



CCBHCs:

Primary Care Screening & Integrating BH Care

Advancing Whole-Person Care

TODAY'S AGENDA

- Why Primary Care Screening & Integrated Care Matter
- CCBHC requirements
- Key considerations
 - Primary Care and Behavioral Health Integration
 - Substance use disorder and mental health Integration



QUESTIONS AND ANSWERS

- Please use the Zoom Q&A feature to submit your questions throughout the session.
- We will answer as many as possible during the webinar and post a recording of the session on the ADMH website.
- Any unanswered questions will be documented, and responses will also be shared by ADMH following this orientation.



POLL

Take a moment and rank your understanding of the CCBHC requirements for primary care screening & monitoring, and integrated care on a scale of 1-5

WHY PRIMARY CARE SCREENING & INTEGRATED CARE MATTER

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The Challenge

- Individuals with SMI and/or SUD face **higher rates of chronic health conditions** (e.g., diabetes, hypertension).
- People with SMI die 10–25 years earlier than the general population, often due to untreated physical health conditions.



The Opportunity

- Integrating primary care screenings into behavioral health services enables **early detection of physical health risks**, while coordinated mental health and substance use care ensures **whole-person treatment**.

Physical health conditions often impact BH symptoms and visa versa. **If we treat one and not the other, we are jeopardizing the person's likelihood of recovery.**

WHY INTEGRATE PRIMARY CARE SCREENING & MONITORING?

- High rates of physical illness in those with psychiatric disorder
- Premature mortality with 20-30-year gap
- Low quality of medical care
- Challenges in accessing medical care
- Costly care with high utilization of inpatient and ED services

Colton, C. W., & Manderscheid, R. W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing chronic disease*, 3(2), A42.



WHY INTEGRATED CARE IS IMPORTANT FOR ALABAMA



DISPROPORTIONATE BH NEEDS

- Higher Rates of SMI & SED
- High Suicide Risk

	AL	US
Of those served, % with SMI/ SED	90.5%/ 97.1%	71.6%/ 71.1%
Suicide Rate	16 per 100K	13 per 100K



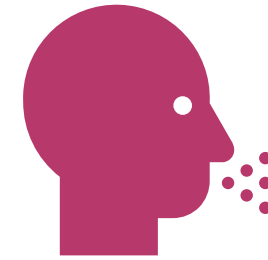
BARRIERS TO ACCESS

- Impact of social determinants of health
- Rural access challenges
- Service Gaps

94% of AL Counties below nat'l median household income

24% of AL population live in rural areas

22 counties lack in-home MH services; 12 lack outpatient SUD treatment



DISPARITIES IN ACCESS & OUTCOMES

- Racial Disparities
- Opioid & SUD Crisis

25.6% of Alabama residents are African American, but just 1 in 3 receive needed BH care

