

THE AFFORDABLE CARE ACT (ACA): IMPACT ON THE FIELD OF CLINICAL MENTAL HEALTH COUNSELING

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2014 AMHCA CONFERENCE

JULY 12, 2014 1:40-3:30 PM

TRAINING OBJECTIVES

1. Identify the different component of the ACA and how it will benefit health care consumers
2. Identify how the ACA will impact the organization and distribution of health care and mental health care in the future
3. Identify what is a Patient Centered Medical Home (PCMH) and an Affordable Care Organization (ACO) and how these structures will impact the delivery of Mental Health Services in the future
4. Identify the impact of the need for CMHC to become better equipped to work with primary care medical professionals
5. Identify the role of preventive mental health services advocated by the ACA
6. Identify the importance of the need for CMHC's to become more comfortable with Behavioral Medicine, Neuroscience, Psychopharmacology, Co-morbidity of mental health issues with substance abuse and addictions and the mutual impact of physical health on mental health on one another



LET'S HAVE A GLOBAL FUN LOOK AT
IT!

http://www.youtube.com/watch?feature=player_embedded&v=JZkk6ueZt-U



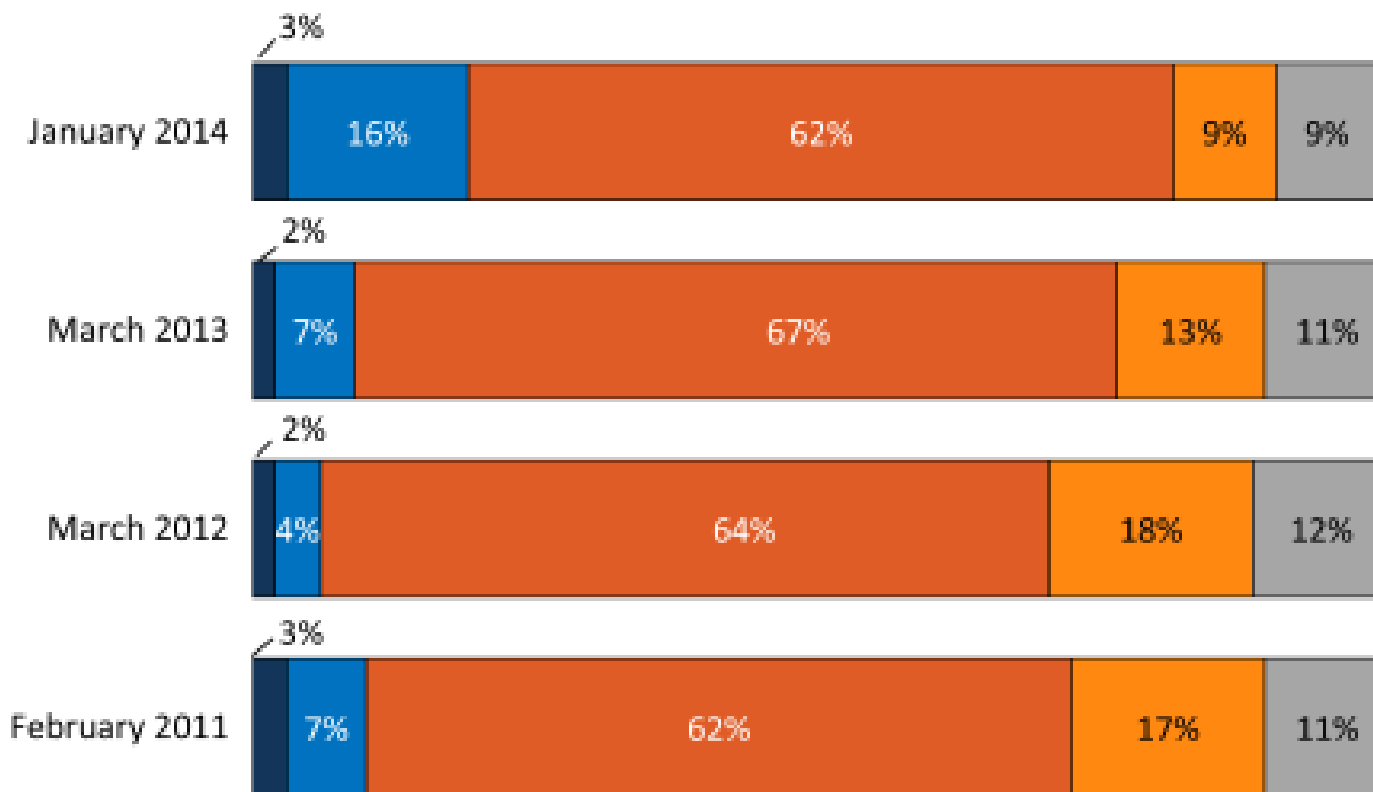
SO HOW MUCH DO AMERICAN'S KNOW ABOUT THE ACA?

In January 2014, the Kaiser Health Tracking Poll found that even after most of the ACA's major provisions took effect on January 1, a large majority of the public (62 percent) continues to believe that only "some" provisions of the ACA have been put into place thus far. Only about one in five (19 percent) say "most" or "all" provisions have been implemented.

Majority Believes Only Some ACA Provisions In Place So Far

As far as you know, how much of the health reform law has been put into place thus far:

■ All of its provisions ■ Most provisions ■ Some provisions ■ None ■ Don't know/ Refused



MAJORITY ARE STILL NEGATIVE ABOUT ACA BUT WANT IT IMPROVED

Views of the law overall remained more negative than positive in January 2014, with 50 percent saying they have an unfavorable view & 34 percent favorable, almost identical to the split in opinion since November 2013. Still, more than half the public overall, including three in ten of those who view the law unfavorably, say opponents should accept that it's the law of the land and work to improve it, while fewer than four in ten want opponents to keep up the repeal fight.

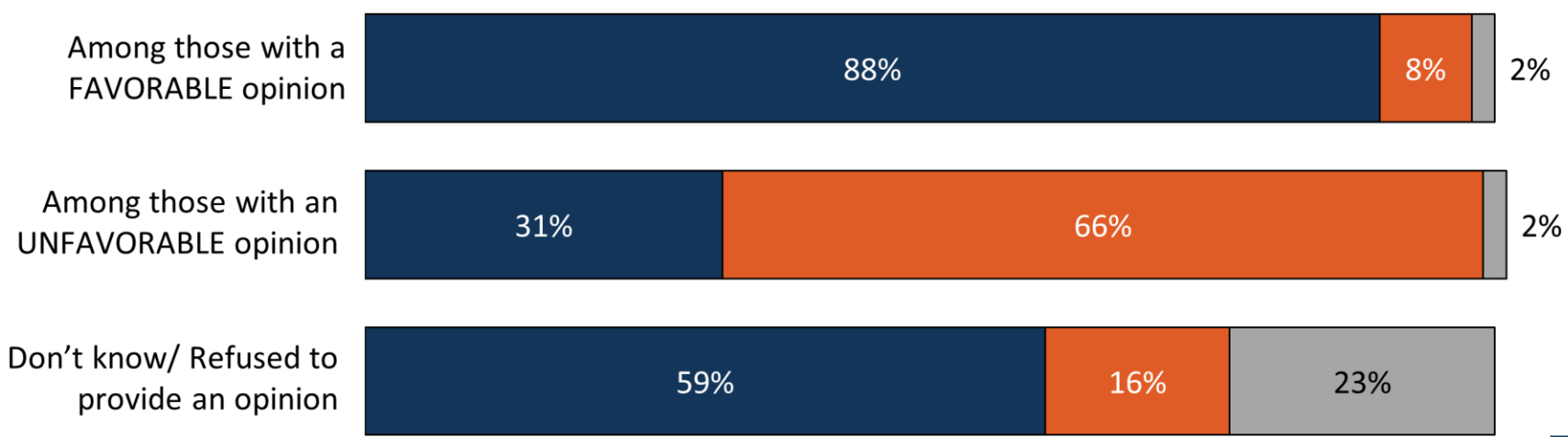
More Want Opponents To Work To Improve Law Rather Than Continue Efforts To Repeal

Do you think opponents of the health care law should continue their efforts to repeal the law or should they accept that it's the law and work to improve it?

■ Accept that it is the law and work to improve it ■ Continue efforts to repeal ■ Don't Know/Refused



By overall opinion of the health care law:



