Preliminary Conference Agenda
Collaborative Family Healthcare Association 15th Annual Conference
October 10-12, 2013 • Omni Interlocken Resort, Broomfield, Colorado U.S.A.

Wednesday, October 9, 2013
2:00PM to 9:00PM CFHA Board of Directors Meeting & Dinner

Thursday, October 10, 2013
8:00AM to 8:30AM Check-in for Pre-Conference Workshop
8:30AM to 4:30PM Pre-Conference Workshop ($199 advance registration required)
- **PC1: Building Leadership Skills for Change Management in Your Practice**
  This is a full-day workshop; there will be a 1-hour break for lunch, however, lunch is not provided.
11:30AM Check-in for Health Policy Summit
12:00PM to 5:00PM Health Policy Summit (by invitation only)
Prior to the conference each year, CFHA invites local representatives to participate in a regional Health Policy Summit on collaborative family healthcare. In this forum, local representatives highlight gains in healthcare reform and best practice implementation and major stakeholders unite around a shared vision for future progress.
12:30PM to 1:00PM Check-in for Pre-Conference Workshop
1:00PM to 4:30PM Pre-Conference Workshops ($129 advance registration required)
- **PC2: Behavioral Health and Unexplained Symptoms: Thinking and Practicing Differently**
- **PC3: Career Innovation for New Professionals**
2:00PM to 6:00PM Conference Registration & Check-in
4:30PM to 5:15PM Newcomers Orientation & Networking Session
If you're attending the CFHA Conference for the first time, this program is for you! Learn more about CFHA, get Conference tips, make friends, and meet CFHA leaders and staff. Don’t miss this informative overview on how to maximize your conference experience.
5:00PM to 6:00PM Welcome Reception - Colorado-Style
Catch-up with friends and meet new colleagues at this informal opening reception.
6:00PM to 8:00PM Conference Welcome & Opening Plenary Session - “Disrupting Stories”
PechaKucha is a simple presentation format where presenters show 20 images, each for 20 seconds. The images advance automatically while the presenter talks along to the images.
You will hear 6 "disrupting” stories from healthcare professionals who will share their perspectives on a variety of subjects. These stimulating talks presented in an entertaining style will give you a taste of the concepts and themes you’ll hear during the 2013 CFHA Conference.
8:00PM to 10:00PM CFHA Regional Learning Collaborative (by invitation only)
Evening on your own

This schedule is subject to change without notice. For the most current version, go online to www.cfha.net
Building Leadership Skills for Change Management in Your Practice

Jeri Hepworth, PhD, Professor and Vice-Chair, Family Medicine, University of Connecticut School of Medicine;
Susan McDaniel, PhD, Dr Laurie Sands Distinguished Professor of Families and Health, University of Rochester Medicine and Dentistry

Abstract Leadership isn’t about title, but is about behavior, intention, and empowering others. With enormous change in our collaborative practices, training programs, medical centers, and departments comes opportunity for Behavioral Health providers, psychotherapists, physicians, nurses, and other members of the healthcare team to increase their participation and leadership. Whether you are interested in practice transformation, educational innovations, or assuming a new formal leadership position, change management skills are necessary.

This interactive workshop will elucidate the change management skills you already use, and those you want to develop as we move through this period of rapid change in healthcare delivery and professional training.

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

- Identify effective leadership skills for change management and recognize how they are related to existing skills of collaborative care professionals.
- Identify a range of individual, program and departmental leadership opportunities that will benefit from their involvement as collaborative care professionals.
- Create a Personal Action Plan to increase change management activities in their home settings.
- Experience leadership exercises that can be adapted for their own settings.

Notes:

- This is a full-day workshop.
- The registration fee for this workshop is $199 per person.
- The workshop fee includes beverage breaks and materials.
- Lunch is not provided; a one-hour break is scheduled at 12PM for workshop participants to get lunch on your own.
Behavioral Health and Unexplained Symptoms: Thinking and Practicing Differently

Kurt Kroenke, MD, Professor of Medicine, Indiana University School of Medicine
Wendy Bradley, MA, Clinical Supervisor/Improvement Advisor, Southcentral Foundation, Anchorage, Alaska
David Clarke, MD, Gastroenterologist, Happy Valley, Oregon; President, Psychophysiologic Disorders Association
Sean Hearn, MD, Family Physician, AllinaHealth, St. Paul, Minnesota
Norm Rasmussen, EdD, Psychologist Consultant, Department of Psychiatry and Psychology and Department of Family Medicine, Mayo Clinic, Rochester, Minnesota

This workshop will focus on integrated approaches to patients with unexplained symptoms. Dr. Kurt Kroenke has published extensively on the epidemiology of unexplained symptoms. His overview will be followed by stories from four people who are working with patients with unexplained symptoms in a variety of ways. These stories will introduce breakout sessions that are interactive and focused on building practical skills.

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

- Explain the epidemiology of medically unexplained symptoms in primary care;
- Describe one approach that medical providers can take in the assessment or management of patients with unexplained symptoms;
- Describe one approach that behavioral health providers can take in the assessment or management of patients with unexplained symptoms;
- List potential benefits of an integrated approach to unexplained symptoms in terms of achieving the Triple Aim of improving health, improving patient experience and managing costs.

Notes:
- This is a half-day workshop.
- The registration fee for this workshop is $129 per person.
- The workshop fee includes beverage breaks and materials.
Pre-Conference Workshops
Thursday, October 10, 2013

PC3 - 1:30PM to 4:30PM

Career Innovation for New Professionals

If you are a graduate student, medical student, or new professional seeking a career in integrated care, you are looking to work on the cutting edge! Chances are, the innovative career you have in mind does not appear in the job ads you’ve been perusing.

This pre-conference workshop is designed to provide you with the tools you need to develop the career in integrated care you are seeking. Plan to connect with like-minded colleagues, learn how best to tap the integrated healthcare market, and launch a unique and dynamic career.

Topics will include:

- Identifying resources to develop your practice and market yourself as an integrated care professional,
- Negotiating employment contracts, and
- Targeting healthcare markets with expanded integrated care offerings.

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

- Define specific elements to include in a “pitch” to bring behavioral health care into an extant medical practice.
- Describe marketing techniques and how to engage them with a range of audiences including administrators, third party payers, primary care providers, and others.

Notes:

- This is a half-day workshop.
- The registration fee for this workshop is $129 per person.
- This workshop is offered at no cost to CFHA Member students and new professionals. You must register in advance and your membership must be current to be eligible for the $0 rate.
- The workshop fee includes beverage breaks and materials.
Plenary Session #1

Thursday, October 10, 2013 - 6:00PM to 8:00PM

Disrupting Stories

PechaKucha is a simple presentation format where presenters show 20 images, each for 20 seconds. The images advance automatically while the presenter talks along to the images. You will hear several "disrupting" stories from healthcare professionals who will share their perspectives on a variety of subjects:

- **Sowing and Harvesting the Literature of Collaborative Family Healthcare**
  Colleen Fogarty and Larry Mauksch - A diverse menu of options for contributing to the literature of collaborative family health care.

- **Clinician as Patient: The Gift of Illness**
  Laura Sudano - Incorporate reflexivity and clinician-as-self insights into healthcare practice.

- **Righting Wrongs and Reforming Rights**
  Laurie Ivey - Awareness of the impact of social and health disparities on gay, lesbian, and bisexual (GLB) individuals and the political/legal issues that affect GLB population.

- **Cold Spotting: Linking Primary Care and Public Health to Create Communities of Solution**
  Jack Westfall - The benefits for improving population health and applying cold-spotting concepts to clinical and community health work.

- **Health in Hope: Finding the Soul of Primary Care**
  Toby Long

These stimulating talks presented in an entertaining style will give you a taste of the concepts and themes you’ll hear during the 2013 CFHA Conference.

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

- Identify a diverse menu of options for contributing to the literature of collaborative family health care.
- Incorporate reflexivity and clinician-as-self insights in healthcare practice.
- Explain the impact of social and health disparities on gay, lesbian, and bisexual (GLB) individuals.
- Describe the components of cold-spotting and the benefits for improving population health.
Friday, October 11, 2013
6:00AM to 7:15AM  Morning Exercise
Join us for morning workouts on Friday and Saturday morning. All fitness levels welcome. Please sign-up for your preferred activity in the registration area when you arrive at the Conference.

- Run, Skip, Walk! Join the group for a 3-mile run but please feel free to skip or walk the route.
- Core Conditioning: This workout will concentrate on your core.

7:00AM to 8:30AM  CFHA Café
Enjoy complimentary coffee and grab a bite to eat with CFHA colleagues. An assortment of light breakfast fare will be available for purchase. CFHA will provide a $5 coupon to Conference registrants that may be applied toward a food purchase in the CFHA Café. (Coupons are not valid in hotel outlets.)

7:00AM to 7:30AM  Setup for Friday Poster Presentations

7:30AM to 3:30PM  Refreshments in CFHA Lounge: Exhibits and Posters
The CFHA Lounge and is designed to promote informal networking between education sessions. The CFHA Lounge will host beverages during breaks and includes a showcase of technology, products, equipment, and services for use in the healthcare profession.

Poster presentations allow author(s) to meet and speak informally with interested viewers, facilitating a greater exchange of ideas and networking opportunities than with oral presentations. Posters will be on display during each refreshment break and there will be a different selection of posters each day.

8:30AM to 10:00AM  Plenary Session - “Exploring National Policy Trends and Opportunities in Collaborative Care”
This plenary session will offer varying perspectives on national trends and key patterns of influence in the United States and Canada related to collaborative care practice, financing, and policy initiatives.

A panel of national experts will guide conference attendees through significant policy changes over the last few years and will discuss best next steps to advocate for change going forward.

10:00AM to 10:30AM  Refreshments in CFHA Lounge: Exhibits and Posters

10:30AM to 12:00PM  Concurrent Education Sessions - Period 1
Each 90-minute period will feature 8 classrooms of simultaneous presentations. Seating for all Conference sessions is on a first-come, first-served basis. Classrooms vary in size and capacity and some sessions may reach standing-room capacity before the presentation begins. A Conference schedule with classroom assignments will be provided when you check-in at the Conference. Plan to arrive early to ensure seating for your preferred sessions.
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12:00PM to 1:15PM  Facilitated Discussion Groups
This program will feature facilitated discussion groups on a variety of topics. Lunch tables will be identified by the list of discussion topics included in your packet. Simply choose a topic and find a seat at the corresponding table. Boxed lunches will be provided.

12:00PM to 1:15PM  Speed Mentoring
This interactive session allows students and other new professionals to meet with leaders in the collaborative care movement and ask questions to help your own career development. Boxed lunches will be provided for your convenience. Space will be limited; please sign-up by 10:30AM in the Conference registration area.

1:30PM to 3:00PM  Concurrent Education Sessions - Period 2
Seating for all Conference sessions is on a first-come, first-served basis. Plan to arrive early to ensure seating for your preferred sessions.

3:00PM to 3:30PM  Refreshments in CFHA Lounge: Exhibits and Posters

3:30PM to 5:00PM  Concurrent Education Sessions - Period 3
Seating for all Conference sessions is on a first-come, first-served basis. Plan to arrive early to ensure seating for your preferred sessions.

5:30PM to 7:00PM  Colorado Beer & Wine Tasting Fundraiser ($50 advance ticket purchase required)
Did you know that Denver brews more beer than any other city with 100 different beers brewed in town daily? Join your CFHA colleagues for this unique and fun event to sample a selection of Colorado beers and wines.

Proceeds will benefit CFHA’s scholarship program that allows students and new professionals to attend CFHA’s Annual Conference at no cost or discounted fees.

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Exploring National Policy Trends and Opportunities in Collaborative Care

This plenary session will offer varying perspectives on national trends and key patterns of influence in the United States and Canada related to collaborative care practice, financing, and policy initiatives. A panel of national experts will guide conference attendees through significant policy changes over the last few years and will discuss best next steps to advocate for change going forward.

Kavita Patel, MD, MS, is a fellow in the Economic Studies program and managing director for clinical transformation and delivery at the Engelberg Center for Health Care Reform. Dr. Patel is also a practicing primary care internist at Johns Hopkins Medicine and served in the Obama administration as director of policy for the Office of Intergovernmental Affairs and Public Engagement in the White House. As deputy staff director on health, she served as a policy analyst and trusted aide to Senator Edward Kennedy and was part of the senior staff of the Health, Education, Labor and Pensions (HELP) Committee under Sen. Kennedy’s leadership. She also has an extensive research and clinical background, having worked as a researcher at the RAND Corporation and as a practicing physician in both California and Oregon. She earned her medical degree from the University of Texas Health Science Center, and her masters in public health from the University of California Los Angeles.

Nick Kates is Professor and Chair of the Department of Psychiatry & Behavioral Neurosciences at McMaster University with a cross appointment in the Department of Family Medicine and a quality improvement advisor with the Hamilton Family Health Team. He is also a senior advisor to Health Quality Ontario and for 5 years he was the Ontario Lead for quality Improvement in primary care. For 12 years he was director of the Hamilton HSO (now FHT) mental health program. He has participated in many health care planning initiatives provincially and nationally and has co-chaired the shared mental health care working group of the Canadian Psychiatric Association and College of Family Physicians of Canada since 1997. He has consulted extensively on building links between specialized and primary care services, redesigning systems of care and improving the quality of care. He is the author of over 65 articles and 2 books. He is a distinguished fellow of both the American Psychiatric Association and the Canadian Psychiatric Association, and an honorary member of the Canadian College of Family Physicians.

Eric Whitney is Health Reporter for Colorado Public Radio. Eric got his start in radio at KDUR, the student-community station at Ft. Lewis College in Durango, Colorado. A series of fellowships supported Eric’s work after that and allowed him to follow his interest in health topics. The Kaiser Family Foundation helped him report on mental health in the United States and infectious disease in southern and east Africa. The Knight Foundation allowed him to spend four months studying epidemiology at the Centers for Disease Control in Atlanta. The Crime, Communities and Culture Fellowship from the Open Society Institute sent Eric to report on prisons in the western U.S. Eric spent most of 2003 living in and reporting from Cape Town, South Africa, as a freelancer before becoming the news director at KRCC in Colorado Springs, a position he held for three years before moving to Colorado Public Radio in 2007.
At the conclusion of this presentation, participants will be able to:

- Discuss changes in the clinical, operational, financial, training and science components of integrated care implementation in each country over the past year.
- Discuss emerging national policy trends in integrated care in the US and Canada.
- Identify policy barriers which could negatively influence the adoption of a less fragmented system of health.
### Preliminary Schedule of Concurrent Education Sessions for the CFHA's 15th Annual Conference

**Friday, October 11, 2013 - Period 1: 10:30AM to 12PM**

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<thead>
<tr>
<th>Time</th>
<th>A Track</th>
<th>B Track</th>
<th>C Track</th>
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<th>F Track</th>
<th>G Track</th>
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| 10:30AM| A1a) Improving Integration: Making Better Use of Behavioral Health Provider Skills  
Shandra M. Brown Levey, Larry Green, Joanna S. Stratton, Maribel Cifuentes, Deborah Seymour  
All audiences Interdisciplinary Team Training | B1a) Forging Medical-Legal Partnerships to Enhance the Patient-Centered Medical Home  
Magrielle H. Eisen  
All audiences Leading/Creating Systemic Change | C1a) The Power of the Patient Centered Care Plan to Transform Primary Care Practice  
Alexander Blount, Larry Mauck, Aimee Valeras  
All audiences Leading/Creating Systemic Change | D1a) Screening and Management of Depression in Primary Care: Feasibility, Utility, and its role in Clinical Outcomes  
William Sieber, Zephon Lister, Alita Newsome, Darren Himeles, Shannon Sampson, Gene Kallenberg  
All audiences Clinical Care/Direct Practice | E1a) A Mindful Heart: Skills-Based Stress Management for Primary Care  
Stacy Ogbeide  
All audiences Clinical Care/Direct Practice | F1) Systemic Applications of The New and Improved Medical Family Therapy and Integrated Care  
Jeri Hepworth, Susan H McDaniel, William J. Doherty  
Advanced Interdisciplinary Team Training | G1a) Engaging Families and Communities in Psychological First Aid: Advancing Practice in Multidisciplinary Fieldwork  
Tai J. Mendenhall, Jerica M. Berge  
Basic Interdisciplinary Team Training | H1a) Dismantling the Silos in Integrated Training  
Colleen Clemency Cordes, Wendy Danto Ellis  
Basic Interdisciplinary Team Training |
| 11:00AM| A1b) Collaborative Reflecting Teams in Healthcare Education  
Lana Kim, Barbara Couden Hernandez  
All audiences Interdisciplinary Team Training | B1b) How Innovators Manage Real World Push-Back: Lessons from VA Integrated Care Implementers  
Laura O. Wray, Andrew S. Pomerantz  
All audiences Clinical Care/Direct Practice | C1b) Improving Behavioral Health Access for At-Risk Patients in an Integrative Healthcare Site  
Cassidy Freitas, William Sieber, Zephon Lister  
All audiences Clinical Care/Direct Practice | D1b) Research findings on Sleep and the Determinants of Health  
Stacy Ogbeide  
Basic Clinical Care/Direct Practice | E1b) Connecting Primary Care and Specialty Mental Health: The Challenge of Moving from Competition to Collaboration  
Mary Jean Morx, Neil Korsen, Cynthia Cartwright, Melissa Cormier  
Advanced Interdisciplinary Team Training | F1b) Developing Cross-Disciplinary Mental Health Teams in Integrated Care Settings  
Cathy M. Hudgins, Jennifer Hodgson  
All audiences Interdisciplinary Team Training | G1b) Creative Collaborations: Bringing the Arts into Healthcare  
Pamela Boeck, Joan Phillips  
Basic Clinical Care/Direct Practice |

