified through the CNA, CQI, and other data processes.



Sample Clinical Pathway: Diabetes

Data & Rationale	Screening	Process
• Type 2 diabetes is twice as common among people with SMI than in the general population • Dysregulated blood sugar can present similarly to altered mental health status	• HbA1c taken every 6 months or when significant change in mental status/symptom acuity	• Results shared with PCP • If outside of normal limits, referred to nurse care coordinator for support

Example Screening List

Screening	Population	Frequency
HIV	Ages 15-65 At risk patients (i.e., IV SUD)	Annually Quarterly
Hepatitis B	Pregnant Adolescents and adults at risk	At first perinatal appt Quarterly
Hepatitis C	Ages 15-65 At risk patients (i.e., IV SUD)	Annually Quarterly
Blood Pressure	All patients At risk patients	Monthly At every appt
Weight	All patients At risk patients	Monthly At every appt
Hemoglobin	Patients with diabetes	At every appt
COPD Screening	Smokes or otherwise at risk	Referred to PCP for screening annually

Implementation Considerations

Assessment

- Which tools will you use?
- What will you do in-house vs. via external data tracking?

Treatment

- Are treatment plans integrated?
- How are you ensuring all treatment team members have the information they need?

Staffing

- Do you have the staff that you need to perform these functions?
- Are all staff working to the top of their skill set?

Training

- Do all staff have basic training needed?
- Do staff understand protocols for positive screens?

D(0

Compass Health Screenings

- Behavioral Health:
  - Metabolic Screen POC – Glucose, A1c and lipid
  - Send out Hep C and HIV
  - Send out any other lab order by psychiatry providers
- Primary Care:
  - All preventative screenings that can be obtained through lab
  - Cervical cancer screening
  - Cologuard/colon cancer screening
  - Physical exam and diagnostics as indicated – EKG, Spirometry

Slide 37

D(0 I think the first bullet may need to read behavioral health and I think you should use the same bullet formatting for behavioral health and primary care (either use bullets or don't use bullets).

De Voursney, David (SAMHSA/CMHS, 2025-03-19T11:23:55.664

What are some of the clinical pathways your CCBHC has developed?

Please enter in the chat.

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Workflow Strategies

Develop a schedule for checking Prescription Drug Monitoring Program.

Utilize a Health Information Exchange, if available. If not, pursue formal relationships with large area health networks to facilitate data sharing.

If patient's physical health team is using remote patient monitoring and the CCBHC can access result, this may eliminate the need to check vitals or other regular screenings.

Develop a cadence for collaboration with physical health team.

Identify triggers for reaching out to physical health team beyond standard check in:

- Dramatic change in mood
- Medication changes
- Recurrence of substance use

Workflow Strategies (cont.)

Ensure staff are working at the top of their scope to maximize job satisfaction and value

Ex: can case managers be trained to take blood pressure rather than using nurses?

Use screenings to help persons served by your CCBHC understand their health.

Ex: develop plain language guidance on what blood pressure is and what the readings mean

Use decision support, pop-ups, or required fields in the EHR to help prompt staff to complete screenings

Share stories with staff to maintain sense of value

Compass Hep V and HIV process

Outpatient primary care screening and monitoring of key health indicators and health risk;

- USPSTF grade A and B recommendations will be available through both collaborating with the client's primary care provider and directly obtaining recommended testing whenever possible.
- Compass Health recommends and provides the following metabolic and preventative screening tests to all CCBHC clients:
  - 1. Hepatitis C testing for everyone 18 to 79 years of age
  - 2. HIV screening for everyone 15 to 65 years of age
  - 3. Age-appropriate Metabolic Syndrome Screening to include the following as indicated:
    - a. Vitals: height, weight, blood pressure, BMI, and/or waist circumference
    - b. Blood glucose or HbA1c if they have a diagnosis of diabetes
    - c. Fasting Lipid Profile
- Compass Health recommends all CCBHC clients establish care or follow up with a primary care provider at least once a year. USPSTF grade A and B recommendations not provided by Compass and the treatment of chronic medical conditions are managed by primary care providers chosen by the client.
  - Team members request the client sign a release of information to obtain results obtained through their primary care provider if that is their preferred site of service or the recommended screening has already been completed.
- Compass Health supports every client's right to make healthcare decisions that align with their value system and preferred service location. Compass Health Network team members will document when a patient refuses a recommended screening in the EHR.

Lessons From a Leader

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Lessons From a Leader

- Tell us about how your CCBHC approached primary care screening and monitoring.
- What challenges did you encounter in implementation? How did you overcome them?

Questions?

Resources

- CCBHC Criteria
- PCSM Case Study
- ODW: CCBHC Scope of Services
- Strategies for Leveraging Your Medical Director as a CCBHC
- Workforce Innovations link

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