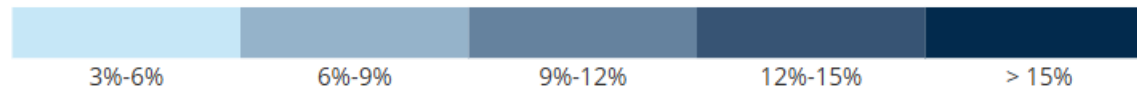
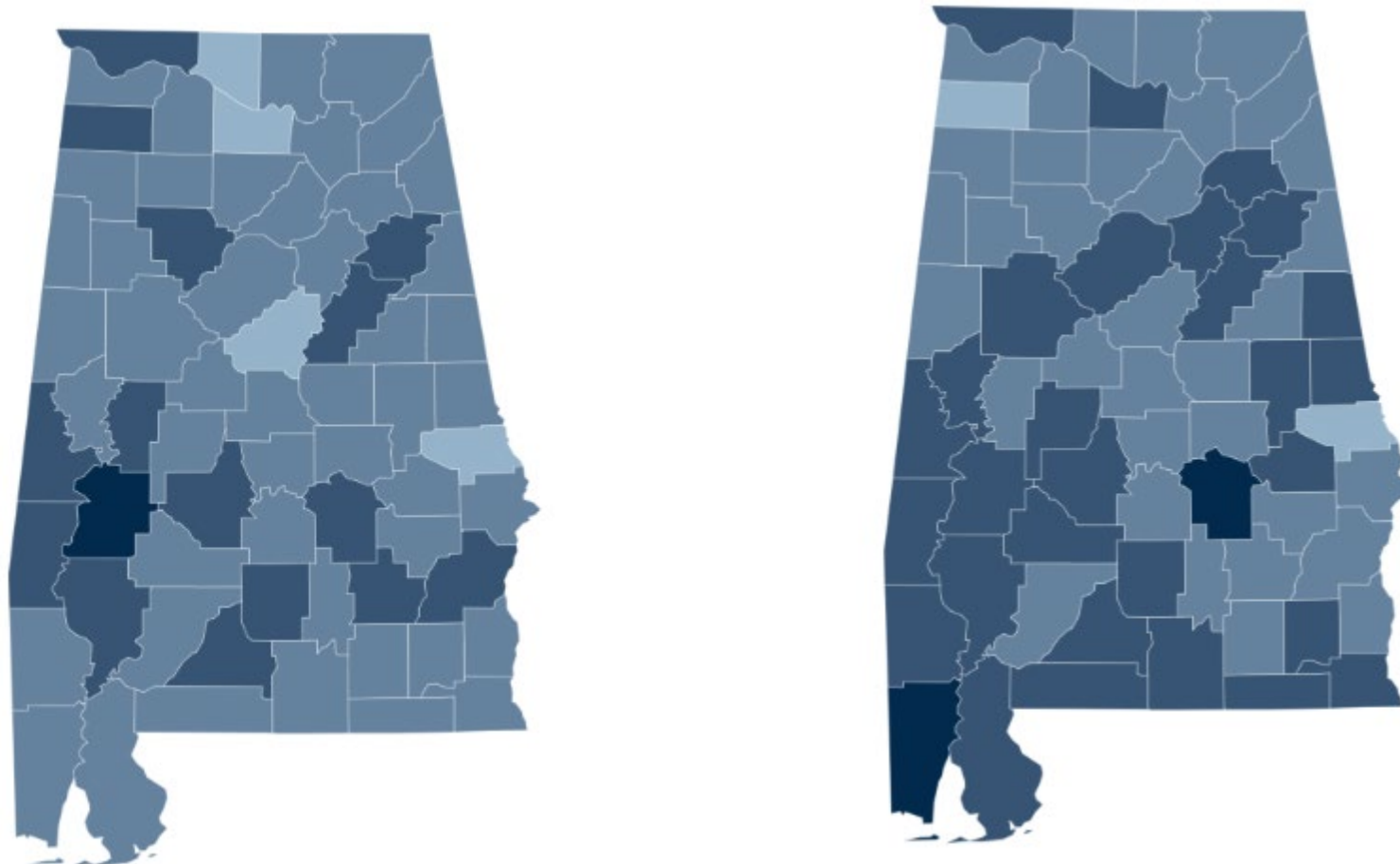
36.8% increase in overdose deaths 2019-2020