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<tr>
<th>Time</th>
<th>Track</th>
<th>Session Title</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>1:30PM</td>
<td>A2a</td>
<td>Let’s Play: Engaging Youth and Families in Physical Activity and Exercise</td>
<td>Tai J. Mendenhall; Jessica M. Berge; William J. Doherty</td>
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<td>Basic Consumer/Patient Engagement</td>
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<td>2PM</td>
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<td>2:10PM</td>
<td>A2b</td>
<td>Providing Care for Children and Adolescents with Complex Medical, Psychological and Developmental Problems: A Collaborative Model</td>
<td>Mary Rineer, Kathleen Shepherd Koljack, Michael J. Sannito, Danny W. Stout</td>
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<td>All audiences</td>
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<td>2:30PM</td>
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<tr>
<td>2:30PM</td>
<td>A2c</td>
<td>Navigating Clinical Barriers in the Management of Severely and Persistently Mentally Ill Patients</td>
<td>Verena Roberts, Elizabeth Lowdermillik, Elaine Hess</td>
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<td>All audiences</td>
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<th>Period 3</th>
<th>A Track</th>
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<tr>
<td>3:30PM</td>
<td>A3a)</td>
<td>2242001</td>
<td>Transforming Colorado Healthcare Policy: Lessons for the Country</td>
<td>Benjamin F. Miller; Katherine Blair</td>
<td>Advanced Public Policy</td>
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<td></td>
<td>B3a)</td>
<td>2262494</td>
<td>Telehealth Video in Primary Care: Clinical Consultation and Training</td>
<td>Rachel Zahn, Karla Torres</td>
<td>Basic Consumer/Patient Engagement</td>
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<td></td>
<td>C3a)</td>
<td>2260779</td>
<td>Behavioral Health in Primary Care: Impact on Medical Utilization and Medical Cost-Offset</td>
<td>Sean M. O’Dell, Tawnya Meadows, Rachel Valleveld</td>
<td>All audiences Leading/Creating Systemic Change FINANCING</td>
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<td></td>
<td>D3a)</td>
<td>2260543</td>
<td>The Four Box Approach to Resolving Ethical Dilemmas in Primary Care Behavioral Practice</td>
<td>Patricia Robinson, Christine Runyan, Jeff Reiter</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td>E3a)</td>
<td>2261064</td>
<td>Community Partners Serving as Members of the PCMH</td>
<td>Roni Christopher</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td>F3a)</td>
<td>2244119</td>
<td>Changing the Way We Treat Chronic Pain: Practical and Profitable Evidence-Based Methods</td>
<td>Daniel Bruns</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td>G3a)</td>
<td>2250397</td>
<td>Combat PTSD: Team-based Approach to Care of the Individual and Family</td>
<td>Anne Van Dyke, Amber Gruber, Michael Gruber</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td></td>
<td>H3a)</td>
<td>2247670</td>
<td>Healthy Weight Management in a Health Care Home: A Feasibility Study</td>
<td>Katharine Wickel, Jerica M. Berge, Dianne R. Neumark-Sztainer</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td>4PM</td>
<td>A3b)</td>
<td>2244044</td>
<td>Health Homes: A Holistic Approach to Service Delivery</td>
<td>David Johnson</td>
<td>All audiences Public Policy</td>
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<td>B3b)</td>
<td>2263386</td>
<td>iPods in the Exam Room: A Pilot Study and a Discussion of Technology’s Role in Patient-Centered Care and Treatment of Chronic Illness</td>
<td>Danielle King, Sally Schwer Canning</td>
<td>All audiences Consumer/Patient Engagement</td>
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<td>C3b)</td>
<td>2261478</td>
<td>Return on Investment: Integrated Behavioral Interventions Interventions That Save Money</td>
<td>Ronald R. O’Donnell</td>
<td>Advanced Clinical Care/Direct Practice FINANCING</td>
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<td>D3b)</td>
<td>2242806</td>
<td>Ethical Management of Multiple Relationships in Primary Care</td>
<td>Laurie C. Ivey, Timothy J. Doenges</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td>E3b)</td>
<td>2260788</td>
<td>Using Narrowband and Broadband Tools for Targeting Appropriate Behavioral Health Treatments</td>
<td>James V. Wojcik, Samuel Hintz, Nicole Shackelford, Jonathan Hoistad</td>
<td>Advanced Clinical Care/Direct Practice</td>
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<td>F3b)</td>
<td>2263650</td>
<td>Implementing Chronic Pain Groups in Two Diverse Family Medicine Residency Clinics: Challenges, Lessons Learned, and Opportunities</td>
<td>Joan B. Fleishman, Jeanna R. Spanning, Christine Runyan</td>
<td>Advanced Clinical Care/Direct Practice</td>
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<td>G3b)</td>
<td>2263443</td>
<td>Challenging the Status Quo Through Policy, Education, Research, and Program Implementation Assistance in the Veterans Health Administration</td>
<td>Andrew S. Pomerantz, Laura W. Wray, Katherine M. Dollar, Larry J. Lantinga</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td>H3b)</td>
<td>2249337</td>
<td>Integrating Behavioral Health into Wellness Visits in Pediatric Primary Care</td>
<td>Jean Cobb, J. David Bull</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td>4:30PM</td>
<td>A3c)</td>
<td>2261393</td>
<td>Pharmacist Assisted Management of Complex Psychiatric Patients in Primary Care</td>
<td>Casey Gallimore, Ken Kushner</td>
<td>All audiences Interdisciplinary Team Training</td>
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<td>B3c)</td>
<td>2261393</td>
<td>Quantifying and Tracking Productivity for Behavioral Health Care Clinicians in a Primary Care Practice</td>
<td>Joni Staigers Haley, William Ginn, Aimee M. Burke Valles</td>
<td>Advanced Financing Integration</td>
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<td>C3c)</td>
<td>2253944</td>
<td>Integrated Behavioral Health Care in a Federally Qualified Health Center (FQHC): Pilot Test of Two Behavioral Health Delivery Models</td>
<td>Jennifer DeGroff</td>
<td>All audiences Clinical Care/Direct Practice</td>
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<td></td>
<td>D3c)</td>
<td>2225484</td>
<td>Myth Busters: Successful Approaches to Sharing Sensitive Information</td>
<td>Shelina D. Foderingham, Elisabeth Gentry, Jonathan Perry</td>
<td>All audiences Leading/Creating Systemic Change</td>
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Improving Integration: Making Better Use of Behavioral Health Provider Skills

Shandra M. Brown Levey, PhD, Licensed Psychologist, Primary Care Psychology Fellow, University of Colorado, School of Medicine

Larry Green, MD, Director, Advancing Care Together Professor, Epperson-Zorn Endowed Chair for Innovation and Integration, University of Colorado, Department of Family Medicine

Joanna S. Stratton, PhD, Assistant Clinical Professor, University of Colorado, Department of Family Medicine, AF Williams Family Medicine Center

Maribel Cifuentes, RN, BSN, Deputy Director, Advancing Care Together Instructor, University of Colorado, Department of Family Medicine

Deborah Seymour, PsyD, Associate Professor, University of Colorado, Department of Family Medicine, AF Williams Family Medicine Center

Behavioral health providers (BHPs) who work in primary care settings are frequently asked to assist with patients who have challenges related to mental health. In addition to offering assistance to patients with mental health concerns, BHPs have a skill set that allows them to help patients improve their health behaviors. In fact, the BHP has training that is so specific to behavior change that it makes them uniquely able to intervene and help patients transform their health and their lives. This presentation will offer data related to ways BHPs skills are currently being used (most often in primary care settings) as well as information related to ways BHP skills can be better used going forward. We will engage the audience in a discussion about ways primary care settings can enhance the use of the BHP skills, improve patient health, decrease primary care physician burnout, and increase patient and provider satisfaction.

Audience Level: All audiences

Track: Interdisciplinary Team Training

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

- Identify ways behavioral health provider skills are most often utilized and where behavioral health provider's skills could be better engaged
- Describe how making better use of behavioral health provider skills can improve patient health, decrease primary care physician burnout, and improve patient and provider satisfaction
- Discuss examples of how behavioral health providers can integrate better into primary care
- Identify opportunities for better integration moving forward.

Collaborative Reflecting Teams in Healthcare Education

Lana Kim, PhD, Assistant Professor, Marriage and Family Therapy, Valdosta State University

Barbara Couden Hernandez, PhD, Professor, School of Medicine Director, Physician Vitality, Loma Linda University

Typical medical simulations in healthcare training do not address the importance of emotional intelligence and relational expertise that are required to give bad news, discuss sexual implications of illness, or engage in family conferences. A reflecting team model has been created for use with mental health interns and physicians. A video will illustrate the methodology used at Loma Linda University School of Medicine. Audience participants will then act as reflecting team members while clinicians discuss sensitive topics with simulated patients.

Audience Level: All audiences
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Track: Interdisciplinary Team Training
At the conclusion of this presentation, participant will be able to:

- Explain how reflecting teams function according to Tom Anderson
- Identify common issues in medical or healthcare provider education that require emotional intelligence and experiential learning to perform well
- Engage as a reflecting team member in a collaborative reflecting team training
- Describe outcome collection and data generation from Collaborative Reflective Team Trainings

B1a (40 minutes)
**Forging Medical-Legal Partnerships to Enhance the Patient-Centered Medical Home**
Magrielle H. Eisen, MSS, MLSP, Stoneleigh Emerging Leader Fellow, The Health Federation of Philadelphia

Community health centers typically provide case management services. However, social workers are stretched and these services rarely go beyond helping patients with referrals, with limited follow up. In the Patient-Centered Medical Home (PCMH), not only care coordination but also case management must be enhanced to help patients and families address the social and economic barriers to wellness and help medical practices to increase efficiency and efficacy of care. Medical Legal Partnerships (MLP), which integrate legal staff into the health care team to address unmet legal needs that undermine provision of health care, challenge the traditional separation between medical and legal professionals and offer an effective path to enhanced case management. Not only does MLP fill existing gaps in care for patients by introducing a unique skill-set to the PCMH, it also removes certain burdens from healthcare providers and case managers by solving problems with solutions that lie beyond the conventional scope of healthcare.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change
At the conclusion of this presentation, participant will be able to:

- Identify social determinants of health with potentially legal solutions.
- Describe how and why legal intervention mitigates certain social determinants of health and enhances healthcare delivery through an innovative, collaborative approach.
- Discuss how Medical-Legal Partnership is consistent with the goals, values, and operation of the Patient-Centered Medical Home and collaborative care.
- Advocate for inclusion of legal staff in the health care setting to better serve patients whose health is undermined by unmet socio-legal needs and improve professional satisfaction for providers and case managers.

B1b (40 minutes)
**How Innovators Manage Real World Push-Back: Lessons from VA Integrated Care Implementers**
Laura O. Wray, PhD, Director, Education/Clinical Core, VA Center for Integrated Healthcare
Andrew S. Pomerantz, MD, National Mental Health Director, Integrated Services Office of Mental Health Service, VA Central Office

As VA primary care undergoes a transformational shift to a medical home model, mental health professionals are being integrated into primary care clinics at all VA medical centers and large community-based outpatient clinics. While mandated across the system, it is up to each site to develop innovations that will yield successful implementation of these programs. VA clinicians and administrators from sites across the country participated in a series discussions about their site successes and challenges. We will share
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these experiences with the audience and engage in an interactive session where participants can discuss their own implementation experiences and learn how common challenges to disrupting the status quo can be successfully addressed and overcome. Participants will also discover that implementation experiences in the VA are similar in many ways to non-VA settings and can provide useful models of change strategies.

**Audience Level:** All audiences

**Track:** Clinical Care/Direct Practice

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

- Describe common challenges faced when attempting to disrupt the status quo by integrating mental health services into primary care.
- Describe successful strategies to overcome common challenges encountered when implementing primary care-mental health integration programs
- Explain how lessons learned at a variety of VA sites during program implementation efforts can be applied to other health care systems
- List implementation strategies that may be helpful at their own site

**C1 (90 minutes)**

**The Power of the Patient Centered Care Plan to Transform Primary Care Practice**

Alexander Blount, EdD, Professor of Family Medicine and Psychiatry, UMass Medical School
Larry Mauksch, Med, Senior Lecturer Department of Family Medicine, University of Washington Medical School
Aimee Valeras, PhD, LICSW, Behavioral Health Department, NH Dartmouth Family Medicine Residency / Leadership Preventive Medicine Residency, Concord Hospital Family Health Center

The transition from provider-centered care to patient-centered care is more difficult in practice than many expected. Both providers and patients have been schooled in the doctor being in charge and laying out the treatment plan for the patient. In this workshop we will offer both the rationale for and practical tips for implementing a truly Patient Centered Care Plan. We have experienced the PCCP as a transformational process for both provider, teams and patients, helping to create a conversation that makes care truly patient centered.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

- Describe the challenges involved in the transformation to patient centered care.
- Negotiate a patient centered care plan with a patient
- Teach the process of doing a PCCP to other team members

**D1a (40 minutes)**

**Screening and Management of Depression in Primary Care: Feasibility, Utility, and its role in Clinical Outcomes**

William Sieber, PhD
Zephon Lister, PhD
Alita Newsome, MA
Darren Himeles, BA
Shannon Sampson, LMFT

This presentation will address the challenges experienced when implementing a program for universal screening for depression. Controversy has continued as to the benefits of such screening, and the current analyses of data uncover factors likely to drive outcomes. This presentation will also expose the audience to how one can leverage the electronic health record to improve services, gain efficiencies, and to promote multi-site research on comparative effectiveness research such as being done in the CFHA-supported Collaborative Care Research Network.

Audience Level: All audiences

Track: Clinical Care/Direct Practice

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

- Describe factors that contribute to the feasibility and utility of universal depression screening and management in primary care
- Discuss what patient and disease condition characteristics most benefited by universal depression screening
- Identify ways in which universal depression screening can be used in the management of patient health clinical outcomes
- Describe the challenges and implications of universal depression screening in primary care settings.

D1b  (40 minutes)

Improving Behavioral Health Access for At-Risk Patients in an Integrative Healthcare Site

Cassidy Freitas, MA
William Sieber, PhD
Zephon Lister, PhD

This presentation will describe the prevalence, referral, and follow-through rates found before and after the implementation of a universal depression screening system. The disparity gap that exists for lower socioeconomic and geriatric patients in terms of behavioral health referral follow-through will also be described. The presenters will then share the experiences of physicians who have been practicing under a newly implemented model that may help bridge the follow-through disparity gap that exists for these at-risk populations.

Audience Level: All audiences

Track: Clinical Care/Direct Practice

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

- Describe the rates of depression and referrals to behavioral health that occurred before and after the implementation of a universal depression screening tool in an integrative healthcare site
- Describe the rates in which lower socioeconomic and geriatric patients are following-through on behavioral health referrals
- Describe a multi-level integrative healthcare model that may bridge the disparity gap for these at-risk populations
- Discuss the experience of physicians who are practicing under the multi-level integrative care model that is suggested

E1a  (25 minutes)

A Mindful Heart: Skills-Based Stress Management for Primary Care
Stacy Ogbeide, Doctoral Candidate, Forest Institute

This presentation will discuss the data from the “Mindful Heart” Program, a skills-based stress management program for primary care. This group intervention was first proposed at the Collaborative Family Healthcare Association conference in 2012. This program focuses on reducing the prevalence of hypertension, a common and reversible condition that is a risk factor for cardiovascular disease (CVD), in the primary care setting. During the presentation, the following information will be discussed: patient outcome data, barriers to treatment, and implications for clinical practice.

**Audience Level:** All audiences  
**Track:** Clinical Care/Direct Practice

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

- Describe the impact of CVD on the U.S. healthcare system
- Describe implementation of a skills-based group intervention for the management of hypertension in medical settings.
- Discuss the practical implications of a skills-based group intervention in a primary care setting.

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**E1b (25 minutes)**

**Research Findings on Sleep and the Determinants of Health**

Stacy Ogbeide, Pre-Doctoral Intern Mercy Hospital - Springfield (Missouri)

The purpose of this study was to examine the relationship between subjective social status (SSS) and objective socioeconomic status (SES) on sleep status (sleep duration and daytime sleepiness). More specifically, the current study examined if SSS or SES was a better predictor of sleep duration and daytime sleepiness. The study sample included 73 primary care patients from a free medical clinic in which low income and insured individuals are primarily treated. Results showed that there was no difference between subjective or objective social status and sleep. Additionally, subjective social status was significantly associated with perceived health status and perceived stress. This study adds to the growing literature regarding social status and determinants of health status beyond SES. The results of this study indicate that it may be beneficial for clinicians working with low-income primary care populations to include measures of SSS in addition to the traditional measures of SES for multidimensional patient care.

**Audience Level:** Basic  
**Track:** Clinical Care/Direct Practice

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

- Identify the difference between subjective social status and objective social status
- Explain the impact of sleep (duration and quality) on health status
- Discuss the benefit of a subjective measure of social status for transient medical populations.