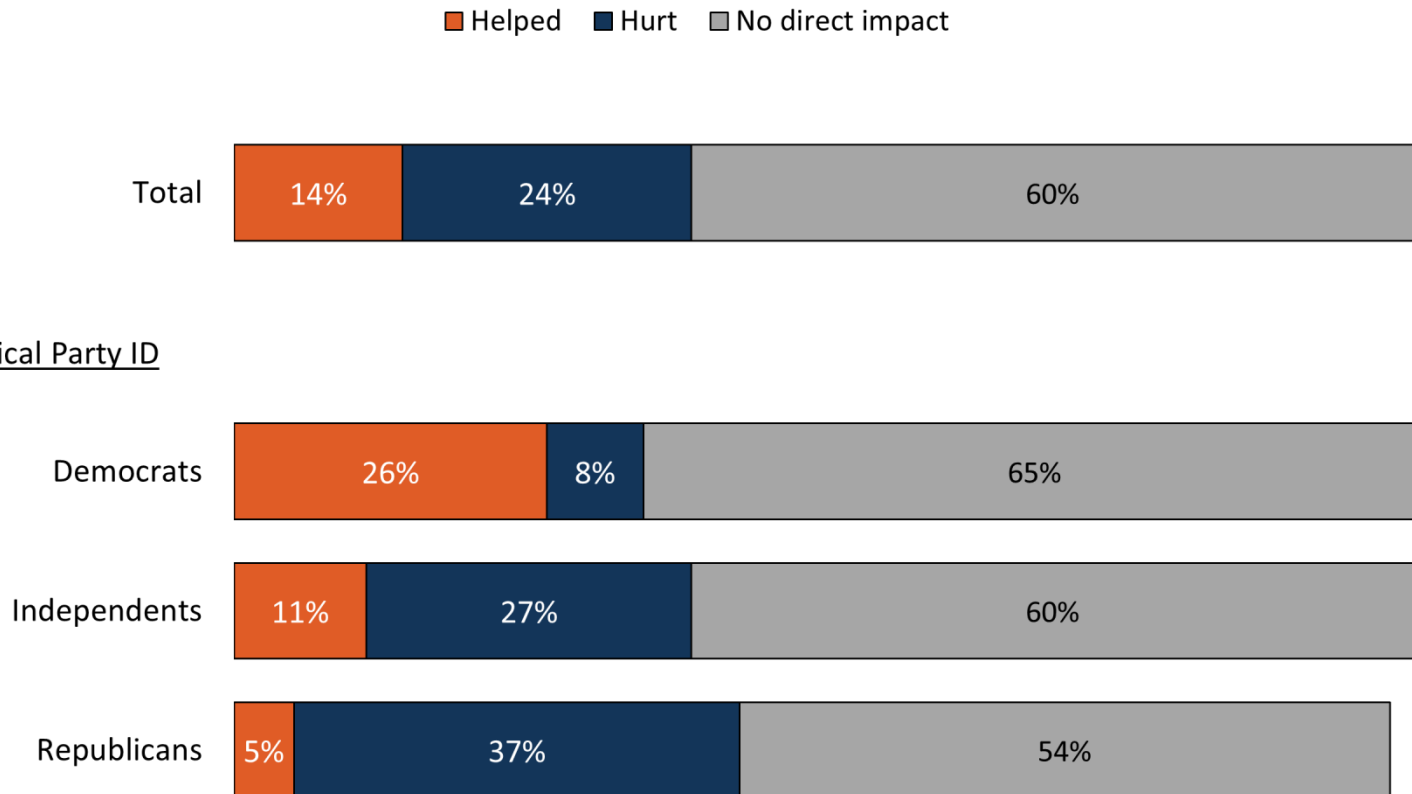
NOTE: "Opponents should leave the law as is (VOL.)" and "Neither of these/opponents should do something else (VOL.)" responses not shown
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted January 14-21, 2014)

RESULTS OF MAY 2014 KAISER POLL

- Most Americans do not feel personally impacted by the law
- Those who say they have felt an impact, more feel they have been harmed than helped by the law
- Republicans more likely say they have been hurt & Democrats more likely say they have been helped
- More continue to want Congress to work on improving the law than repealing it, with those who want improvements calling for lower health care costs, expanded access, and more help for specific populations

Most Report No Direct Impact From ACA; Democrats More Likely to Feel Helped, Republicans More Likely to Feel Hurt

So far, would you say the health care law has directly (helped) you and your family, directly (hurt) you and your family, or has it not had a direct impact?



NOTE: Both helped and hurt (VOL.) and Don't know/Refused answers not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted May 13-19, 2014)

ACA'S OFFICIAL NAME

Official name for "ObamaCare" is the *Patient Protection and Affordable Care Act (PPACA)*. It is also commonly referred to as Obama care, health care reform, or the Affordable Care Act (ACA).

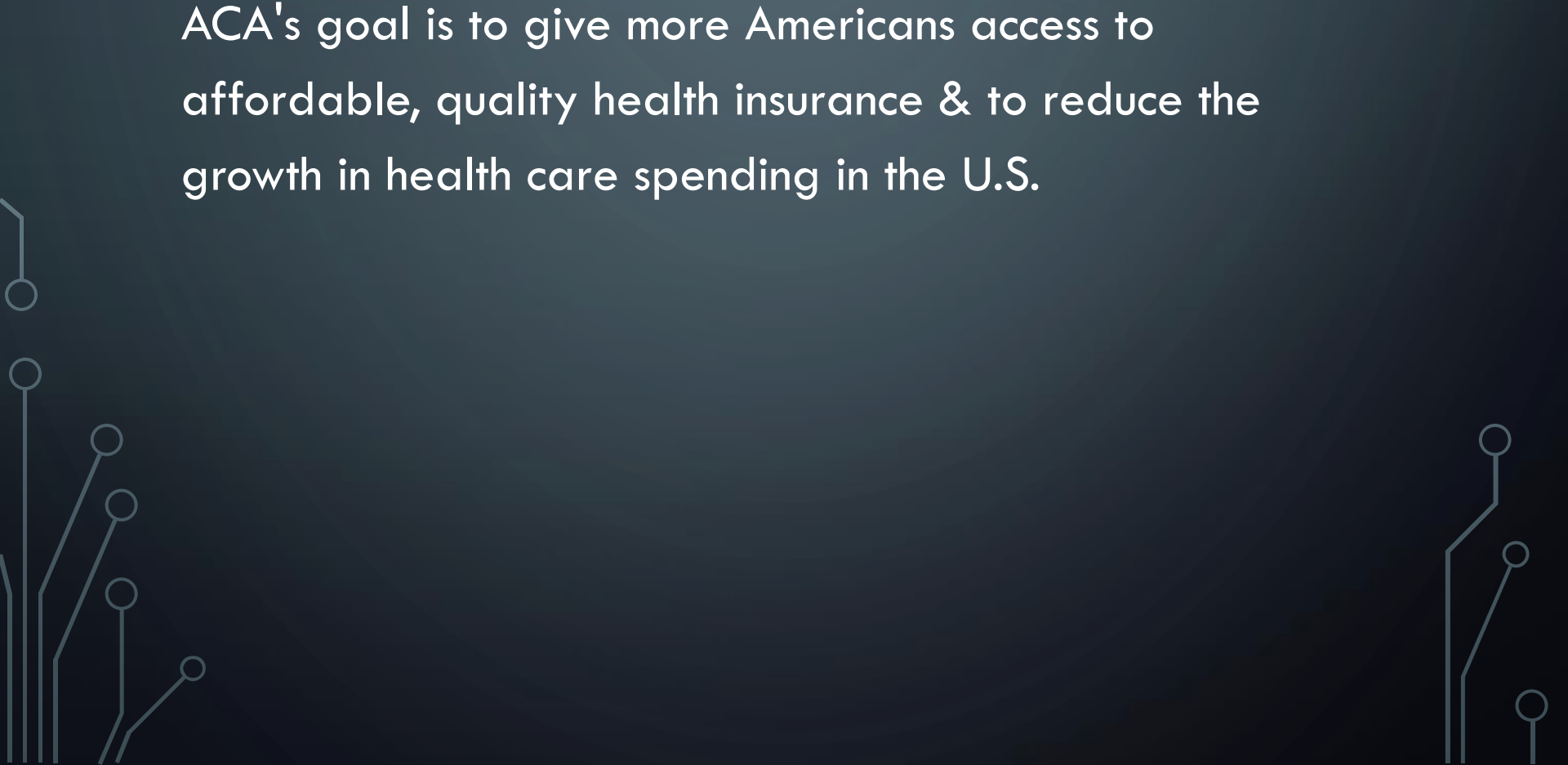
WHEN DID IT BECOME LAW!

- The ACA was signed into law to reform the health care industry by President Barack Obama on March 23, 2010 & upheld by the supreme court on June 28, 2012
- The ACA is "the law of the land"
- Many people had wanted it to be repealed but most are now willing to accept it & refine it



WHAT IS THE GOAL OF ACA

ACA's goal is to give more Americans access to affordable, quality health insurance & to reduce the growth in health care spending in the U.S.



HOW MANY HAVE SIGNED UP FOR ACA

Eligible:

USA: 28,605,000

Florida: 2,545,000

Selected a Plan in Marketplace

USA: 8,019,763 Percentage of Eligible: 28%

Florida: 983,775 Percentage of Eligible: 38.70%

Based on data from Health Insurance Marketplace: Total Enrollment Report, October 1, 2013 – April 19, 2014. Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS) and State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act, Kaiser Family Foundation, November 5, 2013.

<http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-marketplace-eligible-population-2/>

WHAT DOES ACA DO?

- ACA expands the affordability, quality & availability of private & public health insurance through consumer protections, regulations, subsidies, taxes, insurance exchanges & other reforms.
- It does not replace private insurance, Medicare or Medicaid
- It does not regulate health care, it regulates health insurance & some of the worst practices of the for-profit health care industry

WHAT'S THE INDIVIDUAL MANDATE?

Most Americans will have to buy insurance by 2014

- Exempted are those covered by: Medicaid, CHIP (Children's Medicaid Program), Medicare, TRICARE & COBRA

The rest have the option to

- buy private insurance
- obtain insurance through the workplace
- pay a small tax to not have health insurance (mandate)
- buy private insurance through State Health Insurance Exchanges or National Health Exchange like in Florida

HOW ARE SENIORS AFFECTED BY ACA?