532,000 needing but not receiving SUD treatment

DIAGNOSED DIABETES PREVALENCE IS GROWING IN AL

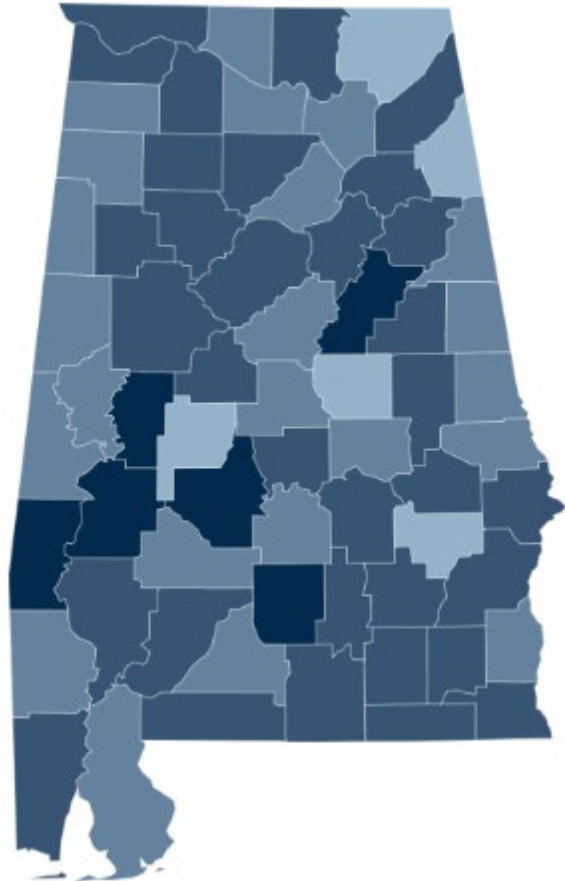
2010

2021

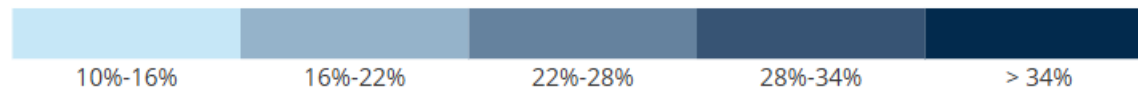
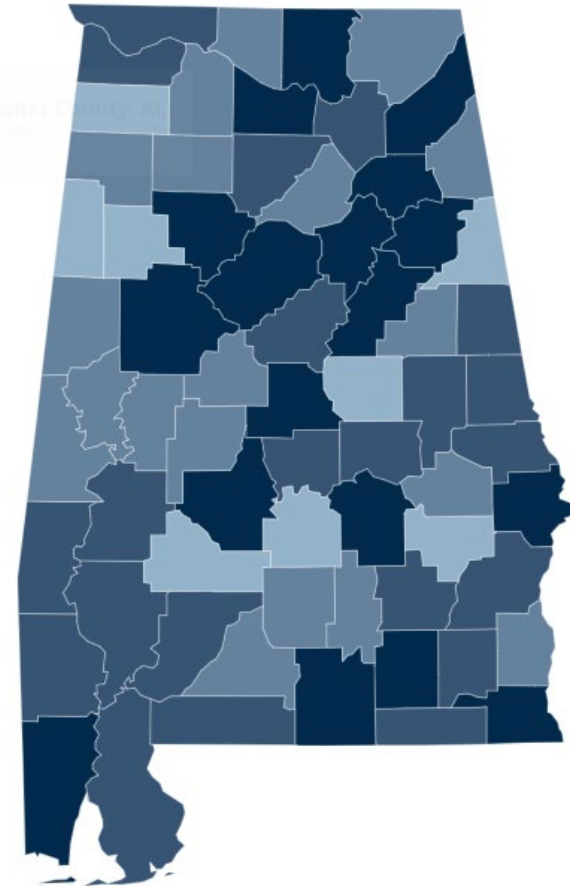


OBESITY PREVALENCE IS GROWING IN AL

2010



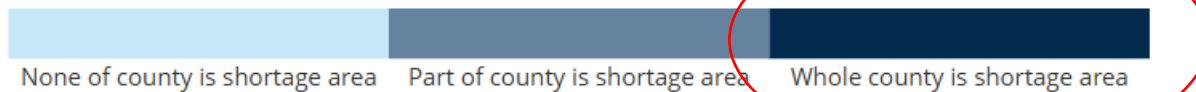
2021



PRIMARY CARE SHORTAGE AREAS



Care Coordination
is ESSENTIAL!!!