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**E1c (25 minutes)**

**Health Related Lifestyle Interventions in Primary Care**

Samantha Monson, PsyD, Integrated Health Psychologist, Lowry Clinic Denver Health & Hospital Authority  
Robert Keeley, MD, Primary Care Physician Denver Health & Hospital Authority, PI: Advancing Care Together  
Matthew Engel, MPH, Researcher Denver Health & Hospital Authority, Project Manager: Advancing Care Together

We turned the usual provider-driven model of integration upside-down to uniquely engage our patients in the process and content of their care. Our innovation is threefold: 1) through focus groups and one-on-one
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Interviews, our patients developed their own self-management tool to activate them around individualized goals. 2) This tool disrupts the single-stream process of medical providers referring patients for behavioral health support, instead facilitating identification of need by patients themselves, as well as by every staff member with whom the patient interacts. 3) We invited patients to challenge our preconceived notions about the way they “should” be “helped;” we solicited their care provision ideas and followed-up to see how different support modalities impacted their success with difficult health behavior changes. We will share some preliminary patient outcomes, and will engage the audience in a discussion around our challenges and epiphanies in our current state of practice redesign.

**Audience Level:** All audiences

**Track:** Consumer/Patient Engagement

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

- Describe a unique model for handing patients back a portion of their care.
- Identify potential pitfalls in having patients drive their own care.
- Discuss the challenges of reframing an established integrated care model

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**F1  (90 minutes)**

**Systemic Applications of The New and Improved Medical Family Therapy and Integrated Care**

Jeri Hepworth, PhD, Professor and Vice-Chair, Family Medicine Director, Faculty Development Programs, University of Connecticut School of Medicine

Susan H. McDaniel, PhD, Dr. Laurie Sands Distinguished Professor of Families & Health Director, Institute for the Family, Department of Psychiatry Associate Chair, Department of Family Medicine University of Rochester Medical Center Rochester NY

William J. Doherty, PhD, Professor, Family Social Science, University of Minnesota

This interactive workshop will focus on the application of Medical Family Therapy skills and concepts to systems change at multiple levels of clinical and social systems. Participants will be exposed to the significant new applications of Medical Family Therapy, reflected in a thorough revision of the classic text. Particular attention will be directed to the ways Medical Family Therapy skills can be applied to new health systems, especially those related to health care reform, patient and community engagement, new medical technologies, and practice redesign. Participants will have opportunities to consider the theoretical, ethical and logistical issues for each of these levels of systems, and consider how each of them can expand their own work to begin to engage and influence a new system in their own environment. This workshop will move between brief didactic presentations, small group discussion and experiences to enable participants to consider the multiple avenues for expanding the application of medical family therapy principles in their own communities.

**Audience Level:** Advanced

**Track:** Interdisciplinary Team Training

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

- Identify the principle concepts of Medical Family Therapy, including its use as a metaframework for other approaches such as CBT, DBT, and psychoeducation.
- Identify how medical family therapy principles can be helpful in systems redesign, from health policy to practice transformation
- Discuss the compelling need for Medical Family Therapy as it relates to ethical, interpersonal, and socioeconomic issues in healthcare.
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- Discuss future opportunities and challenges for family-oriented behavioral health in the emerging healthcare system

G1a  (40 minutes)

Engaging Families and Communities in Psychological First Aid: Advancing Practice in Multidisciplinary Fieldwork
Tai J. Mendenhall, PhD, LMFT, CFT Assistant Professor University of Minnesota Department of Family Social Science
Jerica M. Berge, PhD, LMFT, MPH Assistant Professor University of Minnesota Medical School Department of Family Medicine & Community Health

The visibility and pace of Psychological First Aid (PFA) across both practice- and research- contexts has intensified a great deal -- nationally and internationally -- over the last 10 years. From the formal development and expansion of stand-alone response-teams and those positioned within existing care-structures, to the integration of PFA training as part of standard education and preparation for first-responders (e.g., police, fire, EMT), mental health professionals (e.g., Psychology, Family Therapy), and biomedical providers (e.g., Emergency Medicine, Family Medicine), it is clear that what once was a sub-specialty advanced by a small collection of practitioners and investigators has now transitioned to a mainstream standing within the broader arenas of the helping professions. As the conventional (i.e., individual-focused) practice of PFA has expanded to engage families and communities across both acute and long-term phases of fieldwork, so too has the need to train care providers to think and intervene systemically. In this workshop, presenters will outline what they and others are doing to advance this call. Participants in this workshop will learn about the nature, content, and conduct of critical incident / trauma-response fieldwork with families (not just individuals) and larger-communities as a whole. They will learn about key strategies for interdisciplinary, systems-informed interventions, alongside common team challenges associated with inter-professional boundaries, interpersonal boundaries, and intra/inter-agency collaboration.

Audience Level: Basic
Track: Interdisciplinary Team Training
At the conclusion of this presentation, participant will be able to:
- Communicate familiarity with the evolution of Psychological First Aid (i.e., from an individually-oriented intervention to one that is systems-informed).
- Explain key strategies for interdisciplinary PFA with individuals, couples, and families within acute phases of fieldwork
- Explain key strategies for interdisciplinary PFA within long-terms phases of fieldwork.
- Describe common challenges in trauma response teams associated with inter-professional boundaries, interpersonal boundaries, and intra/inter-agency collaboration.

G1b  (40 minutes)

Connecting Primary Care and Specialty Mental Health: the Challenge of moving from Competition to Collaboration
Mary Jean Mork, LCSW, Program Director, Maine Mental Health Partners and MaineHealth
Neil Korsen, MD, Medical Director, Mental Health Integration Program, MaineHealth
Cynthia Cartwright, MT, RN, MSEd, Program Manager, MaineHealth
Melissa Cormier, LCSW, Clinical Program Manager, Maine Mental Health Partners and MaineHealth

As Accountable Care filters down to the actual work of healthcare, Patient Centered Medical Homes become reality, organizations focus on care coordination, and integrated behavioral health clinicians start to populate practices, previously identified turf lines are challenged. The culture clash between traditional specialty mental health and medical healthcare is marked by a lack of understanding and an inclination to finger-point and blame when coordination doesn't happen easily. This presentation will focus on the role of integrated behavioral health in continuously challenging the status quo relationship between medical care and mental health care. Strategies developed to improve this collaboration aimed at all levels: state-wide and regional networks, organizational leadership, and in primary care practices will be presented.

**Audience Level:** Advanced

**Track:** Interdisciplinary Team Training

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

- Identify the culture clashes and turf battles (and reasons for these clashes) that are present in our evolving healthcare and behavioral health care system.
- Define specific strategies to use to create improved relationships between healthcare and traditional mental health care agencies, organizations and providers.
- Create an action plan targeting relationship-building interventions for their system and their setting.
- Identify helpful strategies that others have used to move systems in a more collaborative direction

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H1a (25 minutes)

**Dismantling the Silos in Integrated Training**

Colleen Clemency Cordes, PhD, Assistant Director, Clinical Associate Professor, Nicholas A. Cummings Doctor of Behavioral Health Program, College of Health Solutions, Arizona State University

Wendy Danto Ellis, DHEd, MC, LPC Behavioral Health Director, Scottsdale Healthcare

As integrated primary care continues to evolve and take root in the American healthcare system, it is evident that multiple systems need to be redesigned to promote effective service delivery. While much attention has been focused on reforming organizational and financial aspects of care, limited attention has been placed on the need to transform our systems of training. In recent years, focus has been placed on the development of the integrated behavioral health workforce (Blount & Miller, 2009). This presentation will focus on breaking down the silos of education and training that exist between behavioral health and medical education programs. The presenters will discuss strategies for interdisciplinary team training, impacting systemic change, and blending the culture of these two systems. The presenters will utilize a case example of a partnership between a behavioral health training program and a family medicine residency training program to highlight an effective transformation of one such partnership. They will suggest ways to generalize this to other educational and clinical partnerships and programs.

**Audience Level:** Basic

**Track:** Interdisciplinary Team Training

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

- Describe how current educational systems continue to promote the silos of medical and behavioral healthcare
- Identify three strategies for transforming our healthcare education programs
- Describe a unique collaborative partnership between a behavioral health and medical residency training program and how this has led to increased provision of collaborative primary care and enhanced provider satisfaction

**H1b (25 minutes)**

**Developing Cross-Disciplinary Mental Health Teams in Integrated Care Settings**

Cathy M. Hudgins, PhD, LPC, LMFT Director, Center for Integrated Care Training and Research
Jennifer Hodgson, PhD, LMFT Professor, East Carolina University, Departments of Child Development & Family Relations and Family Medicine

Behavioral health providers are trained in separate siloes and have been for decades. Now the expectation is that they work together in an integrated care context and automatically understand one another’s competencies, scope of practice and research expertise, and world views. A historical summary of key policy and professional issues that have influenced staffing, training, and practice issues will also be provided as a way to frame the current climate in health care reform. Participants will be asked to consider how their own professional identities, ethics, and training will need to be repositioned and rearticulated in order to be included as recognized, reimbursable members of Integrated Care teams.

**Audience Level:** All audiences

**Track:** Interdisciplinary Team Training

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

- Identify the key policy and professional issues that have influenced staffing, training, and practice issues as a way to frame the current climate in health care reform.
- Define how their own professional identities, ethics, and training will need to be repositioned and rearticulated in order to be included as recognized, reimbursable members of Integrated Care teams
- Describe how unifying the different mental health disciplines and capitalizing on the competencies each profession brings to the team will increase the capacity to treat patients, especially in areas where there is a shortage of providers.
- Apply core competencies that should be recognized by systems who are concerned about making efficient staffing decisions

**H1c (25 minutes)**

**Creative Collaborations: Bringing the Arts into Healthcare**

Pamela Boeck, RN, MSN, CDE, Clinical Instructor, Oklahoma City University Kramer School of Nursing
Joan Phillips, PhD, LPC, LMFT, ATR-BC, Instructor, University of Oklahoma School of Art and Dept. of Human Relations

Through both lecture and experiential learning this presentation will address the burgeoning field of arts in medicine and healthcare along with an overview of the role creative arts therapists play in this growth. Exemplary programs and models will be shared as well as resources for developing such programs for patients, clients, caregivers, medical personnel and the community. One need not be an artist to value and develop the healing potential of creativity, expression and art within a holistic approach to both patient care and staff support. The interactive component of this presentation requires no skill and is meant to demonstrate simple yet effective inroads in bringing creative supportive interventions to healthcare settings.

**Audience Level:** Basic
Track: Clinical Care/Direct Practice

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

- Identify common goals of the creative therapies in healthcare settings both with patients and providers.
- Identify resources for finding and collaborating with appropriately trained creative arts practitioners
- Describe potential applications to incorporate arts and creativity into their work setting
A2a (40 minutes)

**Let's Play: Engaging Youth and Families in Physical Activity and Exercise**

Tai J. Mendenhall, PhD, LMFT, CFT Assistant Professor University of Minnesota Department of Family Social Science

Jerica M. Berge, PhD, LMFT, MPH Assistant Professor University of Minnesota Medical School Department of Family Medicine & Community Health

William J. Doherty, PhD, LMFT, LP Professor University of Minnesota Department of Family Social Science

The Citizen Professional Center at the University of Minnesota has tackled a variety of health care concerns over the last several years, ranging from specific diseases like diabetes to broader community health. Core tenets driving these efforts engage families and communities as co-producers of health (vs. passive recipients of professional services). In this workshop, presenters will describe two initiatives that focus on reducing sedentary lifestyles among youth. One initiative specifically focuses on preventing childhood obesity and the other on targeting diabetes management. Both initiatives (one located in a middle-class, mostly Caucasian suburb and another located in a low-income, inner-city and mostly American Indian neighborhood) represent projects that are authentically owned-and-operated by the communities within which they are positioned. Participants in this workshop will learn about the guiding principles and methods of the Citizen Professional approach (called “Citizen Health Care”), alongside the respective evolutions -- challenges, successes -- of its two youth-oriented projects focusing on physical activity. Key elements and processes differentiating this work from other models of collaborative and community-based work will also be described.

**Audience Level:** Basic

**Track:** Consumer/Patient Engagement

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

- Describe the core tenets, principles, and action strategies of the Citizen Health Care model.
- Describe how Citizen Health Care has been applied across two diverse community settings to engage youth in physical activity.
- Describe how the Citizen Health Care model is used across different health conditions, including obesity prevention and diabetes management.
- Outline key differences between Citizen Health Care and other models of collaborative and community-based work.

A2b (40 minutes)

**Providing Care for Children and Adolescents with Complex Medical, Psychological and Developmental Problems: A Collaborative Model**

Mary Rineer, PhD Chld and Adolescent Program Enrichment Services CAPES Clinic, Director

Kathleen Shepherd Koljack, MD

Michael J. Sannito, PhD LPC

Danny W. Stout, PhD, StatSoft, Inc., CAPES volunteer

This presentation will provide you with an implementable model for the development of a multidisciplinary collaborative team. The Child and Adolescent Program Enrichment Services (CAPES) team consists of the following members: Pediatrician, Child Psychiatrist, Psychologist, Family Therapist, Speech-Language Therapist, Occupational Therapist, Educational Expert, Statistician, Parents and CAPES Team Administrator. The presentation utilizes a model developed by the CAPES team and is designed to serve children and adolescents who present with moderate to severe problems in two or more areas of development. Strategies for statistical analysis of data collected by the CAPES team will be reviewed and discussed. It was hypothesized that the effectiveness of the CAPES program would
be manifested in lower post-test scores on the Child Behavior Checklist that are statistically significant. Tests accounting for reason for referral to the CAPES team and utilizing the Student’s t-test found significantly lower post-test scores in all domains with the exception of Somatic, with all assumptions being met for the Student’s t-test (Affective t (17) = 3.80, p = .001; Anxiety t (17) = 3.02, p < .001; ADHD t (15) = 5.14, p < .001; Oppositional Defiant t (22) = 2.50, p < .001; Conduct t (17) = 4.01, p < .001). There was marginal significant effect for Somatic ( t (8) = 1.94, p = .0088).

**Audience Level:** All audiences

**Track:** Interdisciplinary Team Training

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

- Describe a model of collaborative multidisciplinary care appropriate for complex cases
- Describe the development and implementation of the collaborative multidisciplinary model
- Identify and discuss research models which can be utilized with the collaborative care and approaches to measure and document benefits to patients
- Describe both the advantages and the challenges of this model of care and discuss solutions utilized for common challenges when implementing the collaborative model

**B2a (40 minutes)**

**Online Program Behavioral Health Internship**

C.R. Macchi, Clinical Assistant Professor, Doctor of Behavioral Health Program, Arizona State University

This presentation addresses ways to incorporate new online technologies into the development, administration, and evaluation of an integrated behavioral health clinical internship program. The presentation will examine core components of an internship training program. The rationale for the use of technologies to enhance training and support student intern skill development will be explored. Demonstrations of specific online technologies will be presented.

**Audience Level:** All audiences

**Track:** Interdisciplinary Team Training

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

- Examine core components of a clinical internship program.
- Identify the connections between student intern training experiences and integrative behavioral health practice skills.
- Incorporate new technologies to support pedagogical goals and practice strategies.

**B2b (40 minutes)**

**Navigating the Clinical Barriers in the Management of Severely and Persistently Mentally Ill Patients**

Verena Roberts, PhD, Psychologist, Denver Health

Elizabeth Lowdermilk, MD, Staff Psychiatrist, Denver Health

Elaine Hess, MA, Predoctoral Psychology Intern, Denver Health

The focus of this presentation is to further enhance collaborative care and take behavioral health and psychiatric integration of services within the medical clinic to the next level by focusing on future steps to build upon existing integrated care efforts. We will discuss potential solutions to identified barriers in successfully treating the severely and persistently mentally ill patient population with the aim of detecting a more comprehensive team-based approach; thus setting the future path for efficient, cost-effective, innovative and sustainable care models in
managing high-risk and severely mentally ill patients. Finally, the presentation’s aim is to foster discussion and ideas around what future models of collaborative care may include.

**Audience Level:** Advanced

**Track:** Leading/Creating Systemic Change

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

- Describe the current state of integrated care at Denver Health, an FQHC
- Identify and learn about barriers to successful integrated care, including the treatment of the severely and persistently mentally ill patients
- Develop a framework around how to enhance collaborative patient care and move current integrated behavioral health approaches to the next level
- Form concrete ideas beyond the basic model on how to integrate specific practice options at attendees own site

**C2 (90 minutes)**

**From Cacophony to Clarity: How to Help People Agree Enough About What They Are Talking About to Move Forward Together**

C.J. Peek, PhD, Associate Professor, Dept. of Family Medicine and Community Health, University of Minnesota Medical School

Benjamin F. Miller, PsyD, Assistant Professor, Dept. of Family Medicine, Associate Director of Primary Care Outreach and Research, University of Colorado Depression Center, University of Colorado School of Medicine

Clinician or other implementers of behavioral health integration often come to a point where they want to move their work to a next level of accomplishment that involves bringing new or additional collaborators or stakeholders into the picture. But these conversations are often confusing and difficult because productive conversations require good-enough shared definitions and an orderly way to run a discussion process from start to agreed-upon action. This workshop supplies definitional frameworks commonly needed in integrated care discussions plus a step-wise path for conducting the conversations around a table.

**Audience Level:** Advanced

**Track:** Leading/Creating Systemic Change

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

- Identify common ways that definitional confusion impedes conversation and leads to misunderstanding and frustration
- Use off-the-shelf definitional frameworks to accelerate productive conversations on outcomes, measures, what functions are required, competencies, and business models.
- Modify or construct definitional frameworks for use in their own particular conversations
- Plan and lead a meeting or process that takes a group systematically from a stated goal to a desired outcome “using these definitional frameworks at each step of the way.”