- Seniors greatly benefit from the \$716 billion of wasteful spending cut from Medicare & closing of the donut hole
- Money saved is being reinvested in Medicare & ACA to improve coverage & insure tens of millions of more seniors. Medicare parts A, B, C and D have all been changed almost all for the better

BEHAVIORAL HEALTH CARE REQUIREMENTS ON HOSPITALS

- ACA's new Medicare Value-Based Purchasing Program means hospitals can lose or gain up to 1% of Medicare funding based on a quality v. quantity system
- Hospitals are graded on a number of quality measures related to treatment of patients with heart attacks, heart failures, pneumonia, certain surgical issues, re-admittance rate, as well as patient satisfaction

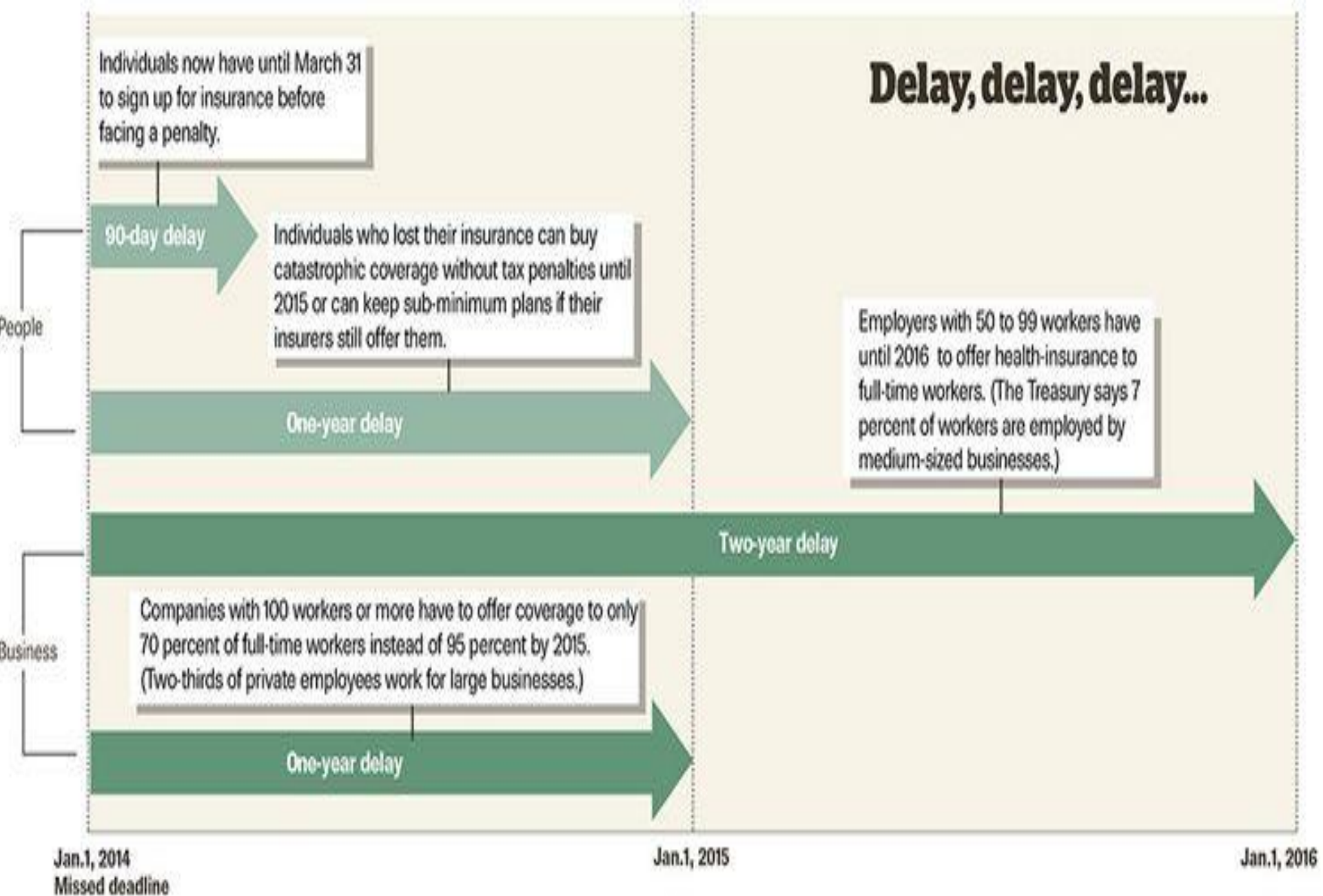
RIGHTS & PROTECTIONS UNDER THE ACA

- Better access to preventive services
- Expanded coverage to millions saving countless lives
- Ensures people can't be denied for preexisting conditions
- Stops insurance companies from dropping people when they are sick
- Lets young adults stay on parents plans until 26
- Regulates insurance premium hikes
- Monitors & approves appeals process

CHANGES IN ACA REGULATIONS SINCE ITS INITIAL ROLL OUT IN OCTOBER 2013

- Deadline extended for individuals to March 31, 2014
- Those who lost their insurance have until 2015 to get catastrophic coverage or keep sub-minimum plans if still offered by their insurance companies
- Full-time workers who work for companies with 50-99 employees must be offered job based health coverage by 2016.
- Large Businesses with 100 or more employees have until 2015 to have 70% of their employees covered instead of 95% covered
- New Enrollment Period: November 15, 2014-February 15, 2015

Delay, delay, delay...



Jan. 1, 2014
Missed deadline

Jan. 1, 2015

Jan. 1, 2016

Note: The Affordable Care Act has generally never required employers with fewer than 50 workers to offer insurance.

Source: Times resource

Times

STATE'S HEALTH INSURANCE EXCHANGE/ MARKETPLACES

ACA exchanges are state or federal run (depends on the state) online marketplaces where health insurance companies compete to be people's providers.

Getting insurance through the marketplace is done by applying for a plan, finding out if one qualifies for subsidies & then comparing competing health plans

A State's "Exchange" is commonly referred to as "Health Insurance Marketplace"

1. ACA OFFERS NEW BENEFITS, RIGHTS & PROTECTIONS

- Provision that let young adults stay on their families' plans until 26
- Stops insurance companies from dropping people when they are sick or if they make an honest mistake on their application
- Prevents against gender discrimination
- Stops insurance companies from making unjustified rate hikes

2. ACA OFFERS NEW BENEFITS, RIGHTS & PROTECTIONS

- Does away with life-time & annual limits
- Give people the right to a rapid appeal of insurance company decisions
- Expands coverage to tens of millions
- Subsidizes health insurance costs
- Requires all insurers to cover people with pre-existing conditions

10 ESSENTIAL HEALTH BENEFITS GUARANTEED BY ACA

1. Ambulatory Patient Care
2. Emergency Care
3. Hospitalization
4. Prescription Drugs
5. Maternity & Newborn Care
6. Mental Health Services & Addiction Treatment
7. Rehabilitative Services & Devices
8. Laboratory Services
9. Preventive services, wellness services & Chronic Disease Treatment
10. Pediatric Services

ESSENTIAL HEALTH BENEFITS GUARANTEED BY ACA & BEHAVIORAL MEDICINE WILL BE ON PARITY WITH PHYSICAL MEDICAL

The 2008 Mental Health Parity and Addictions Equity Act applies to individual plans as well as small group plans – a provision that was inserted into the ACA law as an amendment by Senator Debbie Stabenow (D-MI) during the health reform debate

ADULT PREVENTION SERVICES

- ***Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- ***Alcohol Misuse screening and counseling**
- ***Blood Pressure screening** for all adults
- ***Colorectal Cancer screening** for adults over 50
- ***Depression screening** for adults
- ***Diabetes (Type 2) screening** for adults with high blood pressure
- ***Diet counseling for adults** at higher risk for chronic disease
- *HIV screening for everyone ages 15 to 65, and other ages at increased risk
- ***Obesity screening and counseling** for all adults
- ***Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
- ***Syphilis screening for all adults** at higher risk
- ***Tobacco Use screening for all adults** and cessation interventions for tobacco users
- *Opportunities for CMHC's to provide behavioral medicine interventions

WOMEN'S PREVENTION SERVICES

- * **Abdominal Aortic Aneurysm one-time screening** for women of specified ages who have ever smoked
- * **Alcohol Misuse screening and counseling**
- * **Blood Pressure screening** for all adults
- * **Colorectal Cancer screening** for adults over 50
- * **Depression screening** for adults
- * **Diabetes (Type 2) screening** for adults with high blood pressure
- * **Diet counseling** for adults at higher risk for chronic disease
- * **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
- * **Obesity screening and counseling** for all adults
- * **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
- * **Syphilis screening** for all adults at higher risk
- * **Tobacco Use screening** for all adults and cessation interventions for tobacco users
- * **Opportunities for CMHC's to provide behavioral medicine interventions**

CHILD PREVENTION SERVICES

- ***Autism screening** for children at 18 and 24 months
- ***Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- ***Depression screening** for adolescents
- ***Developmental screening** for children under age 3
- ***Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- ***Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years ,11 to 14 years , 15 to 17 years.
- ***Obesity screening and counseling**
- ***Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
- ***Vision screening** for all children.
- ***Opportunities for CMHC's to provide behavioral medicine interventions**

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WITH THE ACA, THINGS ARE GOING TO CHANGE!

The emerging health needs of Americans is changing and as a result the roles and function of mental health practitioners will be changing as well due to the Affordable Care Act

1. THE IMPLICATIONS OF THE AFFORDABLE CARE BEHAVIORAL MEDICINE INTERVENTIONS

1. ACA calls for the coordination and integration of medical services through the primary care provider for a “whole person orientation” to medical treatment - model currently implemented at some level in VA & Federally Qualified Health Centers (FQHC’s)

2. The ACA calls for creation of Affordable Care Organizations (ACO’s) to provide comprehensive services to Medicare recipients with a strong primary care basis

2. THE IMPLICATIONS OF THE AFFORDABLE CARE BEHAVIORAL MEDICINE INTERVENTIONS

3. The ACA model includes integration of mental & behavioral health services into the Patient-centered medical home (PCMH) which can enhance patient outcomes

4. The ACA model integrates mental, behavioral and medical services under one roof with potential of controlling the costs for patients

3. THE IMPLICATIONS OF THE AFFORDABLE CARE BEHAVIORAL MEDICINE INTERVENTIONS

5. The ACA integrated behavioral medical approach opens a massive opportunity for clinical mental health counselors
6. To be prepared to fill this evolving behavioral medicine role, it is imperative that clinical mental health counseling training programs establish training for future practitioners in these integrated medical settings.

4. THE IMPLICATIONS OF THE AFFORDABLE CARE BEHAVIORAL MEDICINE INTERVENTIONS

7. Beginning 2014 ACA increased access to quality health care including coverage for mental health & substance use disorder services

8. All new small group & individual private market plans are required to cover mental health & substance use disorder services as part of the health care law's "Essential Health Benefits" categories

5. THE IMPLICATIONS OF THE AFFORDABLE CARE BEHAVIORAL MEDICINE INTERVENTIONS

9. Behavioral health benefits are covered at parity with medical & surgical benefits

10. Insurers will no longer be able to deny anyone coverage because of a pre-existing medical or behavioral health condition

11. ACA ensures that new health plans cover recommended preventive benefits without cost sharing, including depression screening for adults & adolescents as well as behavioral assessments for children

1. ADDITIONAL RESULTS OF THE ACA

1. Primary care providers receive 10% Medicare bonus payment for primary care services

2. A new Medicaid state option was created to permit certain Medicaid enrollees to designate a provider as a health home & states taking up the option receive 90% federal matching payments for two years for health home-related services.