THE ROLE OF CCBHC INTEGRATED CARE

- **Comprehensive Solution:** Integrated care through the CCBHC model can address Alabama's unique needs by providing **coordinated services that combine physical, mental, and social health care.**
- **Filling System Gaps:** By prioritizing holistic care, CCBHCs can **reduce disparities, improve health outcomes, and connect underserved populations to necessary resources.**

CCBHC REQUIREMENTS

SAMHSA CRITERIA 4.D



Screening, Assessment, and Diagnosis

Can be provided by CCBHC or through DCO

Includes physical health indicators i.e.,

- Blood pressure, weight/BMI, glucose, cholesterol
 - Tobacco use
-

Can be provided via telehealth

Screening, brief intervention, and referral to treatment (SBIRT) model for SUD

SAMHSA CRITERIA 4.G



Primary Care Screening & Monitoring

HIV and viral hepatitis
Weight assessment
Blood pressure
Diabetes control (A1C)
Ongoing monitoring of conditions
Lab tests

Per ADMH Implementation: If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so if it has a documented 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 ...”

SAMHSA CRITERIA 4.F



Outpatient MH & SUD Services

Outpatient and intensive outpatient
(ASAM levels 1 and 2.1)

Contractor provides both and may use DCO for
supplemental services.

If the CCBHC does not have capacity to prescribe
methadone directly, should have a coordination
agreement with an OTP for methadone treatment.

Minimum evidence-based practices

- Assertive Community Treatment (ACT)
- Multi-Dimensional Family Therapy and/or Functional Family Therapy and/or Multi-Systemic Therapy
- Motivational Interviewing
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- SBIRT

ADMH-REQUIRED BH SCREENING TOOLS

All Persons Served		
Tool	Purpose	Age Range
PHQ-9	Depression/Mental Health	12 years and older
Protocol for Responding to and Assessing Patient's Risks and Experiences (PRAPARE) (2016) or Standardized Health Related Social Needs Screening (HRSN)	Social Determinants of Health	All persons served should receive a HRSN screening. Children/youth may either complete the screening or have a parent/guardian complete the screening on behalf of the family. Note: the PRAPARE tool is for those 18 years or older
Columbia Suicide Severity Rating Scale (C-SSRS)	Suicidality	6 years and older
Adults		
Tool	Purpose	
UNCOPE	Substance Use	19 years and older
Audit-C	Alcohol Use	18 years and older
Adolescents		
Tool	Purpose	
CRAFFT	Substance Use	12-18 years

ADMH-REQUIRED CLINIC REPORTING

Time to Services(I-SERV)	
Tool	N/A
Depression Remission at Six Months (DEP-REM-6)	
Tool	PHQ-9
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	
Tool	Audit-C
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)	
Tool	PHQ-9
Screening for Social Drivers of Health (SDOH)	
Tool	Protocol for Responding to and Assessing Patient's Risks and Experiences (PREPARE) or Standardized Health Related Social Needs Screening (HRSN)

CONSIDERATIONS FOR BUILDING YOUR INTEGRATED CARE MODEL

IMPACT OF INTEGRATION

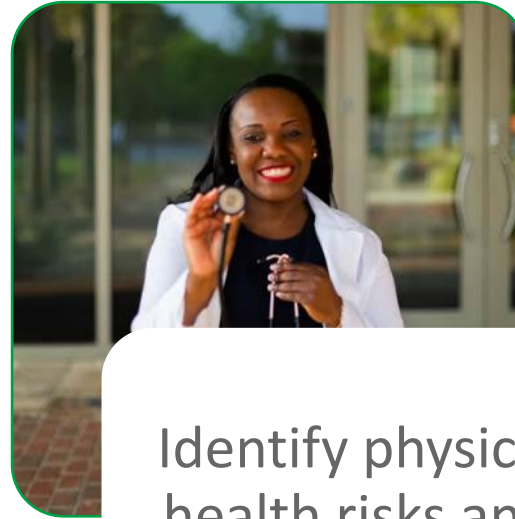
- Improved access to care for co-occurring disorders
- Reduced fragmentation of services
- Better outcomes for clients with complex needs.



PRIMARY CARE SCREENING IN ACTION IN THE CCBHC



Screenings conducted during behavioral health visits (e.g., blood pressure checks)



Identify physical health risks and refer to primary care providers as needed



Ongoing monitoring for chronic conditions like diabetes or heart disease.

Example: A client with depression and undiagnosed hypertension receives a blood pressure screening during their therapy visit and is referred for primary care follow-up.