**D2a (40 minutes)**

**The Brief Intervention Competency Assessment Tool (BI-CAT): A Career Development Planning Tool**

Patricia Robinson, PhD Mountainview Consulting Group, Inc.

Kirk Strosahl, PhD Community Health of Central Washington
Increasingly, both behavioral health providers and primary care providers need more skills for implementing effective brief intervention strategies. This presentation will provide a tool for use in self-assessment of 20 key areas of intervening briefly. Behavioral descriptors of low, adequate, and exemplary competence will be offered to assist participants with making meaningful self-assessments and creating skill development plans for identified areas of deficit.

**Audience Level:** All audiences

**Track:** Interdisciplinary Team Training

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

- Self-assess competency level using the BI-CAT.
- Describe skills needed to improve competency level in three selected areas.
- Make a plan for developing greater competencies in three selected areas.
- Identify one or more professionals who may be able to assist with development of greater competency in three selected areas.

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**D2b (40 minutes)**

**A Team Approach to Behavior Change in Primary Care: It’s Not Just About Symptoms**

Patricia Robinson, PhD  Mountainview Consulting Group, Inc.,

Kirk Strosahl, PhD  Community Health of Central Washington

Often, behavioral health and primary care providers focus on symptom reduction and rely on specific protocols for specific diagnoses. This approach limits providers in their efforts to improve functioning among a diverse group of patients, many of whom have multiple diagnoses. This presentation introduces a game-changing, status quo breaking approach based on both basic and applied science. The techniques you learn will work for most of the patients you see and help you develop resilience for the work you do.

**Audience Level:** All audiences

**Track:** Interdisciplinary Team Training

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

- Discuss clinical, educational, and research opportunities in primary care.
- Describe a system for supporting patient development of a healthy mind and body that includes case conceptualization and team-based interventions that enhance patient psychological flexibility.
- Define psychological flexibility.
- Describe three or more interventions that all members of the Patient Centered Medical Home can use to enhance patient psychological flexibility and/or provider psychological flexibility.

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**E2a (25 minutes)**

**Integrating Comprehensive Pain Management into Primary Care**

Scott M. Safford, PhD  Behavioral Health Consultant, St. Charles Health System

Kimberly S. Swanson, PhD  Behavioral Health Consultant, St. Charles Health System

Effectively managing chronic pain patients, both medically and interpersonally, can be quite difficult. This presentation aims to describe a comprehensive intervention program implemented within an integrated primary care setting that is designed to improve both patient care and physician satisfaction. The goal is to provide attendees with a model of chronic pain care that they might successfully implement within their own primary care clinics or medical training programs.
E2b (25 minutes)

Treating Chronic Pain in Adolescence

Amanda Bye, PsyD, Behavioral Medicine Specialist, Kaiser Permanente

Adolescents with chronic pain have historically been a challenge to treat given the complexity of their symptoms, the high-demand placed on pediatricians and limited empirically based treatment options. Several years ago Kaiser Permanente started a teen chronic pain program to most effectively help these adolescents and their caregivers to be provided with best care from an interdisciplinary approach. The program has been effective in helping patients to manage pain, has significantly decreased medical costs and utilization of resources while providing patient-centered care.

Audience Level: All audiences
Track: Clinical Care/Direct Practice

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

- Identify the type of patients who will benefit from chronic pain treatment
- Integrate medical and mental health treatment to provide best care for teens with chronic pain
- Explain the best practice approaches to treating this population.
- List ways in which this treatment approach has been effective
Concurrent Sessions - Period 2
Friday, October 11, 2013 - 1:30 PM to 3:00 PM

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

- Describe challenges to managing chronic opioid therapy in primary care and residency education.
- Describe elements of multidisciplinary chronic pain treatment.
- Describe development and implementation of our committee.
- Describe typical interventions, preliminary outcome data, challenges to implementation of committee recommendations, and effect on physician satisfaction and education.

F2 (90 minutes)

**Electronic Health Records and Collaborative Care**

This session has been combined to include three presentations.

**Audience Level:** Advanced

**Track:** Clinical Care/Direct Practice

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

- Educate as well as be educated about current practices regarding useful family oriented EMR structures.
- Describe the rationale and strategies for successfully implementing an integrated Electronic Health Record (EHR).
- Identify variables from the EHR that coincide with three area of complexity care assessment-bio-medical, system fragmentation and patient engagement.
- Apply population-based information to develop person-centered healthcare approaches.

**Retrofit your EMR for Collaboration and Family-Centered Care**

Stephanie Trudeau-Hern, MS, Family Therapy Doctoral Intern, University of Minnesota, Allina Healthcare

Randall Reitz, PhD, Director of Behavioral Sciences, St Mary’s Family Medicine Residency

Peter Fifield, MS, Behavioral Health Services Manager, Families First Health and Support Center

Laura Sudano, MA, Medical Family Therapy Fellow, St. Mary’s Family Medicine Residency

Before coming to this workshop, analyze your electronic medical record (EMR) and ask yourself: "Is this tool meeting my clinic’s expectations in providing collaborative family healthcare?" "Would the families I treat recognize themselves in the EMR?" We will present structure we have built in Epic and Centricity and then lead a brainstorming discussion about maximizing an EMR for collaboration and family-oriented care.

**Using the Electronic Health Record to Support Integration in a Behaviorally Enhanced Healthcare Home**

Suzanne Bailey, PsyD, Licensed Clinical Psychologist, Behavioral Health Consultant, Cherokee Health Systems

Parinda Khatri, PhD, Director of Integrated Care, Cherokee Health Systems

Health Information Technology (HIT) represents a key supportive framework for the provision of coordinated, quality, timely, and efficient healthcare services. HIT is fast becoming an essential tool for informing evidence-based practice and clinical decision making, tracking of patient and systems' level data, promoting patient engagement, and facilitating continuity of care coordination. An integrated Electronic Health Record (EHR) presents the opportunity for a multidisciplinary team of healthcare providers to share a central repository of clinical documentation of health information that is exchanged in real-time. Patient Portals improve patients’ access to their health information and provide a conduit for patient-provider communication. The intent of this workshop is to provide an overview of the use of HIT at Cherokee Health Systems, a comprehensive community health organization that integrates behavioral health and primary care. Specifically, the presentation will outline the strategizes utilized to effectively implement an integrated electronic health record designed to promote communication and care coordination between behavioral
health and primary care providers, adoption of a Patient Portal, and meaningful application of evidence based clinical practice and decision making. Lessons learned, operational issues, and training strategies will also be discussed.

**Population-based to Person-centered: Using EHR Variables to Develop Patient Centered Protocols**

Mary R. Talen, PhD

Paul Ravenna, MD, Nortwestern Family Medicine Residency Program

The goals of this clinical and research project are three-fold: (1) expand psychometric properties of the MCAM model to define and identify levels of patient complexity care in three areas—(a) bio-medical complexity, (b) system fragmentation (e.g. continuity of providers, specialists, referrals, insurance) and (c) patient engagement factors and psychosocial concerns, (2) validate this complexity care process to stratify patients’ level of complexity using Electronic Health Records (40,000 unique patient records) compared to expert provider assessment; and (3) initiate population-based protocols and effective patient engagement and system-based strategies to improve patient outcomes for the three levels of complex care. Using EHR variables we have stratified patient panels into levels of complexity ranging from routine/wellcare to moderately complex to high levels of patient complexity in the three core areas—biomedical, system fragmentation and patient engagement. Results of the EHR stratification are being compared to expert team’s assessment of complexity care to refine and develop the criterion-based validity of the complexity EHR factors. These complexity identification factors will then be applied to the out-patient populations and care management protocols for each complexity level. The follow-up plans for validating this tool using criterion-based validity and cost utilization of patients will be shared. A blueprint for patient-centered medical home must address patient complexity by promoting the interplay of population-based approaches to identify patient’s level of complexity and implementing person-centered care that addresses complex concerns. Future horizons include the incorporation of research results into its potential use as a scale or quantitative tool, including item analyses, validity, population-level applications and efficient and specific interventions to trac patient outcomes, cost utilization, and resource management.

**G2a (40 minutes)**

**Successful Integration of Behavioral Health and Primary Care: Creating Partnerships When Providers Think Differently**

Maribel Cifuentes, RN, BSN, Deputy Director, Advancing Care Together Instructor, University of Colorado Department of Family Medicine

Larry Green, MD, Director, Advancing Care Together Professor, Epperson-Zorn Endowed Chair for Innovation and Integration, University of Colorado Department of Family Medicine

Shandra Brown Levey, PhD, Primary Care Psychology Fellow, University of Colorado Department of Family Medicine

Linda Niebauer, Director of Communications, Advancing Care Together, Professional Research Assistant, University of Colorado Department of Family Medicine

Join us for an interactive session designed to explore pitfalls and useful strategies when establishing integrated care partnerships with organizations and individuals who may think and speak differently. Participants will examine lessons learned from primary care practices and community mental health centers currently implementing innovative projects to better integrate the care of their patients and clients in diverse Colorado communities. By the end of the session, you will have a better understanding of critical, preparatory steps to take before “getting married” to your integration partner.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

At the conclusion of this presentation, participant will be able to:
• List key questions you and your partner should answer before "getting married."
• Identify key words and terms that you should define and agree on to describe your joint integration work.
• Identify common pitfalls that can derail your happy union.
• Choose strategies to apply in your setting to improve the likelihood of success in your partnership.

G2b (40 minutes)

Integration Can Work! Demonstrating Cost Effectiveness and Marketing It in the Real World
Natasha B. Gouge, MA, Doctoral Candidate, Department of Psychology, East Tennessee State University
Jodi Polaha, PhD, Associate Professor, Department of Psychology, East Tennessee State University

“But how do you pay for it?” Sigh no more! The indirect benefits of hiring a Behavioral Health Consultant have been demonstrated in large health care industry but not in small, stand-alone practices. Until now! In this session, we will tell you how we answered this worn-out question with a short study comparing productivity and income in one small rural pediatric practice on days with a BHC and days without. Come find out how we showed the providers and staff how this practice saved over $1,000 per day when the BHC was present. We’ll also talk about how we’ve marketed this data to other practices and third party payers.

Audience Level: All audiences
Track: Financing Integration

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

• Define a method of assessing cost effectiveness of behavioral health integration within a primary care clinic
• Discuss results from a study assessing cost effectiveness of behavioral health integration within a primary care clinic
• Identify strategies for disseminating and marketing cost effectiveness results to administrators and third party payers
• Discuss applications of this case study to a wide array of clinics and styles of integration

H2a (25 minutes)

Biopsychosocial Health of Military Couples: Stress, Trauma, and Resiliency
Angela L. Lamson, PhD, LMFT Professor, East Carolina University
Melissa Lewis, PhD, LMFT Visiting Professor, University of Akron
Meghan Lacks, Masters Student, East Carolina University
Lisa Buchner, Masters Student, East Carolina University
Amelia Muse, Masters Student, East Carolina University

This presentation will cover information regarding the physical, psychological, and relational health of military couples. Results will be shared from a year-long study with active duty military personnel and their spouses, including an analysis on marital health and physiological and psychological stressors in the context of military rank, deployment, and gender. Implications for future assessment, treatment, research and policy for military couples will also be presented.

Audience Level: All audiences
Track: Clinical Care/Direct Practice

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

• Identify health risk and resiliency factors for military couples.
Describe the dynamic nature of both military and marital health on military couple's overall health functioning.

Identify outcomes related to assessment and interventions with military couples in the healthcare system.

H2b (25 minutes)

Symptom Presentation and Behavioral Health Intervention in the VA and US Air Force Primary Care Behavioral Health Model

Jennifer S. Funderburk

This presentation will review the most prevalent combinations of presenting symptoms reported by patients seen by VA and USAF behavioral health providers across one clinical day of service, using data collected via a national prospective web-based study. It will also highlight combinations of treatment interventions used to alleviate presenting symptoms as well as a specific examination of those interventions with empirical support. It is hoped that this information may be useful to administrators, supervisors, and current behavioral health providers working in primary care because it provides a "real life" glimpse into what types of patients are seen by providers working in these types of integrated healthcare settings as well as shed light on the types of clinical interventions/treatments more commonly used to target these symptom combinations.

Audience Level: Basic

Track: Clinical Care/Direct Practice

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

- Discuss the most prevalent presenting symptom combinations reported by BHPs in VA and USAF primary care clinics
- Describe the types of clinical interventions employed by BHPs to target these symptom combinations
- Examine the use of empirical-based interventions within this dataset
- Discuss the implication of these results on the clinical practice of BHPs within integrated primary care settings as well as the potential avenues for future clinical intervention research

H2c (25 minutes)

Advancing Integrated Primary Care Education in the VA Medical System

Kendra Campbell, PhD, Primary Care Psychology Fellow, San Francisco VA Medical Center
Daniel Baughn, PhD, Primary Care Psychology Fellow, San Francisco VA Medical Center
Rebecca Shunk, MD, Attending Physician, EdPACT Co-Director, San Francisco VA Medical Center
Eleni Romano, MA Psychology Intern, Louis Stokes Cleveland VA Medical Center, Incoming Primary Care Psychology Fellow, San Francisco VA Medical Center

Leading authorities emphasize the need to prepare health professionals to deliver patient-centered care; this approach ensures quality care in our complex health system. The chronic care model, the patient centered medical home, and VA Patient Aligned Care Teams (PACTs), are all models that emphasize team-based, relationship-centered, population-based, and systems-focused approaches to care resulting in improved health care outcomes as compared to standard primary care services. In order to further advance the current healthcare system, a transformation in clinical education for health care providers is needed. This presentation will outline the recent implementation of an educational training program in integrated primary care at the San Francisco VA Medical Center. The current training model represents a shift in primary education, and embodies an evidence-based, comprehensive, patient-centered, interprofessional care model designed to advance primary care within and beyond the VA.

Audience Level: All audiences
Track: Leading/Creating Systemic Change

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

- Describe the recent development, implementation, and progress of the model of training used in the Education on Patient Aligned Care Team (EdPACT) at the San Francisco VA Medical Center
- Discuss preliminary outcomes of program evaluation for the current model
- Identify potential obstacles in changing the status quo of primary care training
- Discuss directions for future growth within the VA healthcare system and beyond
A3a (40 minutes)

**Transforming Colorado Healthcare Policy: Lessons for the Country**

Benjamin F. Miller, PsyD

Katherine Blair, JD, Health Policy Director, Governor’s Office, State of Colorado

This presentation will highlight Colorado’s road forward with integrated healthcare. The co-presenters, one from academia, the other the health policy director for the Governor of Colorado, will highlight what it has taken to help bring Colorado closer to advancing integrated care in the state. Specifically highlighting innovative state offerings and community leadership, this talk will describe how Colorado has come to be one state leader in integrated care.

**Audience Level:** Advanced

**Track:** Public Policy

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

- List three Colorado initiatives that have helped advance integrated care
- Describe barriers in advancing integrated care in Colorado
- Discuss ways their communities can help advance integrated care through healthcare policy

A3b (40 minutes)

**Health Homes: A Holistic Approach to Service Delivery**

David Johnson, MSW, ACSW AVP Health Care Programs Amerigroup

This presentation provides a brief history and background on health homes, outlines the rational for health homes focused on chronic conditions and reviews current models. Discussed is a danger for States to move quickly without sufficient consideration to system transformation issues, thus maintaining the status quo. The presentation offers a point of view on how health homes can be a disruptive innovation in establishing a new care delivery system

**Audience Level:** All audiences

**Track:** Public Policy

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

- Define health homes in comparison and contrast to patient centered medical homes.
- Describe rational for health homes as a disruptive innovation in health service delivery system.
- Identify health home models and discuss their advantages and disadvantages considering such factors as clinica and financial implications, patient and provider preferences and their orientation to service delivery

B3a (25 minutes)

**Telehealth Video in Primary Care: Clinical Consultation and Training**

Rachel Zahn, PsyD, LCP, Behavioral Health Provider, Co-Director of Clinical Training, Lawndale Christian Health Center

While there exists an increased desire in primary care sites to have collaborative, integrated healthcare that includes behavioral health providers, there still remains a disparity between the numbers of behavioral health providers and the number of patients in need. Within our clinic, the number of medical sites and the number of medical providers has recently increased in our clinic. Consequently, as Behavioral providers, it has become more challenging to respond to the needs of medical providers and patients within our underserved communities. This presentation will discuss a pilot using telehealth video across different medical sites within our clinic to respond to the increased need for clinical consultation and supervision of trainees.
**B3b (25 minutes)**

**iPods in the Exam Room: A Pilot Study and a Discussion of Technology’s Role in Patient-Centered Care and the Treatment of Chronic Illness**

Danielle King, PsyD, Behavioral Health Consultant, Tampa Family Health Centers  
Sally Schwer Canning, PhD, Professor of Psychology Wheaton College

Patient-centered models of care call for primary care teams to educate and engage patients in self management of chronic illnesses. Creative and innovative methods for implementing these goals are needed. Current technologies provide interesting and innovative means through which to support primary care teams in these efforts. This presentation will review the findings of a pilot study which evaluated the acceptability and potential impact of iPod use on patient education in the treatment of depression in three primary care clinics in medically underserved communities. Initial results of this pilot study indicate that both patients and providers responded positively to the podcasts and the podcasts themselves represent one possible solution to current patient education barriers in primary care settings. Additional uses of technology in patient education and self management will be reviewed.