[Unfortunately 24 states did not accept this Medicaid State Option]

3. Small employers receive grants for up to five years to establish wellness programs

2. ADDITIONAL RESULTS OF THE ACA

4. The Center for Medicare & Medicaid Innovation launches the Accountable Care Organization (ACO) Model & Advance Payment ACO Model, which offers shared savings & other payment incentives for selected organizations that provide efficient, coordinated, patient-centered care

5. Some States established American Health Benefit Exchanges & Small Business Health Options Program Exchanges to facilitate purchase of insurance by individuals & small employers

6. Teaching Health Centers are established to provide payments for primary care residency programs in community-based ambulatory patient care centers

TWO HEALTHCARE ORGANIZATIONAL MODELS WHICH ARE DRIVING CHANGE

Two New Medicare/Medicaid models are driving a change in healthcare delivery:

1. Patient Centered Medical Homes (PCMH)
2. Accountable Care Organizations (ACO's)

1. HISTORY OF PCMH

- The patient-centered medical home is not a new concept it has evolved to define a model of primary care excellence
- 1967 “Medical Home” first use in 1967 by the American Academy of Pediatrics
- 1978 the World Health Organization support principle of primary care
- 1996 The Institute of Medicine (IOM) redefined primary care close to PCMH model
- 2002 Family Medicine promotes Medical Homes
- 2005 Research on Primary Care promotes PCMH concepts
- 2006 (A) American College of Physicians adopts Patient Center Physician Guided model of health care (B) Patient Centered Primary Care Collaboration (PCPCC) is founded
- 2007 Major Primary Care Physician Associations endorse joint Principles of Patient-Centered Medical Home
- 2008 Medical Home accreditation began and 65 community health centers in five state transform into PCMH

2. HISTORY OF PCHM

- 2010 ACA includes numerous provisions for enhancing primary care and medical homes
- 2011 (A) Primary care providers receive a 10% Medicare bonus payment for primary care services. (B) new Medicaid state option is created to permit certain Medicaid enrollees to designate a provider as a health home (C) Small employers receive grants for up to five years to establish wellness programs. (D) The CMHO launches the Pioneer Accountable Care Organization (ACO) Model and Advance Payment ACO Model (E) States begin establishing of American Health Benefit Exchanges and Small Business Health Options Program Exchanges, which facilitate the purchase of insurance by individuals and small employers. (F) Teaching Health Centers are established to provide payments for primary care residency programs in community-based ambulatory patient care centers.

3. HISTORY OF PCMH'S

- 2012 47 states have adopted policies and programs to advance the medical home
- 2013 Thanks to ACA
 - (A) some states now operate their own health insurance marketplaces
 - (B) Providers receive 1% point increase in federal matching payments for preventive services
 - (C) Essential Health Benefits in health insurance marketplaces include prevention, wellness and chronic disease management

PATIENT CENTERED MEDICAL HOMES OBJECTIVES ARE

- 1. Patient Centered** - Empowers patients with Information and Understanding
- 2. Comprehensive** - Co-location of care providers in physical and behavioral health
- 3. Coordinated Care** - Through Health Information Technology all providers are kept in touch
- 4. Accessible** – same day appointment & 24/7 availability through technology online
- 5. Committed to Quality & Safety** – Quality Improvement Goals which are tracked

BENEFITS OF PATIENT CENTERED MEDICAL HOMES

1. Patients seek out the right care which is needed-which is often behavioral vs. physical
2. Less use of ER's or delays in seeking care
3. Less duplication of tests, labs & procedures
4. Better control of chronic diseases & other illnesses improving health outcomes
5. Focus on wellness & prevention – reduce incidence & severity of chronic disease or illnesses
6. Cost savings less use of ER's & Hospitals

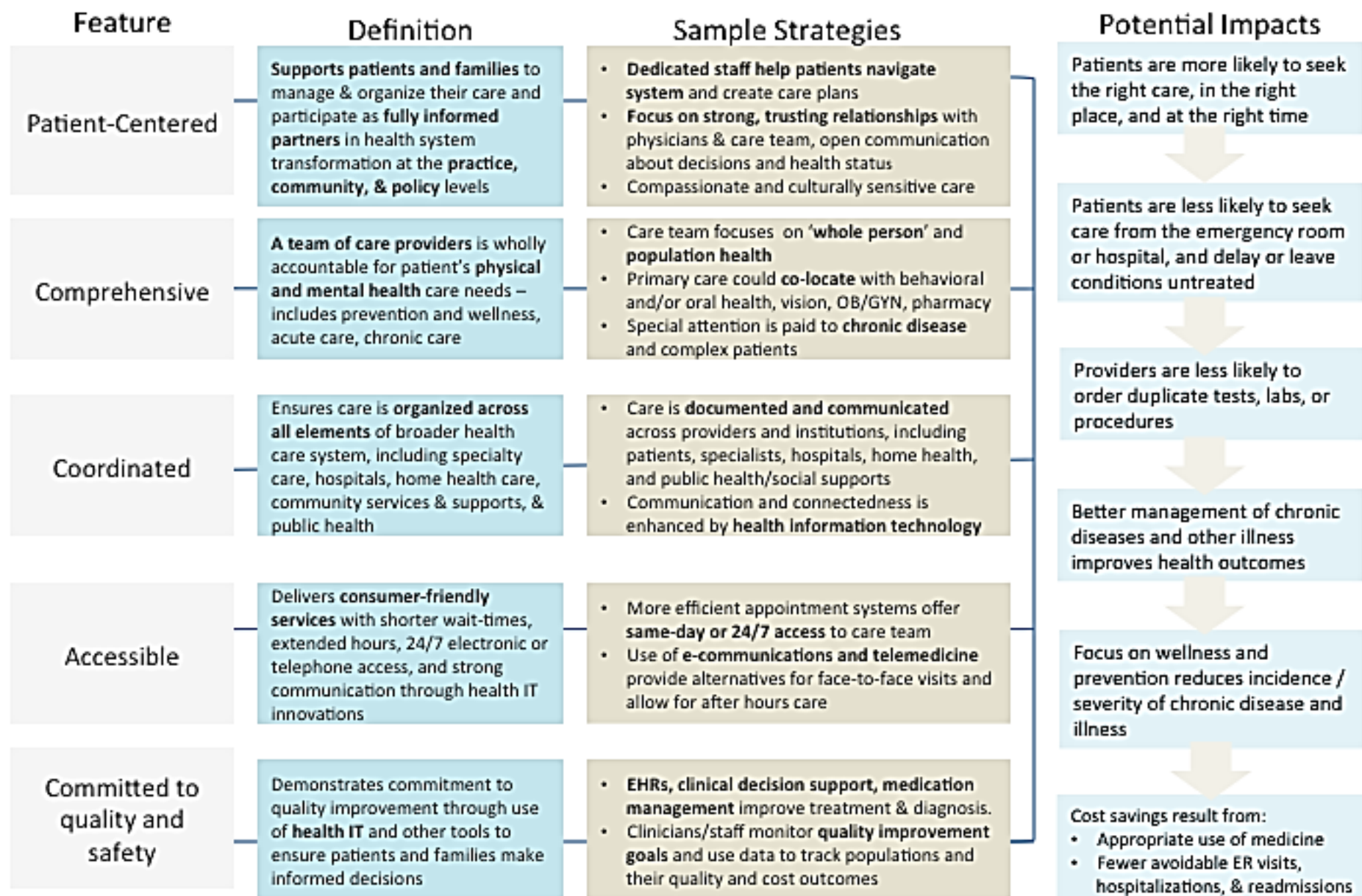
WHAT IS MOVING THE PATIENT CENTERED HOME HEALTH MODEL

In April 2013 the Patient-Centered Primary Care Collaborative Pointed out on it website these factors driving the Home Health Model

1. Unsustainable cost increases in health care delivery
2. Growing availability of data
3. Vast change in the way we communicate

Example: In Denmark, more than 80 percent of health-care encounters & transactions are electronically based & vastly different method of communicating is coming online and it's coming fast, driven by younger generations of patients and physicians.

Why the Medical Home Works: A Framework



PRIMARY AND BEHAVIORAL HEALTH INTEGRATION GRANTS BASED ON MEDICAL HOME MODEL IN ACA

In Florida:

1. Apalachee Center—Tallahassee
2. Community Rehabilitation Center-Jacksonville
3. LifeStream Behavioral Center-Leesburg
4. Lakeside Behavioral Center—Orlando
5. Coastal Behavioral Health Care-Sarasota
6. Miami Behavioral Health Center-Miami

ACCOUNTABLE CARE ORGANIZATIONS

Have a look at the CMS video which overviews the ACO model:

<https://www.youtube.com/watch?v=MZaa1QROQAUor>

Let's see how a Care Case Manager helps an ACO be productive for their patients

<https://www.youtube.com/watch?v=9t5SDPfu5Kk>

GOAL OF ACO'S

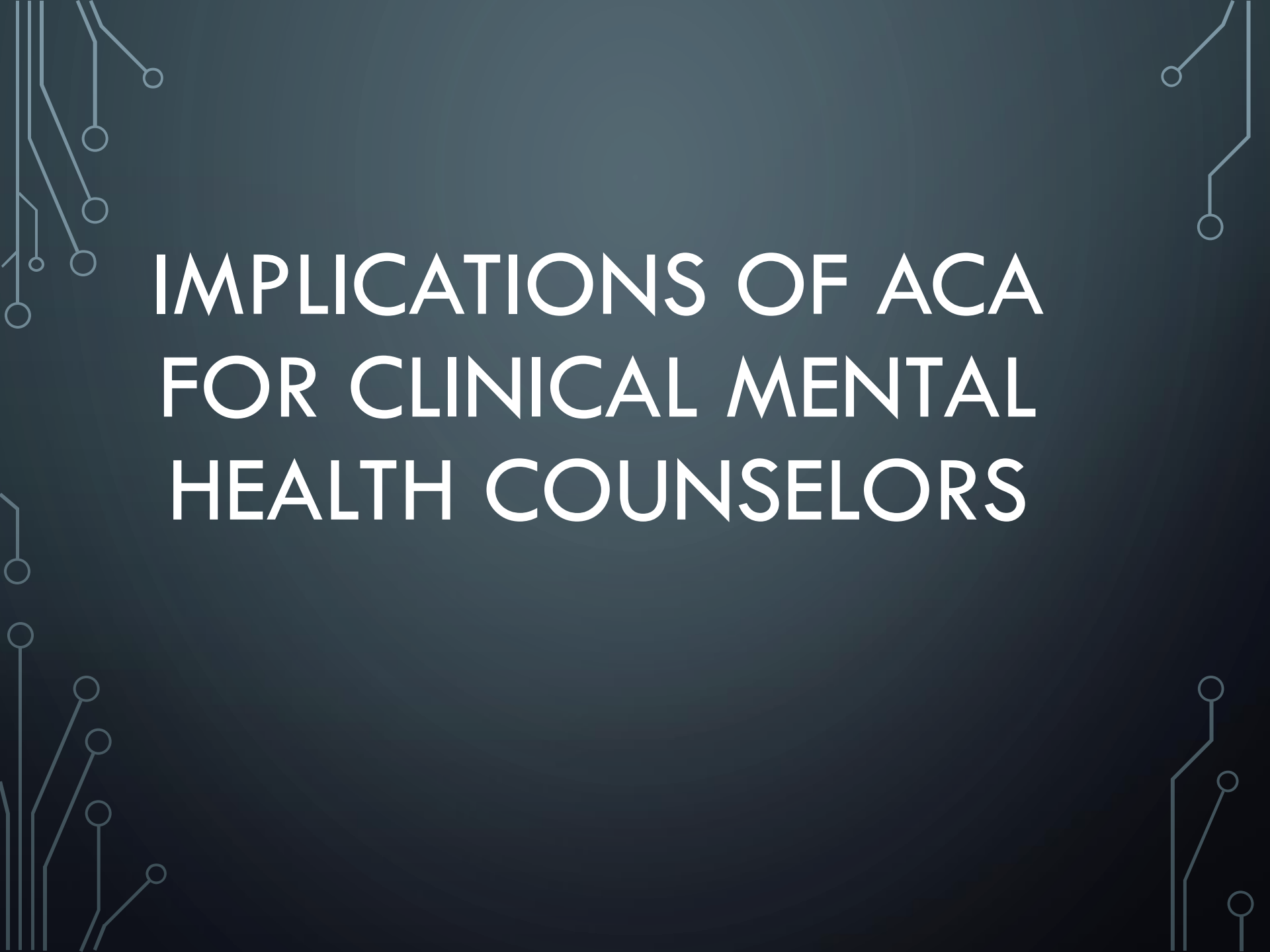
The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

SO WHAT ARE ACO'S

1. ACO assumes financial risk rather than 3rd party payers (government, business or insurance companies) for group of patients assigned to it
2. Consists of more than one hospital & number of primary care clinics with full array of medical & health specialists-who self-refer to their own specialists
3. Control costs by being responsible for full care of patients
4. Integration of mental & behavioral health services into Patient-centered medical homes
5. Enhance patient outcomes through emphasis on prevention, compliance, and immediate 24/7 attention
6. Utilize an integrated behavioral medical approach

ACO'S CURRENTLY IN FLORIDA

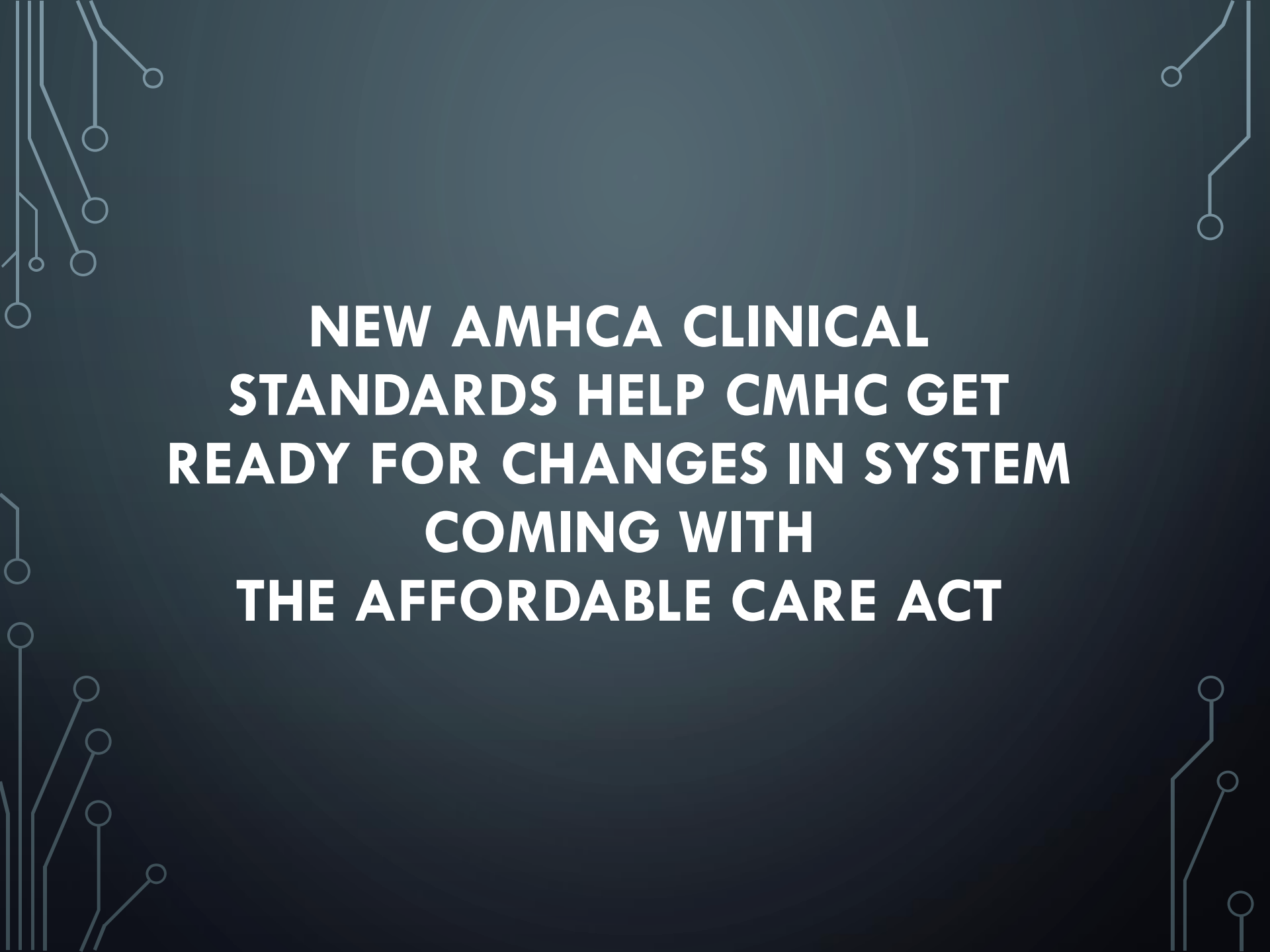
1. Physicians Collaborative Trust ACO LLC Maitland
2. Primary Partners ACIP LLC Clermont Primary Partners, LLC Clermont, Operating in Lake, Orange, Osceola & Polk counties
3. Reliance Healthcare Management Solutions Tampa
4. Accountable Care Partners ACO, LLC Jacksonville
5. Central Florida Physicians Trust Winter Park
6. Nature Coast ACO, LLC Beverly Hills
7. American Health Alliance Ocala
8. Northeast Florida Accountable Care Jacksonville
9. Orlando Regional Medical Center and Florida Blue
10. JSA Healthcare-In all counties in Florida (my doctor's office is a member of this larger statewide group)

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IMPLICATIONS OF ACA FOR CLINICAL MENTAL HEALTH COUNSELORS

POTENTIAL ROLE OF MENTAL HEALTH COUNSELORS UNDER THE ACA

- Conduct Depression, Anxiety & MH Assessments
- Address the stressors which lead folks to seek out medical attention in the first place
- Assist in increasing compliance of patients with the medical directives given them by primary care staff
- Wellness educational programming to help ward off chronic or severe illnesses
- Assisting clients to cope with the medical conditions for which they are receiving medical attention

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**NEW AMHCA CLINICAL
STANDARDS HELP CMHC GET
READY FOR CHANGES IN SYSTEM
COMING WITH
THE AFFORDABLE CARE ACT**

AMHCA'S 2011 EXPANDED CLINICAL STANDARDS FOR TRAINING OF CMHC'S INCLUDE THESE ACA RELATED FACTORS

1. Evidenced-Based Practices

- a. Diagnosis and Treatment Planning using EBP's
- b. Diagnosis of Co-Occurring Disorders & Trauma

2. Biological Basis of Behaviors

- a. Knowledge of Central Nervous System
- b. Lifespan Plasticity of the Brain

3. Psychopharmacology

4. Behavioral Medicine

- a. Neurobiology of Thinking, Emotion & Memory
- b. Neurobiology of mental health disorders (mood, anxiety, psychosis) over life span
- c. Promotion of optimal mental health over the lifespan

POTENTIAL CLINICAL SETTING OPENINGS FOR CMHC'S WITH ACA IMPLEMENTATION

Clinical Mental Health Counselors will be ideally situated to provide Behavioral Medical Interventions based on their expanded training and implementation of AMHCA's Clinical Standards. They will then need to promote themselves in the following settings:

- PCMH's and ACO's
- General Practice: Family Practice & Internal Medicine Clinics
- Rehabilitation In-patient and out-patient Centers
- General and Specialized Hospitals
- Senior Citizen's Independent housing, Assisted Living & Nursing Homes

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WHAT COMPETENCIES ARE NEEDED TO DO WORK IN INTEGRATED MEDICAL SETTINGS?