INTEGRATING PRIMARY CARE SCREENING

Screening and Monitoring Protocols:

- universal screening for general health risk factors
- standardized tools for systematic screening and follow-up

Care Coordination and Referral Systems:

- formal partnerships with primary care providers
- Ensure follow-up mechanisms are in place to monitor engagement with referred care. ★

Workforce Development:

- Train staff on managing chronic health conditions and administering evidence-based interventions
- Build multidisciplinary teams

Data Sharing and Technology:

- EHRs for integrated care planning, population health management, and tracking patient progress
- interoperability between behavioral health and primary care systems.

Patient Engagement and Education:

- Empower patients through education on self-management strategies
- Use culturally tailored strategies to address SDOH and enhance patient activation



POLL

What areas are your organization's biggest challenges in implementing primary care screening & monitoring?

TEAM ROLES FOR INTEGRATED BEHAVIORAL HEALTH

- MH/ SUD Treatment
- Medication Evaluation, Initiation, and Management

Psychiatrist &
BH Clinician



- Engagement
- Support Psychiatrist and RN
- Coordination and referrals with PCP and specialists (cardiology, etc.),
- Ensure care team is aware of physical health status
- Assessment
- Brief Interventions
- Self management

Care
Coordination



- Patient care
- Follow-up on diet/labs/etc.
- Goals and treatment planning
- Education, self-management

RN



- Engagement
- Support and skill development
- Community-based work PRN
- Groups
- Supporting Psychiatrist with patients
- Reinforce importance of consistency with treatment as appropriate