**Audience Level:** All audiences  
**Track:** Consumer/Patient Engagement

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

- Define the role of patient education and self management in the patient-centered treatment of depression and other chronic illnesses in primary care  
- Identify ways in which the use of phone, tablet and iPod-based technologies can help address current limitations in traditional patient education modalities  
- Describe the use of podcasts in providing patient education in primary care and identify the outcomes of a pilot study testing the acceptability and impact of this modality  
- Discuss future opportunities to integrate interactive technology with current patient education, self management, and behavior change strategies

**B3c (25 minutes)**

**Pharmacist Assisted Management of Complex Psychiatric Patients in Primary Care**

Casey Gallimore, PharmD, Clinical Assistant Professor  
Ken Kushner, MA, PhD, Professor

Use of medications to manage mental health conditions in the United States is common. With an estimated two-thirds of all mental health related services provided in the primary care setting, a large proportion of psychotrophic medications are prescribed and monitored by primary care clinicians. In response to this growing trend the Access Community Health Centers (ACHC) in Madison, WI have adopted a multidisciplinary team model that includes a clinical pharmacist focused on assisting primary care clinicians managing psychiatric patients with complex...
medication regimens. Opportunities for collaboration with the clinical pharmacist that were explored at ACHC and may be of benefit to other primary care clinics will be discussed. The presentation will also describe the benefits and challenges of this model of care in managing psychotropic medications, as well as strategies for successful collaboration between primary care clinicians, behavioral health practitioners, data management specialists, and pharmacists on a multidisciplinary team in a primary care clinic.

**Audience Level:** All audiences

**Track:** Interdisciplinary Team Training

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

- Discuss the rationale for collaboration between primary care clinicians, behavioral health consultants, data management specialists and pharmacists in the care of patients prescribed psychotropic medications in primary care.
- Identify key areas in which a pharmacist can provide support to both patients and providers within primary care including assistance with dosing, information regarding potential medication interactions, patient education, medication adherence, and monitor
- Describe potential challenges of collaboration within a multidisciplinary team aimed at providing care to psychiatric patients with complex medication regimens, as well as strategies to overcome these barriers to collaboration.

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**C3a (25 minutes)**

**Behavioral Health in Primary Care: Impact on Medical Utilization and Medical Cost-Offset**

Sean M. O’Dell, MEd, PLMHP

Tawnya Meadows, PhD, BCBA-D, LP

Rachel Valleley, PhD, LP

Behavioral health services are a vital resource that helps to meet a significant public health need. Interestingly, primary care physicians are the de facto first line mental health providers in the pediatric population, not mental health practitioners. Although the field continues to move toward an integrated model of service delivery which increases the collaboration between physicians and mental health practitioners, little is known regarding facets of this model of care as it relates to symptom reduction, potential cost-benefit, and medical cost offset of behavioral health services implemented within primary care settings. Attendees will learn about how integrated behavioral health services impacted health outcomes, subsequent utilization of psychological and medical services, and financial resources in two clinic settings over a year’s time. Implications for practice will be provided, including ways that primary care physicians can partner with mental health practitioners in a sustainable fashion.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

- Explain the impact of integrated care on patient outcomes and service utilization
- Define strategies that can be applied directly to their own practice
- Describe protocols supporting implementation of selected strategies

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**C3b (25 minutes)**

**Return on Investment: Integrated Behavioral Interventions That Save Money**

Ronald R. O’Donnell, PhD, Clinical Professor, Director, Nicholas A. Cummings Doctor of Behavioral Health Degree program
Integrated behavioral health interventions for depression, anxiety and somatizers in primary care have a proven record of producing return on investment in primary care settings. However, these interventions have not been routinely adopted in real-world clinical settings. The movement to Accountable Care Organizations and new payment models based on quality and cost outcomes will result in greater demand for these interventions. This presentation will outline a feasible model for demonstrating ROI for these conditions.

**Audience Level:** Advanced

**Track:** Clinical Care/Direct Practice

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

- Describe the epidemiology of depression, anxiety, and somatizers with co-morbid medical conditions that result in excess healthcare utilization and cost
- Describe population health management interventions for depression, anxiety and somatizers for primary care settings.
- Identify key utilization and related costs of care associated with overuse of medical services and higher costs for depression, anxiety, and somatizers
- Describe eHealth and mHealth resources that are designed to facilitate patient condition self-management

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**C3c (25 minutes)**

**Quantifying and Tracking Productivity for Behavioral Health Clinicians in a Primary Care Practice**

Joni Staigers Haley, MS, LMFT, Manager, Behavioral Health, Concord Hospital Family Health Center, Adjunct Faculty Member, NH Dartmouth Family Medicine Residency

William Gunn, PhD, Licensed Psychologist, Director of Primary Care Behavioral Health, NH-Dartmouth Family Medicine Residency - Concord Hospital

Aimee M. Burke Valeras, PhD, LICSW, Integrated Care Manager, Concord Hospital Family Health Center, Faculty, NH Dartmouth Family Medicine Residency

Behavioral health clinicians in the primary care setting are continually looking for ways to quantify the work and value-added quality of what they bring to the health care team. The frontier of reimbursement for mental health clinicians in primary care is a critical and unavoidable one in the national movement towards integrated behavioral health care. In this community health center that both serves an under-insured population and houses a family medicine residency, the “Integrated Care Manager” (ICM) is a social worker assigned to a clinical team (faculty and resident providers, mid-level providers, nurses, medical assistants). Among other responsibilities, the ICM is responsible for providing day-to-day crisis intervention, assessment, and brief therapy for patients. The ICMs developed a productivity tracking process inspired by the Evaluation and Management (E/M) codes used by their physician practice partners. This system ranks the type of interaction in order to reduce subjectivity between ICMs and to more accurately reflect the value-added to the integrated approach in a clinical encounter. The levels of care will be shared. Data will be presented to show how the variability between ICMs changed before and after this productivity tracking system. Challenges still exist, including how to capture many educational and clinical interactions that fall outside of the 5-level system, as well as the state-to-state variability in reimbursement for such interactions, but this productivity template presents one way to start this essential conversation.

**Audience Level:** Advanced

**Track:** Financing Integration

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

- Describe the ways productivity is captured nation-wide for integrated behavioral health services within primary care.
• Identify one proposed model for capturing productivity for integrated behavioral health care in a medical setting, which parallels that of our medical provider partners.
• Explain how to determine the coding levels based on different types and complexity of interactions.
• Engage in a conversation about how we, as a field, can advocate for integrated behavioral health, through the use of a model that can allow for financial sustainability.

D3 (90 minutes)

**Systemic Applications of The New and Improved Medical Family Therapy and Integrated Care**

Jeri Hepworth, PhD, Professor and Vice-Chair, Family Medicine Director, Faculty Development Programs, University of Connecticut School of Medicine

Susan H. McDaniel, PhD, Dr. Laurie Sands Distinguished Professor of Families & Health Director, Institute for the Family, Department of Psychiatry Associate Chair, Department of Family Medicine University of Rochester Medical Center Rochester NY

William J. Doherty, PhD, Professor, Family Social Science, University of Minnesota

This interactive workshop will focus on the application of Medical Family Therapy skills and concepts to systems change at multiple levels of clinical and social systems. Participants will be exposed to the significant new applications of Medical Family Therapy, reflected in a thorough revision of the classic text. Particular attention will be directed to the ways Medical Family Therapy skills can be applied to new health systems, especially those related to health care reform, patient and community engagement, new medical technologies, and practice redesign. Participants will have opportunities to consider the theoretical, ethical and logistical issues for each of these level of systems, and consider how each of them can expand their own work to begin to engage and influence a new system in their own environment. This workshop will move between brief didactic presentations, small group discussion and experiences to enable participants to consider the multiple avenues for expanding the application of medical family therapy principles in their own communities.

**Audience Level:** Advanced

**Track:** Interdisciplinary Team Training

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

• Identify the principle concepts of Medical Family Therapy, including its use as a metaframework for other approaches such as CBT, DBT, and psychoeducation.
• Identify how medical family therapy principles can be helpful in systems redesign, from health policy to practice transformation.
• Discuss the compelling need for Medical Family Therapy as it relates to ethical, interpersonal, and socioeconomic issues in healthcare.
• Discuss future opportunities and challenges for family-oriented behavioral health in the emerging healthcare system.

E3a (25 minutes)

**Community Partners Serving as Members of the PCMH**

Roni Christopher, MEd, OTR/L Executive Director, Care Transformation, Catholic Healthcare Partners

As we work toward population health management strategies, we have to learn new and innovative ways to treat the patient outside of the waiting room and between primary care visits. Using the standards that guide patient centered medical home transformation, a primary care team can build extensions of themselves through new models of design that train the community and behavioral support staff on how to contribute to the PCMH as a true member of the inter-professional team. In the Perfecting Community Partnerships in Primary Care Practices (PCP2) a joint exchange...
between a FQHC and the Council on Aging created a model where sustaining the Primary Care Patient-Centered approach was realized by the patient in his or her own home while receiving COA services. In the model, methods for exchanging documentation between the sites as well as training the community worker on how to help the FQHC meet the expectations of the PCMH were employed. The pilot results ultimately led to an in practice COA support staff member and new versions of the model to share with local school systems, behavioral health workers, local churches and specialty care.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

- Define the responsibilities of the PCMH to manage and interact with community or clinical referral sources within PCMH standards.
- Recognize PCMH standards to influence and change relationships with external referral sources as a sustainable model of the PCMH transformation.
- Approach community or clinical referral sponsors to create interprofessional teams who care for patients at the population level.

**E3b (25 minutes)**

**Using Narrowband and Broadband Tools for Targeting Appropriate Behavioral Health Treatments**

James V. Wojcik, PhD, Chief Psychologist and Director of Training, Canvas Health

Samuel Hintz, MA, Doctoral Psychology Intern, Canvas Health

Nicole Shackelford, PsyD, Psychologist, Canvas Health

Jonathan Hoistad, PhD, CEO, Natalis Psychology Clinic CEO, Natalis Outcomes

Treatments of a range of mental illness are performed in diverse settings. Are the behavioral health needs of patients presenting in these diverse settings different? This presentation considers patient symptom presentation across three different care settings, considering their range of needs and the relative benefits of broadband or narrowband assessments that may be used to target their treatments.

**Audience Level:** Advanced

**Track:** Clinical Care/Direct Practice

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

- Describe essential differences between broadband and narrowband assessment of mental illness and behavioral health needs
- Explain the range of presentations of mental illness and behavioral health needs across the diverse healthcare settings
- Describe research methods and results of the current study
- Describe implications of results for clinical and systemic decisions

**E3c (25 minutes)**

**Integrated Behavioral Health Care in a Federally Qualified Health Center (FQHC): Pilot Test of Two Behavioral Health Delivery Models**

Jennifer DeGroff, PhD, Director of Outpatient and Integrated Services Adult and Rural Services, AspenPointe Health Services,
Two behavioral healthcare delivery models were simultaneously tested over a 10-week period in the same FQHC clinic. In the Integrated Practice Model, two behavioral health clinicians (BHC’s) co-visited and followed up with patients alongside physical health care providers and addressed the full spectrum of behavioral health care needs. In the second model, the Co-located Model, a BHC co-located a traditional behavioral health practice in the FQHC setting and provided one-on-one, ongoing care to referred clients. Although not targeted, care focused primarily on post-traumatic stress disorder (PTSD) and major depressive disorder (MDD). Stark differences in number of clients seen and productivity were seen. Client outcome data, no-show rates, clinician model preference, and additional data will be compared between the two models, and confounding variables will be discussed.

**Audience Level:** All audiences

**Track:** Clinical Care/Direct Practice

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

- Compare and contrast the Integrated Practice and Co-Located Models of integrated physical/behavioral health care in a physical healthcare setting.
- Identify the basic components of the Integrated Practice Model
- Describe the basic components of the Co-Located Model

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**F3a (40 minutes)**

**Changing the Way We Treat Chronic Pain: Practical and Profitable Evidence-Based Methods**

Daniel Bruns, PsyD, Health Psychology Associates

Pain is the most common reason why patients seek medical care, and chronic pain is one of the most costly of all medical conditions. Treating chronic pain in primary care settings is challenging, with complications that include addressing secondary gain, opioid addiction and other matters. This presentation will review recent scientific advances in our understanding of pain, evidence-based guidelines for pain treatment and assessment, and evidence that the biopsychosocial model saves money. Practical advice for implementation will also be discussed, including developing practice models, methods of billing, and CPT codes that can make pain treatment a profit center rather than a drain on clinic resources. Practical advice will also be offered for implementing pain treatment in capitated service systems.

**Audience Level:** All audiences

**Track:** Clinical Care/Direct Practice

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

- Apply recent scientific advances in our understanding of pain to clinical assessment
- Identify and apply appropriate evidence-based clinical treatment guidelines to their practice
- Implement elements of a chronic pain treatment program that are both clinically practical and financially viable

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**F3b (40 minutes)**

**Implementing Chronic Pain Groups in Two Diverse Family Medicine Residency Clinics: Challenges, Lessons Learned, and Opportunities**

Joan B. Fleishman, PsyD, Postdoctoral Fellow in Primary Care Psychology, Department of Family Medicine and Community Health, University of Massachusetts Medical School

Jeanna R. Spannring, PhD, Postdoctoral Fellow, Department of Family Medicine and Community Health, University of Massachusetts Medical School

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Concurrent Sessions - Period 3
Friday, October 11, 2013 - 3:30 PM to 5:00 PM

Christine Nicole Runyan, PhD, ABPP, Department of Family Medicine and Community Health, University of Massachusetts Medical School

Philip Bolduc, MD, Clinical Assistant Professor, Family Health Center of Worcester, Department of Family Medicine and Community Health, University of Massachusetts Medical School

Primary care providers manage the majority of patients with chronic pain in the US. Patients with chronic pain make up the vast majority of “hot spotters” or high utilizers of medical services and procedures and insurance monies. The primary and established treatment modality for chronic pain remains analgesia despite substantial evidence that chronic pain is a disease of the nervous system. Ever wondered how you could provide more comprehensive, effective, and efficient care for your patients with chronic pain? We will share our experience implementing a group behavioral intervention in the primary care setting. This presentation will cover the process of designing and implementing a multidisciplinary pain program in two family medicine training clinics. Preliminary outcome and qualitative data, including provider and patient feedback will be presented. Strengths and barriers of this process will be discussed.

Audience Level: Advanced
Track: Clinical Care/Direct Practice

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

- Describe the rationale and evidence for non-pharmacologic treatment of chronic pain.
- List the advantages and barriers for implementing chronic pain groups in family medicine training and integrated primary care settings
- Describe the outcomes of chronic pain group interventions in two primary care clinics.
- Identify opportunities for implementing chronic pain groups, including defining the relevant process and clinical outcomes for integrated primary care

G3a (40 minutes)

Combat PTSD: Team-based Approach to Care of the Individual and Family

Anne Van Dyke, PhD, ABPP, Director of Behavioral Medicine Beaumont Health System - Troy Family Medicine Residency Program

Amber Gruber, DO, Faculty and Osteopathic Curriculum Director, Beaumont Health System - Troy Family Medicine Residency Program

Captain Michael Gruber, Bachelor of Science in Engineering Psychology Navistar - Logistics Engineer

A multidisciplinary panel comprised of a health psychologist, family physician, and combat veteran will bring to life the varied and far reaching consequences of Combat PTSD. Discussion will highlight how the diagnosis of Combat PTSD can be a hopeful one leading to the concept of “posttraumatic growth.” Key elements needed from an integrated team approach to reach such an outcome will be clarified. The multifaceted scope of the disorder will be outlined, as well as the goals of integrative treatment. Audience discussion and participation will be sought throughout.

Audience Level: All audiences
Track: Clinical Care/Direct Practice

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

- Discuss the prevalence and impact of Combat PTSD on both the individual and the family
- Define the scope of specialized medical and mental health services needed for returning war veterans and their families
- Describe the ability of health care providers to effectively and longitudinally diagnose and treat Combat PTSD from a biopsychosocial model

G3b (40 minutes)

**Challenging the Status Quo Through Policy, Education, Research, and Program Implementation Assistance in the Veterans Health Administration**

Andrew S. Pomerantz, MD
Laura O. Wray, PhD
Katherine M. Dollar, PhD
Larry J. Lantinga, PhD

Old perceptions and entrenched cognitions die hard, making the status quo difficult to challenge. Yet, our experiences supporting the implementation of integrated care within the Veterans Health Administration suggest that system-level programmatic efforts can yield real change in the delivery of health care. This presentation will provide information on what 5 years of experience in integrating mental and behavioral health care into VA primary care has taught us, including lessons learned that can be applied in any setting. Presenters will describe how a dynamic synergy is emerging among policy development, research initiatives, educational efforts, and program implementation assistance. An overview of current VHA integrated care research endeavors and identified next steps will be discussed.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

- Describe 5 years of experience in integrated care implementation within the VHA including recent innovations to fully integrate mental health into the Medical Home (Patient Aligned Care Teams).
- Explain how lessons learned from integrating care within the VHA can be applied in any setting
- Describe how a dynamic synergy is emerging among policy development, research initiatives, educational efforts, and program implementation assistance
- Describe current integrated care research projects within the VHA, how these research projects are improving care and informing policy, education, and implementation assistance, and understand future research directions.