WHAT IS THE FEDERAL (SAMHSA) STANDARD FOR INTEGRATED MEDICAL CARE?

3 distinct levels of integrated care:

1. Coordinated Care

- Level 1: Minimal Collaboration
- Level 2: Basic Collaboration at a distance

2. Co-located Care

- Level 3: Basic Collaboration on site
- Level 4: Close Collaboration with some System Integration

3. Integrated Care

- Level 5: Close Collaboration Approaching an Integrated Practice
- Level 6: Full Collaboration in a Transformed/Merged Practice

WHAT IS THE ROLE OF A BEHAVIORAL HEALTH CARE PROVIDER?

Principles of the Integrated Medical Model:

Principle #1: The Behavioral Health Consultant's role is to identify, treat, triage & manage primary care patients with medical and/or behavioral health problems

Principle #2: The Behavioral Health Consultant functions as a core member of primary care team, providing consultative services

Principle #3: The Primary Care Behavioral Health Model is grounded in a population-based care philosophy

Principle #4: The Behavioral Health Consultant seeks to enhance delivery of behavioral health services at primary care level & works to support smooth interface between primary care & specialty services (Mental Health & Substance Abuse Treatment).

A TOOLKIT IDENTIFIES COMPETENCIES NEEDED IN INTEGRATED MEDICINE?

Primary Care Behavioral Health Toolkit (Mountainview Consulting Group, 2013)

This manual provides both institutional & individual practitioner self-assessments for readiness for integrated primary care behavioral health

You can download this kit at:

http://www.pcpci.org/sites/default/files/resources/PCBH%20Implementation%20Kit_FINAL.pdf

RESPONSIBILITIES OF BEHAVIORAL HEALTH CONSULTANTS

Behavioral Health Consultant (PHC) in Primary Care Behavioral Health (PCBH) has following role:

BHC role is a behavioral health provider who:

- 1) Operates in consultative role within primary care team utilizing PCBH Model
- 2) Provides recommendations regarding behavioral interventions to referring Primary Care Clinician (PCC)
- 3) Conducts brief interventions with referred patients on behalf of referring Primary Care Clinician PCC

PCPCI Toolkit identifies responsibilities of a Behavioral Health Consultant as:

1. Maintains visible presence to PCCs during clinic operating hours
2. Is available for “curbside” consultation (a brief interaction between PCB & PCC) by being in clinic or available by phone or pager
3. Is available for same day & scheduled initial consultations with patients referred by PCCs
4. Performs brief, limited follow-up visits for selected patients
5. Provides a range of services including screening for common conditions, assessments & interventions related to chronic disease management programs
6. Conducts risk assessments, as indicated
7. Provides psycho-education for patients during individual & group visits

8. Assists in development of clinical pathway programs, group medical appointments, classes & behavior focused practice protocols.

9. Provides brief behavioral & cognitive behavioral interventions for patients

10. Triage patients with severe or high-risk behavioral problems to CBHS or other community resources for specialty MH services consistent with Step-up/Step-down criteria

11. Provides PCCs with same-day verbal feedback on client encounters either in person or by phone

12. Facilitates & oversees referrals to specialty MH / SA services & when appropriate, support a smooth transition from specialty MH / SA services to primary care & supports collaboration of PCCs & psychiatrists concerning medication protocols

Read more about within the Primary Care Behavioral Health Toolkit available at:

http://www.pccpi.org/sites/default/files/resources/PCBH%20Implementation%20Kit_FINAL.pdf

AMERICAN HOSPITAL ASSOCIATION (AHA) POSTED A MODEL

The recommendations for *Workforce Roles in a Redesigned Primary Care Model* in 2013 on their website at: <http://www.aha.org/content/13/13-0110-wf-primary-care.pdf>

Their overall recommendations for all health care professional workforce is: They need to be educated within the context of inter-disciplinary clinical learning teams.

Their overall recommendation a Primary Care Delivery Model is:

- Primary health care should be centered around the patient and family in a user-driven design, in all aspects of practice.
- Hospitals should evolve from traditional “hospitals” to “health systems,” partnering with community organizations and patients in order to advance the community’s wellness and health needs.
- Hospitals, or health systems, can serve as catalysts for linking and integrating the various components of health and wellness together for patients in a way that provides a sustainable infrastructure of health care for patients and the community.
- In order to mitigate rising health care costs, a fundamental shift in reimbursement will need to occur

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Importance of Behavioral Medicine under the ACA

DEFINITION OF BEHAVIORAL MEDICINE

Behavioral Medicine is the interdisciplinary field concerned with the development and the integration of behavioral, psychosocial, and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation.

(Definition is provided by Society of Behavioral Medicine on their website at: <http://www.sbm.org/about>)

INTEGRATED BEHAVIORAL MEDICINE SPECIALTY FOCUS IN DSM-5

- Neurocognitive Disorders
- Hormonal Imbalances
- Cardiovascular Health Conditions
- Respiratory Difficulties
- Chronic Health Conditions
- Cancers: Bladder, Breast, Colon, Rectal, Uterine-Ovarian, Kidney, Leukemia, Lung, Melanoma, Non-Hodgkin Lymphoma, Pancreatic, Prostate, Thyroid

RULE OF THUMB IN DIAGNOSING MEDICALLY RELATED CONDITIONS

First: Put in the ICD code for the Medical Condition

Second: Put in the mental health disorder related to the Medical Condition

SCHIZOPHRENIA & PSYCHOTIC DISORDER CO-OCCURRING WITH MEDICAL CONDITION

- 293.81 (F06.2) Psychotic Disorder due to Another Medical Condition with delusions
- 293.82 (F06.0) Psychotic Disorder due to Another Medical Condition with hallucinations
- 293.89 (F06.1) Catatonic Disorder Associated with Another Medical Condition
- 293.89 (F06.1) Catatonic Disorder Due to Another Medical Condition

BIPOLAR CO-OCCURRING WITH MEDICAL CONDITION

- 293.83 (F06.33) Bipolar and Related Disorder due to Another Medical Condition with manic features
- 293.83 (F06.33) Bipolar and Related Disorder due to Another Medical Condition with manic-or hypomanic-like episode
- 293.83 (F06.34) Bipolar and Related Disorder due to Another Medical Condition with mixed features

DEPRESSIVE DISORDER CO-OCCURRING WITH MEDICAL CONDITION

- 293.83 (F06.31) Depressive Disorder Due to Another Medical Condition with depressive features
- 293.83 (F06.32) Depressive Disorder Due to Another Medical Condition with major depressive-like episodes
- 293.83 (F06.34) Depressive Disorder Due to Another Medical Condition with mixed features

The background is a dark blue gradient. In the corners, there are decorative white lines that resemble a circuit board or a network diagram, with small circles at the end of the lines.

ANXIETY DISORDER CO-OCCURRING WITH MEDICAL CONDITION

293.84 (F06.4) Anxiety Disorder Due to Another Medical
Condition

OBSESSIVE-COMPULSIVE CO-OCCURRING WITH MEDICAL CONDITION

294.8 (F06.8) Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

Specify if with obsessive-compulsive-disorder-like symptoms or with appearance preoccupation or with hoarding symptoms or with hair-pulling symptoms or with skin picking symptoms

SOMATIC SYMPTOM & RELATED DISORDERS

- 300.82 (F45.1) Somatic Symptom Disorder
- 300.7 (F45.21) Illness Anxiety Disorder Conversion Disorders (Functional Neurological Symptoms Disorder)
- 300.11 (F44.4) Conversion Disorder with weakness or paralysis
- 300.11 (F44.4) Conversion Disorder with abnormal movement
- 300.11 (F44.4) Conversion Disorder with swallowing symptoms
- 300.11 (F44.4) Conversion Disorder with speech symptoms
- 300.11 (F44.5) Conversion Disorder with attacks or seizures
- 300.11 (F44.6) Conversion Disorder with anesthesia or sensory loss
- 300.11 (F44.6) Conversion Disorder with special sensory symptom
- 300.11 (F44.7) Conversion Disorder with mixed symptoms
- 316 (F54) Psychological Factors Affecting Medical Condition
- 300.19 (F68.10) Factitious Disorder (includes Factitious Disorder Imposed on Self, Factitious Disorder imposed on Another)
- 300.89 (F45.8) Other Specified Somatic Symptom and Related Disorder
- 300.82 (F45.9) Unspecified Somatic Symptom and Related Disorder

FEEDING & EATING DISORDERS

- 307.52 (F98.3) Pica in Children
- 307.52 (F50.8) Pica in Adults
- 307.53 (98.21) Rumination Disorder
- 307.59 (50.8) Avoidant/Restrictive Food Intake Disorder
- 307.1 (F50.01) Anorexia Nervosa Restricting type
- 307.1 (F50.02) Anorexia Nervosa Binge-eating/purging type
- 307.51 (F50.2) Bulimia Nervosa
- 307.59 (F50.8) Other Specified Feeding or Eating Disorder
- 307.50 (F50.9) Unspecified Feeding or Eating Disorder

ELIMINATION DISORDERS

- 307.6 (F98.0) Enuresis
- 307.7 (F98.1) Encopresis
- 788.39 (N39.498) Other Specified Elimination Disorder with urinary symptoms
- 787.60 (R15.9) Other Specified Elimination Disorder with fecal symptoms
- 788.30 (R32) Unspecified Elimination Disorder with urinary symptoms
- 787.60 (R15.9) Unspecified Elimination Disorder with fecal symptoms

SLEEP-WAKE DISORDERS

- 780.52 (G47.00) Insomnia Disorder
- 780.54 (G47.10) Hypersomnolence Disorder
- 347.00 (G47.419) Narcolepsy without Cataplexy but with hypocretin deficiency
- 347.01 (G47.411) Narcolepsy with Cataplexy but without hypocretin deficiency
- 347.00 (G47.419) Autosomal dominant cerebellar ataxia, deafness, and narcolepsy
- 347.00 (G47.419) Autosomal dominant narcolepsy, obesity and type 2 diabetes
- 347.10 (47.429) Narcolepsy secondary to another medical condition

Breathing-Related Sleep Disorders

327.23 (G47.33) Obstructive Sleep Apnea Hypopnea

Central Sleep Apnea

- 327.21 (G47.31) Idiopathic Sleep Apnea
- 786.04 (R06.3) Cheyne-Stokes Breathing
- 780.57 (G47.37) Central Sleep Apnea comorbid with opioid use (first code opioid use disorder if present.)