Peer Recovery



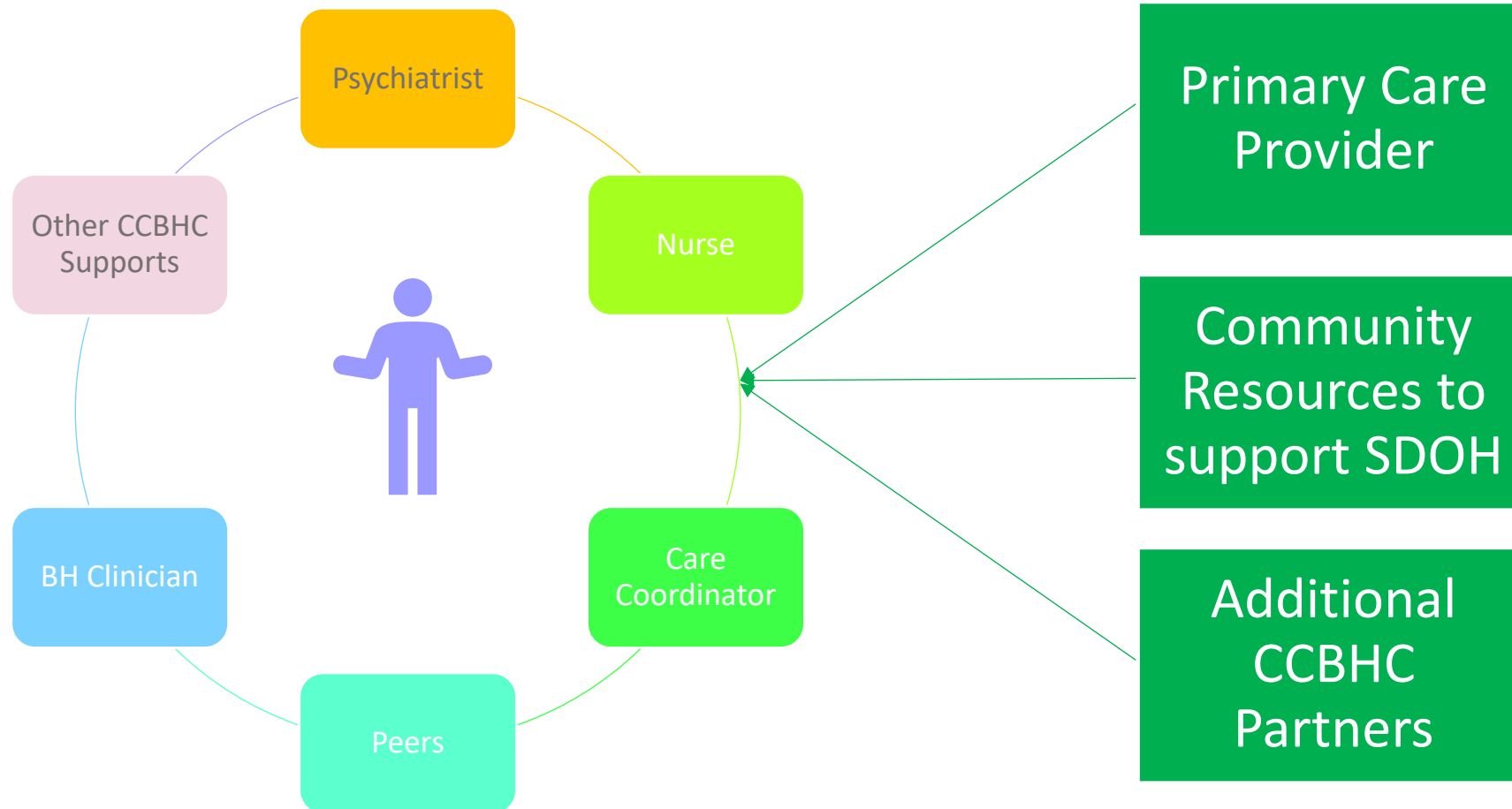


CARE COORDINATION IS THE BRIDGE

Medical Assistant or Community Health Worker (Unlicensed) can:

- Complete a screening health risk assessment (HRA)
- Follow up on needs identified on HRA
- Schedule appointments
- Follow-up on PCP, care gaps, and hospital/ED
- Assist with community resources for SDOH and healthy living
- Provide patient coaching

CONSIDERATION FOR INTERDISCIPLINARY TEAM MODEL



CONSIDERATIONS FOR PROGRAM STRUCTURE

Project Management

- Who will be on the project team?
- Who will create and manage the work plan?
- Who will oversee these workflows?
- Communication plan within the office

Program Milieu (environment)

- Routine expectation of and welcome to treatment for both disorders.
- Display and distribution of literature and patient educational materials.

CONSIDERATIONS FOR CLINICAL PROCESSES

Assessment

- What screening tools will you use?
- How will you build in **universal** screening methods for both MH and SUD, and primary care?
- What primary care screenings will you do in house vs. referral and external data tracking?
- Is MH, SUD and physical health history documented in EHR?
- How are you planning to integrate stage-wise assessment?

Treatment

- Are MH, SUD and physical health goals all reflected in treatment plans?
- Are you providing specialized interventions for co-occurring MH/ SUD?
- How are you collaborating with primary care providers?
- How are you ensuring all treatment team members, including the person served, have the same information
- How are you including peers and recovery supports on the treatment team?

CONSIDERATIONS FOR WORKFORCE

Staffing

- Do you have a prescriber of both psychotropic and MAT medications on staff/ onsite?
- Does the person served have access to all 3 approved forms of MOUD, and is MAT being utilized for alcohol and nicotine as well?
- Do you have clinical staff with substantive MH/SUD experience?
- How will you design case review/ utilization review procedures that support co-occurring disorder treatment?

Training

- Do all staff members have basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders?
- Do clinical staff members have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders?
- Do **all staff** understand the importance of MAT and its associated mortality reduction? Is it understood enough to educate the person served?



POLL

What areas are your organization's biggest challenges in implementing integrated care?



QUESTIONS

POLL

Take a moment and rank your understanding of the CCBHC requirements for primary care screening & monitoring, and integrated care on a scale of 1-5



WATCH
THIS
SPACE

ADDITIONAL TUESDAY TA SESSIONS

- Care coordination & Case Management
- Workflows for Centralized Intake, Triaging & Staffing
- Quality and Reporting
- Services for Veteran's and Armed Forces

CONTACT US

We're here to help! If you're interested in learning more about CCBHCs or have questions, contact us at ccbhc.dmh@mh.alabama.gov

Check out our CCBHC Implementation Bulletins here:

<https://mh.alabama.gov/ccbhc-implementation-bulletins/>