H3a (25 minutes)

**Healthy Weight Management in a Health Care Home: A Feasibility Study**

Katharine Wickel, MS, LAMFT
Jerica M. Berge, PhD, MPH, LMFT, CFLE
Dianne R. Neumark-Sztainer, PhD, MPH

Obesity is a major health problem facing youth today, especially among adolescents from racially/ethnically and socio-economically diverse families. UMatter is an obesity prevention intervention for diverse adolescent girls ages 10-16 years and their parents. UMatter uses an interdisciplinary approach within a Health Care Home primary care setting to help adolescent girls feel good about their bodies (e.g., body image) so that they will want to take care of their bodies through healthful eating habits and physical activity and avoiding short-term dieting. Results of the UMatter feasibility study suggest that UMatter is feasible within a primary care clinic and initial results suggest trends towards more healthful eating and physical activity in adolescent girls.
Integrating Behavioral Health into Wellness Visits in Pediatric Primary Care

Jean Cobb, PhD, Behavioral Health Consultant, Cherokee Health Systems

J. David Bull, PsyD, Behavioral Health Consultant, Cherokee Health Systems

Pediatric primary care typically involves a developmental approach to healthcare and growth, has a relatively high frequency of contact, and often addresses psychosocial, developmental, and contextual issues as a routine part of care. The following presentation focuses on a model to integrate behavioral health into routine pediatric care. Specifically, the rationale and clinical use of specific screening tools, identification and triage of psychosocial and developmental problems, management of clinic flow and efficiency, and quality service delivery during well-child visits will be discussed. The presentation illustrates a team approach aimed at more fully addressing the needs of patients and their families within the pediatric primary care setting.

Myth Busters: Successful Approaches to Sharing Sensitive Information

Shelina D. Foderingham, LMSW, MPH, Behavioral Health Integration Lead, Program Manager, New Orleans Charitable Health Fund

Elisabeth Gentry, LMSW, MPH, Evaluation Manager

Jonathan Perry, BS, Program Coordinator, New Orleans Charitable Health Fund

Increasingly there is a movement to provide person-centered, holistic care to individuals with co-occurring physical health, behavioral health, and social service needs. Integrated care teams provide the best system for supporting patients in managing their own health. While sharing electronic patient information has long been perceived to be a challenge, there are alternatives to this viewpoint. Considering new Health Information Technology (HIT) tools, the coordination of patient care can now move from being an innovative strategy used only by early adopters to an established standard of care used in all clinical settings. Providers must consider how to share sensitive health
information in a way that maintains privacy and adheres to state and federal regulations while allowing for improved quality of care delivery through seamless coordination of services. This session shares examples of how this is being done in one community.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

- Explain the perceived barriers and challenges with sharing and exchanging substance abuse and mental health information
- Describe the structural and procedural benefits and unintended consequences of sharing or exchanging information
- Discuss recommendations and future implications of sharing and exchanging substance abuse and mental health information
Saturday, October 12, 2013

6:00AM to 7:15AM  Morning Exercise
Join us for morning workouts - all fitness levels welcome. Please sign-up for your preferred activity in the registration area when you arrive at the Conference.
- **Run, Skip, Walk!** Join the group on a 3-mile run but please feel free to skip or walk the route.
- **Dance Workout (Afro/Caribe):** Have you ever wanted to try a dance workout class? This is your chance! No dance experience required. You just need to have the desire to move.

7:00AM to 8:30AM  CFHA Café
Enjoy complimentary coffee and grab a bite to eat with CFHA colleagues. An assortment of light breakfast fare will be available for purchase. CFHA will provide a $5 coupon to Conference registrants that may be applied toward a food purchase in the CFHA Cafe. (Coupons are not valid in hotel outlets.)

7:00AM to 7:30AM  Setup for Saturday Poster Presentations

7:30AM to 3:30PM  Refreshments in CFHA Lounge: Exhibits and Posters
The CFHA Lounge and is designed to promote informal networking between education sessions. The CFHA Lounge will host beverages during breaks and includes a showcase of technology, products, equipment, and services for use in the healthcare profession.

Poster presentations allow author(s) to meet and speak informally with interested viewers, facilitating a greater exchange of ideas and networking opportunities than with oral presentations. Posters will be on display during each refreshment break and there will be a different selection of posters each day.

8:30AM to 10:00AM  Plenary Session - “TED-Style Talks”
This plenary program will include three powerful, short talks, each focused on a single topic or idea. These engaging presentations will jump-start your day at the CFHA Conference.

10:00AM to 10:30AM  Refreshments in CFHA Lounge: Exhibits and Posters

10:30AM to 12:00PM  Concurrent Education Sessions - Period 4
Each 90-minute period will feature 8 classrooms of simultaneous presentations. Seating for all Conference sessions is on a first-come, first-served basis. Classrooms vary in size and capacity and some sessions may reach standing-room capacity before the presentation begins. A Conference schedule with classroom assignments will be provided when you check-in at the Conference. Plan to arrive early to ensure seating for your preferred sessions.

12:00PM to 1:15PM  CFHA Awards Lunch
Please join us as we honor and celebrate individuals, teams and organizations that exemplify the values of CFHA.

1:30PM to 3:00PM  Concurrent Education Sessions - Period 5
Seating for all Conference sessions is on a first-come, first-served basis. Plan to arrive early to ensure seating for your preferred sessions.

This schedule is subject to change without notice. For the most current version, go online to www.cfha.net
Preliminary Conference Agenda
Collaborative Family Healthcare Association 15th Annual Conference
October 10-12, 2013 • Omni Interlocken Resort, Broomfield, Colorado U.S.A.

3:00PM to 3:30PM  Refreshments in CFHA Lounge: Exhibits and Posters

3:30PM to 4:30PM  Conference Wrap-up Session
Please join CFHA leaders for a brief wrap-up to the 2013 Conference. Share your experiences and offer suggestions to help us plan future Conferences.

4:30PM to 8:30PM  Excursion to Boulder ($10 advance ticket purchase required)
Shuttle transportation will be provided to Boulder. Discover a beautiful community, nestled at the foot of the mountains, that combines outdoor adventure with hip, urban entertainment.

4:30PM to 8:30PM  CFHA Dinner Groups in Boulder
Dinner groups encourage professional interaction in an informal, relaxed environment. Reservations are available at a selected number of Boulder restaurants on a first-come, first-served basis. Participants are responsible for their own meal costs and transportation. (Hint: Purchase a ticket for the Excursion to Boulder.)

Sign up for your preferred restaurant at the CFHA Registration Desk before 12 PM on Saturday; more details will be available when you sign-up.

This schedule is subject to change without notice. For the most current version, go online to www.cfha.net
Plenary Session #3

Saturday, October 12, 2013 - 8:30AM to 10:00AM

TED-Style Talks

This plenary program will include three powerful, short talks, each focused on a single topic or idea. These engaging presentations will jump-start your day at the CFHA Conference.

Childhood Obesity - Why It is Difficult to Win This Battle

Efforts have existed for years to stem the tide of childhood obesity yet the numbers continue to be out of control. A key factor in this battle is that the causes of obesity are multifactorial and are frequently not approached with this fact in mind. Dr. Reginald Washington, Chief Medical Officer of the Rocky Mountain Hospital for Children, will explore some of the lesser known elements of the obesogenic environment.

What's Sex Got To Do With It?

Medical Family Therapist and Clinical Sexologist Tina Schermer Sellers, PhD, examines the connection between sexual health, medicine, culture and well-being. Lighthearted yet compelling, this talk proposes ways medicine (and physicians) can exist to contrast the confusing consumer messages received about sexuality and offer instead trusted knowledge about intimacy and sexual health. Tina will help us see how the elixir of intimacy and pleasure is something we could all stand another drop of.

Paintbrush Warrior

Regina Holliday is an activist, artist, speaker and author. She utilizes the tools of technology and social media to better understand the patient condition and the landscape of medicine, and paints the content she hears from the patient view. This talk will focus on the intersection of HIT, Art and Patient Advocacy. Learn about the power of art imagery to help shape health policy and better appreciate the immense resource of patient/caregiver perspective as a team member in the clinical encounter.

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

- Identify three elements that contribute to the obesogenic environment.
- Discuss the advantages of integrated care in treating sexual problems.
- Describe how the power of art imagery can help to shape health policy.
## Preliminary Schedule of Concurrent Education Sessions for the CFHA’s 15th Annual Conference

### Saturday, October 12, 2013 - Period 4: 10:30AM to 12PM

<table>
<thead>
<tr>
<th>Period 4</th>
<th>A Track</th>
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<td>Preparing Medical Students for Integrated, Patient-Centered Care</td>
<td>Implementing ADHD Intervention for Children in an Integrated Pediatric Primary Care Setting</td>
<td>Collaborating to Improve Patient Advocacy</td>
<td>Overcoming Rural Service Delivery Barriers: Three Examples in Integrated Care</td>
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<td>Implementing ADHD Assessment and Intervention for Children in an Integrated Pediatric Primary Care Setting</td>
<td>Fifty-five Word Stories: A Tool for Reflection and Disrupting our Status Quo</td>
<td>Creative Responses to Patients with Complex Problems and Dysfunctional Styles of Interaction</td>
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<td>Introducing the Alchemy of Community Based Collaboration into Medical Education</td>
<td>Depression &amp; Anxiety Intervention</td>
<td>Attending to Lesbian, Gay, Bisexual and Transgender Health: Improving Health Disparities Through Physician Education</td>
<td>Reading Between the Lines: A Rubric for Critically Analyzing the Collaborative Care Literature</td>
<td>Patient Centered Medical Home Project: Rural Integrated Behavioral Healthcare in a Federally Qualified Community Health Center System</td>
<td>Dementia in Primary Care: Integrated Care Strategies to Improve Detection and Management</td>
<td>Enhancing the Medical Practice: Creative Approaches to Systems-Level Change in Primary Care</td>
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This schedule is subject to change without notice.

Version 7/18/2013
### Preliminary Schedule of Concurrent Education Sessions for the CFHA’s 15th Annual Conference

**Saturday, October 12, 2013 - Period 5: 1:30PM to 3PM**

<table>
<thead>
<tr>
<th>Time</th>
<th>Track</th>
<th>Session Title</th>
<th>Presenter(s)</th>
<th>Audience</th>
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<tbody>
<tr>
<td>1:30PM</td>
<td>A5a</td>
<td>Empowering Female Patients in Multi-disciplinary Settings</td>
<td>Aimee Galick, Beth A. Patrick</td>
<td>All audiences</td>
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<td></td>
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<td>The Multiple Roles of Behavioral Health Consultants in Smoking cessation</td>
<td>David Strong, William Sieber, Sharon Cummings, Alita Newsome, Madison Noble, Gene Kallenberg</td>
<td>Clinical Care/Direct Practice</td>
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<tr>
<td></td>
<td>B5a</td>
<td>Ideas That Make a Difference, Tips for Success and Overcoming Barriers:</td>
<td>Larry Mauksch, Colleen Fogarty</td>
<td>Basic</td>
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<td></td>
<td>Scholarship Through Peer Reviewed Publication</td>
<td>All audiences</td>
<td>Clinical Care/Direct Practice</td>
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<tr>
<td></td>
<td>C5</td>
<td>The Evolution of Integrated Care at Kaiser Permanente</td>
<td>Arne Beck, Joanne Whalen</td>
<td>All audiences Leading/Creating Systemic Change</td>
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<tr>
<td></td>
<td>D5a</td>
<td>Anything Goes? Developing a New Measure of Fidelity for Behavioral Health</td>
<td>All audiences</td>
<td>Leading/Creating Systemic Change</td>
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<tr>
<td></td>
<td>E5a</td>
<td>Measuring the Quality of Integrated Care: The AHRQ Integration Quality</td>
<td>Neil Korsen, Benjamin Miller, Vasudha Narayanan, CI Peek</td>
<td>All audiences Leading/Creating Systemic Change</td>
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<td></td>
<td>F5a</td>
<td>Maximizing Reimbursement in Today’s Fee for Service World</td>
<td>Mary Jean Mork</td>
<td>Basic</td>
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<tr>
<td>2PM</td>
<td>G5a</td>
<td>Coordinated Care Organizations: Oregon’s Path to the Future</td>
<td>Robin Henderson</td>
<td>Financing Integration</td>
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<td></td>
<td>H5a</td>
<td>Innovative Partnerships for Successful Integrated Health Care - A Texas</td>
<td>All audiences</td>
<td>Public Policy</td>
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<td></td>
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<td>Perspective</td>
<td>All audiences</td>
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<tr>
<td>2:10PM</td>
<td>A5b</td>
<td>Fire and Gun Fire: A Naturopathic and Academic Approach to Anger in Young Men</td>
<td>Steven M. Rissman</td>
<td>All audiences</td>
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<td>The Use of Technology in the Treatment of Diabetes</td>
<td>Cheryl Bene Masters, Jerome Nymberg</td>
<td>Clinical Care/Direct Practice</td>
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<td></td>
<td>B5b</td>
<td>Reducing Medical Costs and Improving Clinical Care, Coordination, and</td>
<td>Sara Tracy, Kevin Vanderveen, Joanne Whalen</td>
<td>All audiences Leading/Creating Systemic Change</td>
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<td></td>
<td>Outcomes for High Utilizers of Emergency Care Services</td>
<td>All audiences</td>
<td>Leading/Creating Systemic Change</td>
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<td>2:20PM</td>
<td>C5b</td>
<td>Using a Same/Next Day Appointment Schedule System to Reduce No-Shows in a</td>
<td>David Trotter, Daniel Mullin, Christine Runyan</td>
<td>All audiences Leading/Creating Systemic Change</td>
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<td>PCMH Behavioral Health Service</td>
<td>All audiences</td>
<td>Clinical Care/Direct Practice</td>
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<td></td>
<td>D5b</td>
<td>Applying Community Based Participatory Research to Facilitate Community</td>
<td>Peter Rainey, Paul Springer, Richard Bischoff</td>
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<td></td>
<td>E5b</td>
<td>Mental Healthcare, Interprofessional Collaboration, and Patient Empowerment</td>
<td>All audiences</td>
<td>Leading/Creating Systemic Change</td>
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<td>F5b</td>
<td>Fire: A Naturopathic and Academic Approach to Anger in Young Men</td>
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<td>G5b</td>
<td>Early Lessons in Global Budget Model Testing for Integrated Care</td>
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<td>Fire: A Naturopathic and Academic Approach to Anger in Young Men</td>
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<td>2:30PM</td>
<td>A5c</td>
<td>Lessons Learned in Geriatric Collaborative Care Research: What if the Status</td>
<td>Katherine Buck, Dennis Russo, Eric Watson</td>
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<td>Quo Just Won’t Budge?</td>
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<td>Research: What if the Status Quo Just Won’t Budge?</td>
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This schedule is subject to change without notice.  
Version 7/18/2013
A4a (40 minutes)

**Preparing Medical Students for Integrated, Patient-Centered Care**

Kathy L. Bradley-Klug, PhD, NCSP Associate Chair, Department of Psychological & Social Foundations Associate Professor, Graduate Programs in School Psychology College of Education, University of South Florida

Kira Zwygart, MD, FAAFP Associate Professor and Interim Chair, Department of Family Medicine, University of South Florida Morsani College of Medicine

Interdisciplinary health care starts with changing teaching practices at the pre-service level. The SELECT program at the University of South Florida was developed to prepare a subset of medical students to be leaders in medicine through exposure to team-based, patient centered care at the system, practice, and interpersonal levels. Elements of this program include clinical mentorship with interdisciplinary care teams, individualized faculty coaching, didactic and applied experiences to improve self-awareness and relationship management, and a visit to a patient's home or workplace to help students appreciate how quality of life is affected by health status. An overview of the curriculum will be shared, as well as outcome data from two years of program implementation, gathered from students focus groups, faculty ratings, and patient satisfaction scales. Implications for improving pre-service education across disciplines to promote integrated care will be discussed.

**Audience Level:** All audiences

**Track:** Interdisciplinary Team Training

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

- Identify the critical components of a medical student curriculum designed to prepare health professionals to deliver integrated, patient-centered care
- Describe the importance of interdisciplinary collaboration in the development of this training curriculum
- Define the outcomes of this training curriculum
- Discuss the implications for future development of inter-professional training in integrated care

A4b (40 minutes)

**Introducing the Alchemy of Community-Based Collaboration into Medical Education**

Ajantha Jayabarathan, Family Physician, Assistant Professor, Dalhousie Department of Family medicine

Lynette Reid, PhD, Associate Professor, Department of Bioethics, Dalhousie University, Unit Head, Professional Competencies Unit

Linda Bayers, PhD, Community Health Educator, Mental Health First Aid Instructor, Executive Director, Self-Help Connection, Adjunct Professor, Faculty of Health Professions, Dalhousie University, Co-tutor, Professional Competences Unit

Joseph Sadek FRCPC, DABPN (Psych & Neuro), MBA, BSc Pharm Department of Psychiatry, Dalhousie University

Citizen voices and the patient journey are often drowned out within the clamor of the biomedical model of healthcare. Nowhere is this more evident than in undergraduate medical training. In an interactive fishbowl activity, a bioethicist, community health educator, family physician, and psychiatrist model how community based collaborative mental health care has been integrated into medical education renewal. The audience will participate in smaller fishbowls to customize this process for their own communities of practice.

**Audience Level:** All audiences

**Track:** Education/Training

At the conclusion of this presentation, participant will be able to:
Concurrent Sessions - Period 4
Saturday, October 12, 2013 - 10:30 AM to 12:00 PM

- Describe an innovative, working model that introduces the citizen’s experience as a patient into health education and the complex web of collaborative mental health education
- Present outcomes of the intervention: personal, student, teachers, community based organization and academic institution
- Apply the model to fit communities of practice
- Discuss the opportunities and challenges encountered

B4b (40 minutes)

**Depression & Anxiety Intervention**

Marisa Taylor  
Rachael Meir  
Stephanie Rachel Speer  
Christine Garcia

Presenters will inform and engage the audience on the topic of an innovative approach to treat depression and anxiety. Denver Health Managed Care has developed an evidenced-based phone counseling intervention found to improve symptomology related to depression and anxiety. Presenters will discuss research findings, intervention techniques, applicability, and benefits of this valuable approach to treating mental health issues.