Sleep-Related Hyperventilation

- 327.24 (G47.34) Idiopathic hypoventilation
- 327.25 (G47.35) Congenital central alveolar hypoventilation
- 327.26 (G47.36) Comorbid sleep-related hypoventilation

Circadian Rhythm Sleep-Wake Disorders

- 307.45 (G47.21) Circadian Rhythm Sleep-Wake Disorder
Delayed sleep phase type
- 307.45 (G47.22) Circadian Rhythm Sleep-Wake Disorder
Advanced sleep phase type
- 307.45 (G47.23) Circadian Rhythm Sleep-Wake Disorder
Irregular sleep-wake type
- 307.45 (G47.24) Circadian Rhythm Sleep-Wake Disorder Non-24
hour sleep-wake type
- 307.45 (G47.26) Circadian Rhythm Sleep-Wake Disorder Shift
Work type

Parasomnias

- 307.46 (F51.3) Non-Rapid Eye Movement Sleep Arousal Disorder Sleepwalking Type *Specify if: With sleep-related eating; With sleep-related sexual behavior (Sexsomnia)*
- 307.46 (F51.4) Non-Rapid Eye Movement Sleep Arousal Disorder Sleep terror type
- 307.47 (F51.5) Nightmare Disorder *Specify if: during sleep onset. Specify if: With associated non-sleep disorder; With associated other medical condition; With associated other sleep disorder*
- 327.42 (G47.52) Rapid Eye Movement Sleep Behavior Disorder
- 333.94 (G25.81) Restless Legs Syndrome

SEXUAL DYSFUNCTIONS

- 302.74 (F52.32) Delayed Ejaculation
- 302.72 (F52.21) Erectile Disorder
- 302.73 (F52.31) Female Orgasmic Disorder *Specify if:
Never experienced an orgasm under any situation*
- 302.72 (F52.22) Female Sexual Interest/Arousal Disorder
- 302.76 (F52.6) Genito-Pelvic Pain/Penetration Disorder
- 302.71 (F52.0) Male Hypoactive Sexual Desire Disorder
- 302.75 (F52.4) Premature (Early) Ejaculation

FOCUS OF BEHAVIORAL MEDICINE

Life-span approach to health & health care for:

- Children
- Teens
- Adults
- Seniors
- In racially and ethnically diverse communities

DESIRED IMPACT OF BEHAVIORAL MEDICINE

- **Changes in behavior and lifestyle can**
- Improve health
- Prevent illness
- Reduce symptoms of illness
- **Behavioral changes can help people:**
- Feel better physically and emotionally
- Improve their health status
- Increase their self-care skills
- Improve their ability to live with chronic illness.
- **Behavioral interventions can:**
- Improve effectiveness of medical interventions
- Help reduce overutilization of the health care system
- Reduce the overall costs of care

KEY STRATEGIES OF BEHAVIORAL MEDICINE

- Lifestyle Change
- Training
- Social Support

EXAMPLES OF GOALS OF LIFESTYLE CHANGE

- Improve nutrition
- Increase physical activity
- Stop smoking
- Use medications appropriately
- Practice safer sex
- Prevent and reduce alcohol and drug abuse

EXAMPLES OF TRAINING IN BEHAVIORAL MEDICINE

- Coping skills training
- Relaxation training
- Self-monitoring personal health
- Stress management
- Time management
- Pain management
- Problem-solving
- Communication skills
- Priority-setting

EXAMPLES OF SOCIAL SUPPORT

- Group education
- Caretaker support and training
- Health counseling
- Community-based sports events

AGE RELATED BEHAVIORAL MEDICINE FOCUS

- Children's Health
- Adolescent Health
- Women's Health
- Men's Health
- Aging
- Brain's Neuroplasticity

BABY BOOMER GENERATION ARE AGING

- The increase in Boomers aging and their impact on the medical and mental health field cannot be ignored or underestimated
- It is imperative that CMHC's be armed with Behavioral Medicine techniques to address the needs of this geriatric population to address their chronic health issues, disabilities and cognitive decline needs

WEIGHT MANAGEMENT FOCUS

- Obesity
- Exercise
- Diet
- Nutrition
- Cognitive Approach to Approaching Weight
- Body Image
- Eating Disorders

EMOTIONS RELATED

- Coping with Depression
- Coping with Bipolar Disorder
- Coping with Anxiety
- Coping with Obsessive Compulsive disorder
- Coping with PTSD
- Coping with Panic Disorder

MUSCULAR/SKELETAL RELATED FOCUS

- Arthritis
- Chronic Pain
- Disease-Related Pain
- Low Back Pain
- Myofascial Pain
- Fibromyalgia
- Accident related Pain
- Multiple Sclerosis
- Lupus
- Parkinson's Disease
- ALS

REHABILITATION FOCUS

- Developmental Disability
- Accident Related
- Neurological Condition Related
- Aging Related

PULMONARY RELATED FOCUS

- Asthma
- Allergy
- Cystic Fibrosis
- Pulmonary Disease

ALLERGY RELATED FOCUS

- Seasonal allergies
- Food allergies
- Environmental allergies

CARDIOVASCULAR RELATED FOCUS

- Type A vs Type B Personality Style
- Chronic hostility vs lowered hostility
- Heart Disease
- Hypertension
- Stroke

GASTROINTESTINAL RELATED FOCUS

- Diabetes
- Incontinence
- Irritable Bowel Syndrome IBS
- Ulcers

RENAL DISEASE RELATED FOCUS

- Dialysis
- Kidney Transplant Process

NEUROLOGICAL RELATED FOCUS

- Neurodevelopmental Disorders
 - ADHD
 - Autism
- Headaches
- Epilepsy
- TBI
- Tics
- Brain Plasticity

CANCER RELATED FOCUS

- Early identification of symptoms
- Getting routine testing for Cancer related symptoms
- Coping with Diagnosis
- Coping with Treatments
- Coping with physical health during treatment process

SEXUALLY TRANSMITTED DISEASES RELATED

- Information on STD's
- Education on Steps to Take to prevent STD's
- Information on HIV/AIDS
- Surviving getting HIV/AIDS through lifestyle change

ADDICTION RELATED FOCUS

- Substance Abuse
- Alcohol
- Illegal Drugs
- Prescription Drugs
- Tobacco-Nicotine
- Caffeine
- Other compulsive addictions: gambling, sex, computer

FOCUS ON CONNECTEDNESS WITH OTHERS

- Social Relationships
- Isolation
- Loneliness
- Avoidance of Contact with Others
- Sense of Community

SPIRITUALITY FOCUS

- Internal vs External Locus of Control issues
- Spiritual Practices which encourage healing and good health
- Maintaining a Positive Outlook on Life which encourages physical healing and good health

DEATH AND DYING FOCUS

- Coping with a Terminal Diagnosis
- Making sense of Life from a new perspective
- Maintaining one's composure facing the end of life

EXAMPLES OF BEHAVIORAL MEDICINE INTERVENTIONS

- Biofeedback
- Cognitive Behavioral Therapy (CBT)
- Neurofeedback
- Meditation
- Guided Imagery
- Mindfulness
- Clinical Self-Hypnosis
- Yoga
- Tai Chi
- Relaxation Training
- Progressive Muscle Relaxation
- Transcendental Meditation
- Self-Regulation Skills-learn to put control of health under one's own personal locus of control

EXAMPLES OF OUTCOME GOALS OF BEHAVIORAL MEDICINE INTERVENTIONS

- Prevent disease onset
- Lower blood pressure
- Lower serum cholesterol
- Reduce body fat
- Reverse atherosclerosis
- Decrease pain
- Reduce surgical complications
- Decrease complications of pregnancy
- Enhance immune response
- Increase compliance with treatment – medication plans
- Increase relaxation
- Increase functional capacity
- Improve sleep
- Improve productivity at work & school
- Improve strength, endurance, and mobility
- Improve quality of life

The background is a dark blue gradient. In the four corners, there are decorative white line-art patterns resembling circuit boards or neural networks, with lines connecting to small circles.

ASSESSMENTS FOR BEHAVIORAL MEDICAL USE BY CMHC

PATIENT HEALTH CARE QUESTIONNAIRES SCREENERS

They screen for most common types of mental disorders presenting in medical populations:

- Depressive
- Anxiety
- Somatoform
- Alcohol
- Eating disorders
- Concise, self-administered screening, Quick & user-friendly
- PHCQ forms available at: <http://www.phqscreeners.com/>

PHQ FORMS

1. PHQ: assesses Depression, Anxiety, Eating Disorders and Alcohol Abuse
2. PHQ-9: Depressive Scale from PHQ
3. GAD-7: Anxiety Screener from PHQ
4. PHQ-15: Somatic Symptom Scale from PHQ
5. PHQ-SADS: Includes PHQ-9, GAD-7, PHQ-15 plus panic measure
6. Brief PHQ: PHQ-9 and panic measures plus items on stressors & women's health

DSM-5 ASSESSMENTS

Available at:

<http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>

- 1. DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult, 11-17, Parent Report for Children**
- 2. Level 2: Adult Scale by PROMIS:** anger, depression, mania, repetitive thoughts, sleep disturbance, substance use
- 3. Level 2: Children Scale by PROMIS (Parent Report) & 11-17:** anger, anxiety, depression, inattention, irritability, mania, sleep disturbance, substance use

4. Disorder-Specific Severity Measures

- Agoraphobia, Generalized Anxiety, Panic Disorder, Separation Anxiety, Specific Phobia, Acute Stress, PTSD

5. Disability Measures

- World Health Organization Disability Assessment Schedule

6. Personality Inventories

- The Personality Inventory for DSM-5 - Adult & Children

7. Early Development and Home Background

- Clinician and Parent/Guardian

8. Cultural Formulation Interviews

TO ADDRESS ACA CHANGES: WHAT SKILLS DO MENTAL HEALTH COUNSELORS NEED?