**Audience Level:** Advanced  
**Track:** Consumer/Patient Engagement

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

- Identify benefits of this adjunctive treatment  
- List applicability of this intervention modality  
- Explain specific techniques and skills taught by this counseling intervention

C4b (40 minutes)

**Attending to Lesbian, Gay, Bisexual and Transgender Health: Improving Health Disparities Through Physician Education**

Chandra Hartman, MD, FAAFP Assistant Professor, University of Colorado Health Sciences Center, Rose Family Medicine Residency  
Benjamin Kirkley, MD, Rose Family Medicine Residency  
Arwen Johnson, MD, Rose Family Medicine Residency

Lesbian, gay, bisexual and transgender health is a broad topic which receives limited attention in medical school and residency training programs, even in primary care specialties. Studies also show that this population is marginalized in our current health system. A survey of residents at Rose Family Medicine in Denver, CO revealed a lack of knowledge and comfort in care of this large group of patients. We developed and implemented a longitudinal curriculum to address this need and our presentation will serve as a general blueprint for LGBT curricular implementation in a variety of clinical and training settings. Our target audience will be healthcare providers and educators.

**Audience Level:** Basic  
**Track:** Clinical Care/Direct Practice

At the conclusion of this presentation, participant will be able to:
Concurrent Sessions - Period 4
Saturday, October 12, 2013 - 10:30 AM to 12:00 PM

- Discuss the rationale for an LGBT curriculum within training programs
- Identify national educational guidelines for an LGBT curriculum
- Apply the basics of implementing a training curriculum in a multidisciplinary team setting

D4b (40 minutes)

**Reading Between the Lines: A Rubric for Critically Analyzing the Collaborative Care Literature**

Randall Reitz, PhD, LMFT, Director of Behavioral Sciences, St. Mary’s Family Medicine Residency
Keith Dickerson, MD, Faculty Physician, St. Mary’s Family Medicine Residency
Laura Sudano, MA, Medical Family Therapy Fellow, St. Mary’s Family Medicine Residency
Sabrina DiGioia, DO, Faculty Physician, St. Mary’s Family Medicine Residency

Not every clinician needs JAMA-level statistical chops, but every clinician should be able to assess the quality of research literature and extrapolate implications for his/her work setting. Based on the book, "Between the Lines: Finding the Truth in Medical Literature," this session will present a rubric for analyzing the collaborative care literature that can be easily applied by non-researchers. Through small discussion groups we will use this model to critically analyze the 2013 NEJM article on the "Myths, Presumptions, and Facts About Obesity".

**Audience Level:** Basic

**Track:** Leading/Creating Systemic Change

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

- Describe 4 guidelines for analyzing research literature
- Analyze recent obesity best-practices guidelines
- Advocate for a clinical model based on scientific findings

E4a (40 minutes)

**Overcoming Rural Service Delivery Barriers: Three Examples in Integrated Care**

Alysia Hoover-Thompson, MS, Pre-Doctoral Psychology Intern, Stone Mountain Health Services
Jodi Polaha, PhD, Associate Professor, Department of Psychology, East Tennessee State University
Catherine Jones-Hazledine, PhD, Licensed Psychologist, Western Nebraska Behavioral Health

Integration in rural primary care has well-delineated advantages, but there are barriers to developing a workforce in these areas. In this presentation, representatives from three novel rural service delivery programs will discuss specific strategies for overcoming these barriers. Attendees will learn how a rural Federally Qualified Health Center grew from 0 to 6 full-time psychologists in two years, how a graduate training program uses telehealth to provide services at rural primary care clinics, and how integrated clinics in the Frontier counties of Nebraska ensure a future workforce starting by targeting high school students.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

- Discuss barriers to growing a workforce in rural communities.
- Identify strategies for developing a workforce in integrated rural practice
- Describe three programs successfully overcoming barriers

E4b (40 minutes)
Patient Centered Medical Home Project: Rural Integrated Behavioral Healthcare in a Federally Qualified Community Health Center System

Bill McFeature, PhD

Health Care Reform will bring new behavioral health initiatives that will increase visibility and accountability for all health centers. A SVCHS, Inc. rural health center will hire typically on average 3-4 front desk staff (non-centralized and centralized call systems), 2-3 medical care practitioners (MD, FNP, and PA) with 3-4 supportive nursing staff (LPN), care coordinator (RN, LPN, MA) and 1 behavioral health provider (psychologist, LPC/LMFT, and LCSW). A practical, patient-centered template will align with the Triple Aim quality metric measures described by Dr. Berwick: 1) Improving coordinated care, 2) Improving the health of identified patient populations, and 3) Reduce per capita cost of healthcare. These metric measures clearly align with the patient centered medical home concept and NCQA/JCAHO certification requirements set forth within primary care. This presentation will describe a rural community health center’s participation in a one year PCMH Learning Collaborative Project with a core focus on a primary care and behavioral health integration model.

Audience Level: Advanced

Track: Clinical Care/Direct Practice

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

- Identify primary care and brief behavioral health structural, clinical, and financial measures that align with the PCMH model of care.
- Describe evidence-based clinical practices that promote the coordinated care between the PCP and BH/BHC.
- Define standard screening measures and brief intervention treatment services utilized in primary care settings.
- Discuss the importance of conducting performance improvement measures through extraction of integrative care data, i.e., comorbidity factors (both medical and behavioral health conditions).

Implementing ADHD Assessment and Intervention for Children in an Integrated Pediatric Primary Care Setting

Parinda Khatri, PhD, Director of Integrated Care, Cherokee Health Systems
Kara Johansen, PsyD, Pediatric Behavioral Health Consultant

While symptoms of ADHD can adversely affect a child’s academic, family, and peer relational functioning, it is often inappropriately assessed and treated. Integrated pediatric primary care, composed of behavioral and medical providers, represents an ideal setting to implement appropriate assessment and intervention guidelines for ADHD. As an integrated community health care organization, Cherokee Health Systems strives to be a behaviorally enhanced healthcare home designed to address the spectrum of physical and behavioral concerns of children and their families. The intent of this workshop is to provide an overview of an ADHD assessment and intervention protocol in an integrated pediatric community healthcare setting.

Audience Level: Advanced

Track: Clinical Care/Direct Practice

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

- Describe a model of an integrated community pediatric healthcare setting
- Describe the rationale for ADHD assessment and intervention in a pediatric healthcare home.
- Discuss the protocol for a primary care based ADHD management protocol for children and adolescents
- Apply strategies for implementation, including lessons learned, of a pediatric primary care based ADHD management protocol
F4b (40 minutes)

**Dementia in Primary Care: Integrated Care Strategies to Improve Detection and Management**

Laura O. Wray, PhD, Director, Education/Clinical Core Veterans Affairs, VISN 2 Center for Integrated Healthcare  
Christina L. Vair, PhD, Psychology Post-Doctoral Fellow, Veterans Affairs Advanced Fellowship Program in Mental Illness Research and Treatment, VA Center for Integrated Healthcare, Western New York Healthcare System  
David A. Hunsinger, MD, MSHA Medical Director, Binghamton Veterans Affairs Outpatient Clinic

Awareness of the value and importance of integrating assessment of cognitive decline in annual examinations of older adults in primary care (PC) is growing, however, rates of detection of dementia in PC remain low. This presentation will provide a brief overview of timely research findings and discussion of relevant clinical practice applications. Presenters will engage the audience in discussion about ways to increase collaboration between medical and behavioral health providers in service of identifying undetected dementia, integrating validated brief screening tools to assess for cognitive impairment into clinical practice, and partnering with families to address management of dementia and co-morbid conditions.

**Audience Level:** Basic  
**Track:** Clinical Care/Direct Practice

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

- Identify warning signs and risk factors for dementia in older primary care patients  
- Discuss ways to improve detection of dementia in primary care.  
- Describe evidence-based strategies to improve recognition of dementia in primary care, including description of validated screening tools that can be readily integrated into primary care assessment for dementia.  
- Discuss strategies to engage medical and behavioral health providers in collaboration to improve the primary care of patients with dementia.

G4a (40 minutes)

**Fifty-five Word Stories: A Tool for Reflection and Disrupting our Status Quo**

Colleen T. Fogarty, MD, MSc, Associate Professor, University of Rochester Department of Family Medicine

This seminar will review the origin of the fifty-five word story and share examples published in the medical literature. We will discuss a theoretical rationale for using the 55 word format and will review strategies to write brief stories. Participants will be invited to write their ideas and develop fifty-five word stories, then share this work in small groups. The session summary will solicit participant ideas on applying this work to teaching trainees, to sharing in teams, and to use in personal/professional reflection.

**Audience Level:** All audiences  
**Track:** Interdisciplinary Team Training

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

- Discuss the technique for writing a fifty-five word story.  
- Develop a fifty-five word story in response to a choice of writing prompts based on their teaching and/or practice.  
- Apply a group use of fifty-five word story reading to reflect and understand others’ experiences in collaborative healthcare.  
- Discuss potential uses of brief narrative writing in training, team building, collaboration, and self-reflection.
G4b (40 minutes)

**Enhancing the Medical Practice: Creative Approaches to Systems-Level Change in Primary Care**

Shelley Hosterman, PhD, Associate, Geisinger Health System  
Tawnya Meadows, PhD, Associate, Geisinger Health System  
Heather Babyar, PhD, Post-Doc, Geisinger Health System

Behavioral health providers in truly integrated care practices serve a broad range of roles. Behavioral health providers are in a unique position to improve the overall quality of the patient experience beyond fulfilling the more traditional roles of treatment, consults, and warm hand offs. Skill sets in prevention and intervention for systems-level issues are unique and applicable within the primary care setting. Purpose of the presentation is to highlight several creative contributions of behavioral health providers within the pediatric primary care setting. These projects focus on enhancing skills and knowledge of primary care partners. Attendees will walk away with ideas and materials already implemented and enthusiastically received within the primary care setting. These will include a behavioral rewards program, physician education in a variety of formats, and examination room activities to engage patients.

**Audience Level:** All audiences  
**Track:** Leading/Creating Systemic Change

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

- Describe activities beyond warm handoffs and therapy in which psychologists engage to enhance integrated care  
- Implement strategies psychologists can guide to improve patient satisfaction of those receiving medical care  
- Use behavioral principles to enhance general clinic practices

H4a (40 minutes)

**Creative Responses to Patients with Complex Problems and Dysfunctional Styles of Interaction**

Donald E. Nease, Jr., MD, Associate Professor of Family Medicine, University of Colorado Denver  
Franklyn Dornfest, MD, Associate Professor of Family Medicine - retired, Oregon Health Sciences University

Using a combination of presented material, audience participation and group discussion, we will explore the use of Balint’s small group method to increase primary care practices’ ability to serve more flexibly as a secure base for patients with complex problems and dysfunctional attachment styles. Attendees with diverse professional backgrounds and roles are encouraged to attend.

**Audience Level:** Advanced  
**Track:** Interdisciplinary Team Training

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

- Identify ways in which Attachment Theory is relevant in primary care.  
- Describe the basic format of a Balint group that includes practice staff in a variety of roles.  
- Discuss the applicability of a Balint group to create a Secure Base within a Medical Home.  
- Discuss pros and cons of using the demonstrated approach in one's own workplace.

H4b (40 minutes)

**Engaging Families and Communities in Psychological First Aid: Advancing Practice in Multidisciplinary Fieldwork**
Tai J. Mendenhall, PhD, LMFT, CFT Assistant Professor University of Minnesota Department of Family Social Science
Jerica M. Berge, PhD, LMFT, MPH Assistant Professor University of Minnesota Medical School Department of Family Medicine & Community Health

The visibility and pace of Psychological First Aid (PFA) across both practice- and research- contexts has intensified a great deal -- nationally and internationally -- over the last 10 years. From the formal development and expansion of stand-alone response-teams and those positioned within existing care-structures, to the integration of PFA training as part of standard education and preparation for first-responders (e.g., police, fire, EMT), mental health professionals (e.g., Psychology, Family Therapy), and biomedical providers (e.g., Emergency Medicine, Family Medicine), it is clear that what once was a sub-specialty advanced by a small collection of practitioners and investigators has now transitioned to a mainstream standing within the broader arenas of the helping professions. As the conventional (i.e., individual-focused) practice of PFA has expanded to engage families and communities across both acute and long-term phases of fieldwork, so too has the need to train care providers to think and intervene systemically. In this workshop, presenters will outline what they and others are doing to advance this call. Participants in this workshop will learn about the nature, content, and conduct of critical incident / trauma-response fieldwork with families (not just individuals) and larger-communities as a whole. They will learn about key strategies for interdisciplinary, systems-informed interventions, alongside common team challenges associated with inter-professional boundaries, interpersonal boundaries, and intra/inter-agency collaboration.

**Audience Level:** Basic

**Track:** Interdisciplinary Team Training

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

- Communicate familiarity with the evolution of Psychological First Aid (i.e., from an individually-oriented intervention to one that is systems-informed).
- Explain key strategies for interdisciplinary PFA with individuals, couples, and families within acute phases of fieldwork
- Explain key strategies for interdisciplinary PFA within long-term phases of fieldwork.
- Describe common challenges in trauma response teams associated with inter-professional boundaries, interpersonal boundaries, and intra/inter-agency collaboration.
A5a (25 minutes)

**Empowering Female Patients in Multi-disciplinary Settings**

Aimee Galick, PhD(c)  Medical Family Therapist Intern, Loma Linda Medical Center, Adjunct faculty, Loma Linda University

Beth A. Patrick, MA, Medical Family Therapist Intern, Loma Linda Transplantation Institute, Third year Doctoral Student, Loma Linda University

Over the past century medical discourse has become the dominant perspective on illness. Relational discourses, which carry less power, are frequently adopted by women and inform their thoughts, feelings, and behavior. Medical family therapy seeks to improve service delivery by bridging these competing systems of language with their differences in systemic power. The purpose of this interactive presentation is to facilitate participant’s understanding of women’s gendered health and illness experiences based on the presenters’ research examining women’s experiences with illness. As well as, learn how they can empower female patients as health care professionals. We provide a culturally-relevant inter-disciplinary model that is straightforward, broad, brief, and easy to apply in a variety of encounters with female patients.

**Audience Level:** All audiences

**Track:** Clinical Care/Direct Practice

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

- Describe how women’s illness experiences and interactions with family and healthcare providers are negatively impacted by dominant gender discourses
- Identify what women want in the treatment of illness based on findings from a qualitative meta-analysis
- Discuss what they can do as health care providers to empower women to manage behaviors, emotions, and family relationships

A5b (25 minutes)

**Fire and Gun Fire: A Naturopathic and Academic Approach to Anger in Young Men**

Steven M. Rissman, ND/Associate Professor, Metropolitan State University of Denver

Following the school massacre in Newtown, CT, the gun control debate was revived on a national level. But a NY Times article by Princeton professor Christy Wampole went to the heart of the issue—angry white men. “Can you imagine being in the shoes of the one who feels his power slipping away... a centripetal hatred moves inward toward the self as a centrifugal hatred is cast outward at others.” In this stimulating presentation, Dr. Steve Rissman, a naturopathic physician and associate professor at Metropolitan State University of Denver, teaches a class on “Anger in Men”, as well as several other men’s health courses. In this presentation, Dr. Rissman will discuss the roots of young men’s anger and naturopathic therapeutics to bring balance to the powerful emotion of anger.

**Audience Level:** All audiences

**Track:** Clinical Care/Direct Practice

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

- Describe the cultural perspectives on men’s anger.
- Explain the scientific rationale behind complementary and alternative treatment modalities for anger in young men.
- Discuss the pathophysiology of anger.
- Identify key sociologic contributors to the increase of anger in young men.
Lessons Learned in Geriatric Collaborative Care Research: What if the Status Quo Just Won’t Budge?

Katherine Buck, MS, LMFT Doctoral Candidate, Clinical Health Psychology East Carolina University

Dennis Russo, PhD, ABPP Clinical Professor of Family Medicine and Psychology, Head Of Behavioral Medicine, Department of Family Medicine, East Carolina University

Eric Watson, MS, Doctoral Student, Clinical Health Psychology, East Carolina University

The study of depression in medically hospitalized geriatric patients is increasingly important given the aging US population as well as the illness burden and increased risk of negative outcomes for depressed elderly patients (Levy, 2011). The current study was undertaken to evaluate both rates of depression in our own geriatric population as well as missed depression diagnoses. Depression in patients was studied in a dedicated family medicine inpatient unit, assessing self detection of depression, standardized measure of depression (Geriatric Depression Scale), and provider detection of depression (MD/RN). Despite a supportive environment and collegial team, significant challenges to collaborative care research still existed, including the status quo of healthcare provision. Suggestions for improving the process of collaborative care research for geriatric patients will be discussed.

Audience Level: All audiences

Track: Clinical Care/Direct Practice

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

- Describe the importance of collaborative care research regarding mental health (depression) outcomes for older adults in medical settings
- Identify challenges to collaborative care research in an inpatient setting with geriatric populations
- Discuss solutions to collaborative care research barriers for geriatric, inpatient populations

The Multiple Roles of Behavioral Health Consultants in Smoking Cessation

David Strong, PhD

William Sieber, PhD

Sharon Cummings, PhD

Alita Newsome, MA

Madison Noble, BA

Gene Kallenberg, MD

This presentation will analyze the factors that affect rates of smoking cessation, including ethnicity and co-morbid mental health problems. Those responsible for the design and oversight of integrated behavioral health services will learn how to leverage staff in identifying and treating patients with these comorbid conditions. We will address the clinical and operational implications of these results, involving multiple provider specialties in an integrated fashion.