- Ability to understand dynamics of Human Development to capture good psychosocial history of clients
- Diagnosis of and treatment for behavioral pathology
- Evidenced based practices in psychotherapy to provide credible treatment to clients
- Understanding of basic neuroscience of brain and nervous system to understand roots of emotional responses to life's stressors
- Understanding of psychopharmacological treatment of psychopathology

EVIDENCE BASED OR EVIDENCE-INFORMED TREATMENT

1. The treatment regimen shall be individualized based on the Client's age, diagnosis & circumstances. This includes, but is not limited to, addressing grief, loss, trauma, and criminogenic factors affecting Client
2. Maintain fidelity of the approved evidence-based or evidence informed treatment program through monitoring effectiveness of program
3. Maintain documentation of staff training received and/or skills in t evidence based treatment for which Client will be engaged to restore the highest possible level of function

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TOOLS ON WWW.COPING.US TO BUILD SKILLS NEEDED IN ACA RELATED WORK

- 1. Evidenced Based Practices**
- 2. Neuroscience**
- 3. Psychopharmacology**
- 4. Behavioral Medicine**

EVIDENCED-BASE PRACTICES

<http://coping.us/evidencedbasedpractices.html>

1. Overview of Evidenced Based Practices
2. Anxiety Disorder
3. Obsessive-Compulsive Disorder (OCD)
4. PTSD
5. Phobias
6. Depressive Disorders
7. Bipolar Disorder
8. Alcohol Dependence
9. Substance Abuse
10. Anorexia
11. Bulimia
12. Autism
13. ADHD
14. Guidebooks for EBPs
15. Resources on Evidenced Based Practices

APPS THAT WORK

- For Clients
- For Practitioners
- Moving the concept of Telehealth to new levels

<http://coping.us/evidencedbasedpractices/appsthatwork.html>

NEUROSCIENCE

<http://coping.us/introtoneuroscience.html>

1. Basics of Neuroscience
2. Stress Response of Humans
3. Lectures on Neuroscience
4. Traumatic Brain Injury

PSYCHOPHARMACOLOGY

<http://coping.us/psychopharmacology.html>

Psychopharmacology Chart

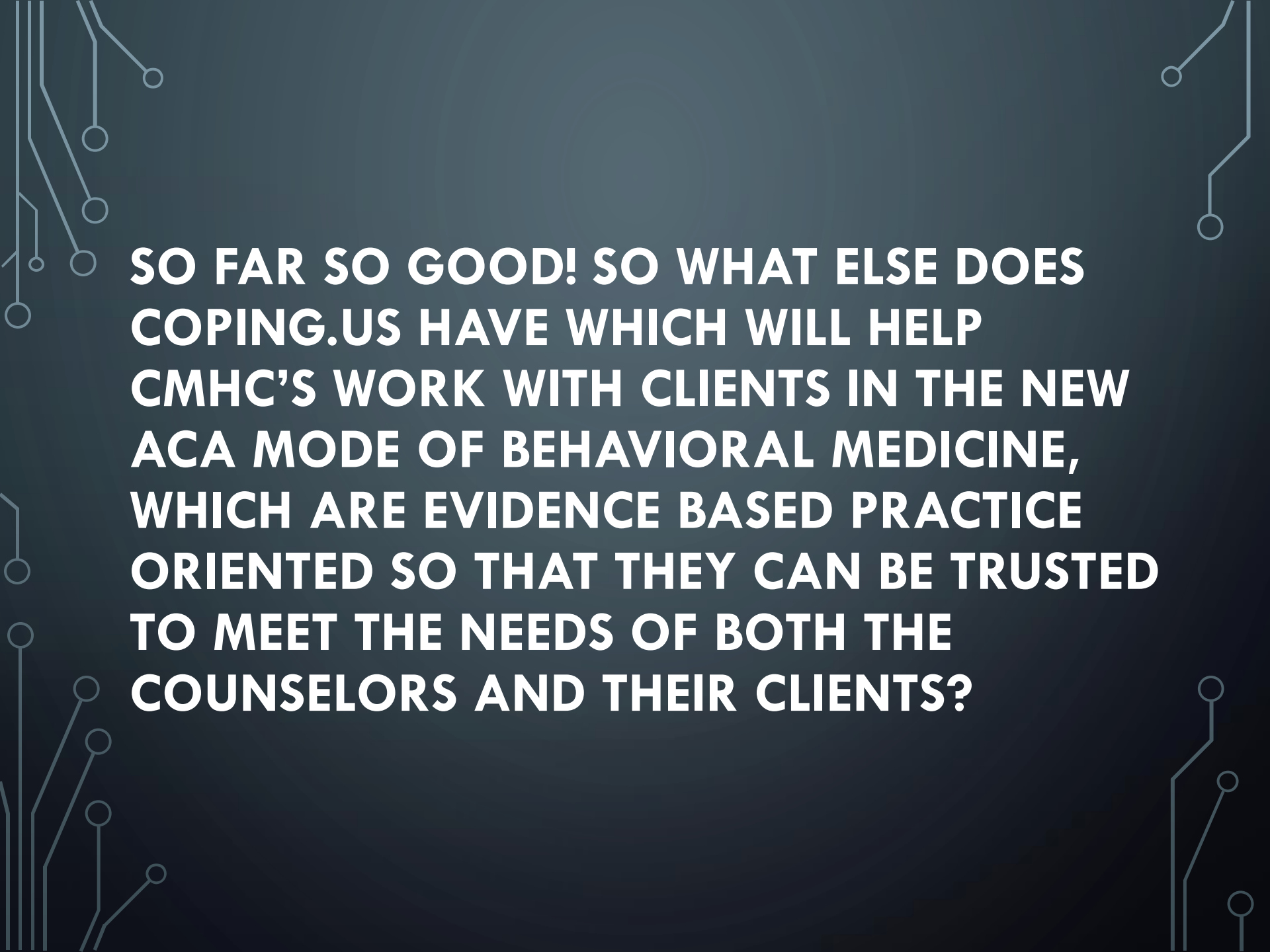
Drug Classifications to treat the following conditions:

- ADHD
 - Alcohol Disorder
 - Schizophrenia and other Psychotic Disorders
 - Depressive Disorders
 - Bipolar Disorder
 - Anxiety Disorders
 - Eating Disorders
 - Dementia
-
- ✓ Generic names of each drug
 - ✓ Commercial names of each drug
 - ✓ Time to reach clinical level for each drug
 - ✓ Benefits of each drug
 - ✓ Side effects of each drug

BEHAVIORAL MEDICINE

<http://coping.us/introbehavioralmedicine.html>

1. Background on Behavioral Medicine
2. Lectures on Behavioral Medicine
3. Behavioral Medicine Introductory Bibliography
4. Internet Resources on Behavioral Medicine
5. Impact of ACA on work of CMHC



SO FAR SO GOOD! SO WHAT ELSE DOES COPING.US HAVE WHICH WILL HELP CMHC'S WORK WITH CLIENTS IN THE NEW ACA MODE OF BEHAVIORAL MEDICINE, WHICH ARE EVIDENCE BASED PRACTICE ORIENTED SO THAT THEY CAN BE TRUSTED TO MEET THE NEEDS OF BOTH THE COUNSELORS AND THEIR CLIENTS?

EBP TOOLS ON WWW.COPING.US

Tools for Coping: CBT based Client Workbooks

- SEA's: 12 Step Program in Self-Esteem Recovery
- Laying the Foundation: Tools for overcoming Patterns of Low Self-Esteem
- Tools for Handling Loss and Grief
- Tools for Personal Growth
- Tools for Relationships
- Tools for Communications
- Tools for Anger Work-Out
- Tools for Handling Control Issues
- Growing Down: Tools for Healing the Inner Child
- Tools for a Balanced Lifestyle: weight management program

HOW CAN CMHC USE TOOLS FOR COPING SERIES

Clinical mental health counselors can utilize these workbooks with their clients to:

- Expedite their treatment
- Encourage their recovery
- Sustain their well-being
- Identify triggers for & steps to prevent relapse

Tools for Coping Handbooks enable CMHC's to challenge clients to:

- Maintain personal growth in between sessions by use of:
 - Exercises
 - Tools for changing behaviors
 - Journal writing

These free online workbooks are cost effective interventions based in clinically sound principles which have an evidenced based support in Cognitive Behavior Therapy for their efficacy & positive results

IN SUMMARY

Today we looked at

1. The implications of the new Affordable Care Act (ACA) and how available tools can help clinical mental health counselors prepare themselves to be better able to present themselves to the medical community as legitimate partners in the prevention and treatment of mental illness in the next century
2. The new 2011 AMHCA CMHC Clinical Standards and how they encourage CMHC to tackle the ACA goals
3. The need for Counselors to become Behavioral Medicine Specialists armed with understanding of Neuroscience, Psychopharmacology, Evidenced Based Practices to enable them to work with ACO's and PCMH's

INTERNET RESOURCES

Healthcare Marketplace: <https://www.healthcare.gov/>

Obamacare Facts: <http://obamacarefacts.com/obamacare-facts.php>

Centers for Medicare & Medicaid Services Information on ACO:
<http://innovation.cms.gov/initiatives/aco/>

Patient-Centered Primary Care Collaborative:
<http://www.pcpcc.org/content/history-0>

Patient Health Questionnaire (PHQ) Screeners: <http://www.phqscreeners.com/>

Society of Behavioral Medicine: <http://www.sbm.org/>

National Council for Behavioral Health: <http://www.thenationalcouncil.org/>

The Kaiser Family Foundation: <http://kff.org/>

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THANK YOU ALL!

- Any further questions or clarifications you would like at this time?