Audience Level: Basic

Track: Clinical Care/Direct Practice

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

- Describe factors that contribute to the feasibility of concurrent mental health and tobacco cessation treatment
• Discuss the role of behavioral health providers in smoking cessation efforts
• Describe the mechanisms by which clinical staff members can be leveraged to identify and treat patients

B5b (40 minutes)

**Virtually Possible: The Use of Technology in the Treatment of Diabetes**

Cheryl Bene Masters, PhD Clinical Psychologist Director, Behavioral Health Service Line Cabarrus Family Medicine
Jerome Nymberg, MD, Family Physician Co-Director, Behavioral Medicine Education, Cabarrus Family Medicine

Effective management of diabetes often eludes traditional primary care intervention. In an effort to enhance access to treatment in a group of uncontrolled diabetics, we compared: 1) virtual access to a multidisciplinary team, to 2) office based multidisciplinary team care, to 3) usual primary care intervention. We will present results demonstrating psychosocial factors in glycemic control and lessons learned from the world of virtual treatment.

**Audience Level:** All audiences

**Track:** Clinical Care/Direct Practice

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

• Identify the relationship between mood, stress and diabetes.
• Describe the prominent psychosocial obstacles to diabetes management.
• Identify the advantages of virtual services as a platform for diabetes management.

C5 (90 minutes)

**Ideas That Make a Difference, Tips for Success and Overcoming Barriers: Scholarship Through Peer Reviewed Publication**

Larry Mauksch, Med, Senior Lecturer, Department of Family Medicine, University of Washington, and Co-editor, Families, Systems, and Health: The Journal of Collaborative Family Healthcare
Colleen Fogarty, MD, MSc, Associate Professor, University of Rochester Department of Family Medicine

Publishing an article in a peer reviewed journal is a powerful way to promote change. This seminar, facilitated by the co-Editors of Families, Systems, and Health: The journal of collaborative family health care,, will define strategies for preparing a manuscript. We will explore knowledge gaps in the field of collaborative family health care and examine common barriers to publication. The workshop will include tips for success, especially for clinicians and others new to the writing and publishing experience. Our goal is to help participants contribute the field by sharing their knowledge and experience through submitting one of several article formats.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

• Describe major steps in the preparation of a peer reviewed manuscript
• Name one idea for publication.
• Identify personal barriers to pursuing publication
• Define some tips for publication success

D5a (40 minutes)

**The Evolution of Integrated Care at Kaiser Permanente Colorado: Challenges and Opportunities**

Arne Beck, PhD
Joanne Whalen, PhD

This presentation will provide a broad overview of integrated care programs at Kaiser Permanente Colorado, focusing on behavioral health services in primary care and for at risk populations. Challenges and opportunities related to implementation of these clinical care programs, either through operational initiatives or research grants, will be discussed, including virtual integration models of care delivery, staffing and work flows, use of technologies for population management, and training non-behavioral health providers to deliver behavioral health services. Programs to be presented include Behavioral Medicine Specialist (BMS), Depression Care Management (DCM) program in primary care, Care of Physical, Mental, And Substance Use Syndromes (COMPASS), and Prevention and treatment of perinatal depression.

Audience Level: All audiences

Track: Leading/Creating Systemic Change

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

- Describe the integrated care programs at KPCO that are presented.
- Identify issues related to implementing integrated care at KPCO, including clinician roles, work flows, and use of electronic medical records data for population management and clinical trial recruitment.
- Discuss the variety of integrated care models used in KPCO for primary care and for specific populations.

D5b (40 minutes)

Reducing Medical Costs and Improving Clinical Care, Coordination and Outcomes by Reducing Admissions for High Utilizers of Emergency Care Services

Sara Tracy, MSPH, Senior Manager, Emergency Services & South Hospital Operations, Kaiser Foundation Health Plan of Colorado

Kevin Vanderveen, MD, Colorado Permanente Medical Group Assistant Regional Department Chief, Emergency Services Physician Director, Telephone Medicine Center

Joanne Whalen, PsyD, Licensed Clinical Psychologist & Behavioral Medicine Specialist, Kaiser Permanente of Colorado

Emergency department care is some of the most expensive and potentially fragmented care in our medical system today. Patients with chronic and challenging medical conditions are not generally best treated by emergency providers, but rather by a close relationship with a care team in a medical home. With a growing need to improve coordination of care and outcomes for these patients and decrease rising medical costs, Kaiser Permanente of Colorado, a large healthcare insurer and health care provider, sought to reduce emergency room admission rates for high utilizers of emergency services resulting in a 60-80% reduction in emergency room costs and visits. Presenters will illustrate the development and implementation of integrated care conference teams within the primary care setting to successfully reach these goals, as well as articulate challenges and lessons learned in the development of this program, such as gaining provider, leadership, and care team buy in, creation of standardized documentation and care plans, and collaboration with communities providers and emergency services. Members of the team will show how KPCO was able to successfully implement and roll out of care conference teams throughout the twenty plus primary care clinics within the Kaiser Denver/Boulder area, while improving coordination of care and achieving savings of $1million plus yearly in emergency department costs. Several case studies will be reviewed to illustrate application of this program.

Audience Level: All audiences

Track: Leading/Creating Systemic Change

At the conclusion of this presentation, participant will be able to:
• Identify one model of using integrated care teams to reduce emergency room admission rates and recommendations for replication in other health care settings.
• Identify key players in a health care organization needed to implement such a program.
• Identify critical components for successful implementation of care conferences.

E5a (40 minutes)

**Anything Goes? Developing a New Measure of Fidelity for Behavioral Health Providers in Integrated Primary Care**

Gregory P. Beehler, PhD, MA, Clinical Research Psychologist, VA Center for Integrated Healthcare
Jennifer S. Funderburk, PhD, Clinical Research Psychologist, VA Center for Integrated Healthcare
Katherine M. Dollar, PhD, Clinical Coordinator, VA Center for Integrated Healthcare

Have you ever wondered if there are things you should be doing (or not doing) as a behavioral health provider in integrated primary care (IPC)? Does it sometimes feel like “anything goes” in IPC? This presentation will discuss the concept of fidelity, or adherence to a model of health services delivery, in relation to behavioral health providers in IPC. Although there are many potential models of IPC practice, most have overlapping conceptual underpinnings. An expert consensus panel was recently conducted by VA researchers to determine essential and prohibited behaviors for behavioral health providers in IPC, regardless of the particular health care setting. The result of the expert consensus is a new self-report measure of fidelity for frontline IPC behavioral health providers, the Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ). This presentation will discuss its development, validation, and results from a recent field test.

**Audience Level:** Basic

**Track:** Clinical Care/Direct Practice

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

• Define fidelity of implementation as applied to behavioral health providers in integrated primary care
• Identify potential sources of low and high fidelity among behavioral health provider behaviors in primary care
• Describe the psychometric properties and intended use of a new measure of fidelity for behavioral health provider behaviors in primary care
• Describe VA behavioral health provider reactions to a field test of a new measure of fidelity

E5b (40 minutes)

**Using a Same/Next Day Appointment Schedule System to Reduce No-Shows in a PCMH Behavioral Health Service**

David RM Trotter, PhD, Primary Care Behavioral Health Fellow, UMass Medical School Department of Family Medicine and Community Health
Daniel Mullin, PsyD, Assistant Professor, UMass Medical School Department of Family Medicine and Community Health
Christine Runyan, PhD, Associate Professor, UMass Medical School Department of Family Medicine and Community Health

Although healthcare reform promises a remuneration system aligned with population health and quality incentives, the current fee for service system still dominates. Until the fiscal shift occurs, unused appointments due to “no-shows” and late cancelations represent both real and indirect costs for behavioral health providers, especially those embedded in NCQA medical homes. Many clinics adopt “same/next day” scheduling systems to reduce unused
appointment slots for medical providers; however, behavioral health providers have been slow to embrace this strategy. This presentation will describe the implementation and outcomes of a same/next day scheduling system for behavioral health used in a primary care clinic with Level 3 NCQA recognition.

**Audience Level:** All audiences

**Track:** Clinical Care/Direct Practice

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

- Discuss data on no-show rates within medical and behavioral health practices
- Describe the same/next day schedule system for behavioral health used within an NCQA recognized integrated primary care health center
- Discuss the benefits, limitations, and feasibility of designing and implementing a same/next day scheduling system.

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**F5a (40 minutes)**

**Measuring the Quality of Integrated Care: The AHRQ Integration Quality Measures Atlas**

Neil Korsen, MD, MS Medical Director, Behavioral Health Integration Program, MaineHealth

Benjamin Miller, PsyD, Assistant Professor, Department of Family Medicine University of Colorado Denver School of Medicine

Vasudha Narayanan, MA, MBA, MS Senior Study Director, Westat

C.J. Peek, PhD, Associate Professor, Department of Family Medicine and Community Health, University of Minnesota Medical School

Are you implementing behavioral health integration and want to be able to measure and improve the service? Are you the evaluator on an integration project and want to know what validated measures exist? The AHRQ Integration Quality Measurement Atlas is a resource for you. This session will introduce you to the Atlas. We will review the development process and the web based functionality. But most importantly, we want to hear from you. You represent the potential users of the Atlas, and we’d like to understand your needs and how well the current Version 1.0 meets them.

**Audience Level:** All audiences

**Track:** Leading/Creating Systemic Change

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

- Describe the development process for the Integration Quality Measures Atlas
- Explain the connection between the Lexicon definition and the measurement framework
- Explain at least two ways to navigate the atlas to find needed quality measurement information
- Identify a starter set of quality measures that can be used by people implementing integration

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**F5b (40 minutes)**

**Applying Community Based Participatory Research to Facilitate Community Mental Healthcare, Interprofessional Collaboration and Patient Empowerment**

Peter Rainey, MS, PLMHP, Medical Family Therapy Intern, University of Nebraska Medical Center

Paul Springer, PhD, LHMP, Assistant Professor Department of Child, Youth and Family Studies, Marriage and Family Therapy Program, University of Nebraska-Lincoln
Tackling the challenges of healthcare delivery at the local level goes beyond the availability of resources and the perception of care. It requires that researchers, healthcare providers and community members collaborate and combine their resources to identify and overcome healthcare challenges. This presentation will describe a collaborative research strategy to overcome community specific healthcare challenges and how it is particularly effective when working in rural communities where resources are limited. At the conclusion of this presentation, the participant will be able to: Describe and define CBPR’s collaborative research process. Explain how CBPR principles can be applied to overcome healthcare challenges. Explain the different levels of impact that CBPR can have on a local care culture. Apply CBPR strategies to facilitate collaborative research principles back home in their care culture and community.

**Audience Level:** Basic

**Track:** Leading/Creating Systemic Change

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

- Describe and define the community based participatory research process and key principles that need to be applied to succeed at the process to overcome healthcare challenges.
- Describe community level, interprofessional level, provider and patient level outcomes that the CBPR process can generate.
- Apply CBPR principles to their own care culture
- Define a conceptual plan for how they might employ CBPR principles to attend to one healthcare challenge in their community

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**G5a (40 minutes)**

**Maximizing Reimbursement in Today's Fee for Service World**

Mary Jean Mork, LCSW, Program Director, MaineHealth and Maine Mental Health Partners

While we hope and plan for payment reform and better ways to get paid for collaborative care, we are stuck trying to get paid within the present payment system. This workshop will review the fundamentals of reimbursement for integrated behavioral health services focusing on how to maximize payment while adhering to the present rules and regulations. Codes, settings, payer differences and documentation expectations will be discussed, as well as methods of tracking and monitoring financial productivity. Participants will be offered tools and resources to use in their practice settings.

**Audience Level:** Basic

**Track:** Financing Integration

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

- Describe factors that affect the present system of billing & reimbursement for behavior health in primary care
- Discuss strategies to support sustainability of integrated practice
- Identify tools and resources that will assist them in maximizing reimbursement in their own programs

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**G5b (40 minutes)**

**Early Lessons in Global Budget Model Testing for Integrated Care**

Shandra M. Brown Levey, PhD, Licensed Psychologist, Primary Care Psychology Fellow, University of Colorado, School of Medicine

Emma C. Gilchrist, MPH, Professional Research Assistant, University of Colorado School of Medicine

Polly V. Kurtz, MBA, Executive Director, CFHA
Patrick Gordon, MPA, Associate Vice President, Rocky Mountain Health Plans

Regardless of how effective mental health, behavioral health, and substance use integration can be in primary care, financially sustaining integrated care is consistently listed as one of the most significant barriers for the field. As such, creating a payment model that can support integrated care is needed. In a partnership and sponsored by the Colorado Health Foundation, Rocky Mountain Health Plans, the CU Department of Family Medicine, and the Collaborative Family Healthcare Association is testing a global budget model for integrated healthcare in practices on the Western Slope of Colorado. This presentation will discuss early lessons learned as we work to determine if a global payment method will financially support and sustain behavioral health in primary care, look at how different payment models affect clinical models of integration and their related costs, and test the real world application of a global methodology on primary care practices who have integrated behavioral health with the end goal to inform policy.

Audience Level: All audiences

Track: Financing Integration

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

- Describe early lessons related to determining if a global payment method will financially support and sustain behavioral health in primary care.
- Discuss how different payment models affect clinical models of integration.
- Describe a global payment model for healthcare that includes risk adjusted prospective payment, shared risk, and incentive opportunity.

H5a (25 minutes)

Coordinated Care Organizations: Oregon’s Path to the Future

Robin Henderson, PsyD, Executive Director, Central Oregon Health Council

This presentation will focus on developments in Oregon through their Coordinated Care Organizations which focus primarily on the Medicaid population. Attendees will hear the latest developments in innovation and payment methodologies targeted at high-risk/high need population groups from the perspective of the Central Oregon Health Council—a community-based governance organization currently managing more than 30,000 covered lives. Initiative based in integrated care across the lifespan will highlight clinical and fiscal innovations based in Triple Aim initiatives, and feature the latest outcome data on better health, better care and better value for the community of patients and providers. The latest developments in global payment innovation and outcomes will be shared to provide a clear understanding of the potential for Medicaid reform in a captured environment.

Audience Level: All audiences

Track: Public Policy

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

- Describe key initiatives identified within a community targeted at improving the overall population health of the community, engaging patients in their healthcare and lowering the overall healthcare spend within the community.
- Discuss the components needed to ensure community engagement in healthcare transformation efforts targeted at the Medicaid population.
- Identify key transformation objectives that impact high cost populations within a community and begin to develop strategies for replication within their own communities.
- Define key activation strategies to assist in engaging diverse communities in healthcare transformation (ie: community members, social services, private and public health interests and payers).
Innovative Partnerships for Successful Integrated Health Care - A Texas Perspective

Alejandra Posada, Med, Director of Education and Training, Mental Health America of Greater Houston
Rick Ybarra, MA, Program Officer, Hogg Foundation for Mental Health

Organizational partnerships can play a critical role in integrated health care. In Texas, the Hogg Foundation for Mental Health’s Integrated Health Care (IHC) Planning and Implementation Grantees, eleven organizations located throughout the state, have formed and leveraged diverse partnerships to successfully integrate care and broaden their reach in the community. In addition to the “classic” FQHC/LMHA partnerships, the grantees have developed innovative partnerships with organizations such as academic/training institutions, hospitals/emergency rooms, substance abuse providers, other providers of health care services and support services, K-12 schools, and a health information exchange. Using the experiences of selected grantees (urban and rural) as examples, this presentation will explore the processes and practices utilized to build and sustain solid partnerships; the roles of the various organizations involved in each partnership; and benefits to each organization and to their communities. Attendees will gain both an understanding of the key components that have made the grantees’ partnerships successful as well as practical information about how to implement similar partnership arrangements.

Audience Level: All audiences
Track: Leading/Creating Systemic Change

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

- Identify at least three examples of successful, innovative organizational partnerships implemented by the Hogg Foundation's IHC Grantees.
- Identify at least three diverse types of organizations (i.e., beyond primary care and mental health providers) that may play important roles as partners in IHC programs.
- Describe at least three processes and practices used to build and sustain successful partnerships Describe how such processes and practices might be implemented in attendees' own communities.

Optimizing the Probability of Successful Integration Implementation

Susan Grantham, MPP, MPH, PhD, JSI Research & Training Institute, Inc.

To enhance service coordination and address inter-related medical and behavioral health needs, 24 provider organizations (representing 67 service locations) in the State of Maine sought to better integrate behavioral and physical health care. Using a realist evaluation frame (Pawson and Tilley, 1997), we describe the interplay across “mechanism,” context, and outcomes related to the reach, adoption, and implementation of these integrated efforts. Understanding these key mechanisms and the individual, organizational, and environmental factors that facilitate or impede these mechanisms optimizes the probability of successful integration. This session will discuss the evaluation, including a description of participating organizations, methods, and findings. Additionally it will provide strategies for organizations planning integration or newly underway to enhance their capacity to implement integrated approaches to care.

Audience Level: All audiences
Track: Leading/Creating Systemic Change

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

- Explain how program factors and context affect probability of successful implementation
Apply one new strategy from the Maine experience for increasing the probability of successful integration implementation

Discuss one new strategy from the audience for increasing the probability of successful integration implementation