A QUICK START GUIDE TO BEHAVIORAL HEALTH INTEGRATION FOR SAFETY-NET PRIMARY CARE PROVIDERS

Integrating behavioral health (mental health and substance use) services into a primary care system involves changes across an organization's workforce, administration, clinical operations, and more. Providers adding behavioral health services as part of a developing integrated care system have many options to explore and paths to take.

Behavioral health integration encompasses the management and delivery of health services so that individuals receive a continuum of preventive and restorative mental health and addiction services, according to their needs over time, and across different levels of the health system.¹ Successful integration involves more than increasing access to behavioral health services through enhanced referral processes or co-location; the system of care delivery is transformed.

The following decision chart points health care providers wondering where to begin, or seeking more information about implementing a specific aspect of integrated care, to available resources.

SAMHSA-HRSA Center for Integrated Health Solutions



Substance Abuse and Montal Health Services Administrator

SAM

www.samhsa.gov 1-877-8AMHSA-7 (1-877-726-4727)

44

Around the time that my bipolar condition was identified, I was diagnosed with kidney disease. Between the two disorders, it was a pretty upsetting time in my life... My doctors, dialysis clinic staff, and mental health case manager are well-connected. They take a team approach, and they each check on the status of my health... Today I have control over my health; it doesn't have control of me. The coordinated care allows me to feel like I can go out and be a part of the community.

Cassandra McCallister

Board Member, Washtenaw Community Health Organization, Ypsilanti, Ml

WWW.integration.samhsa.gov

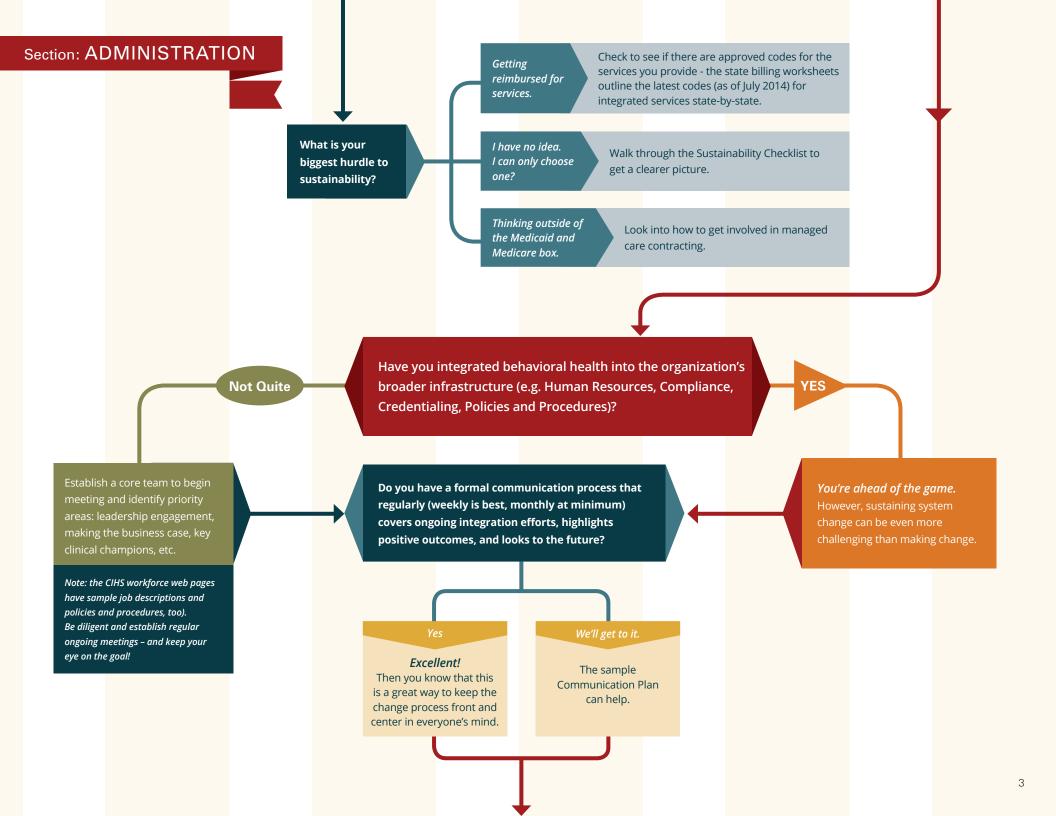
1. WHO definition of Integrated Care - http://www.who.int/healthsystems/service_delivery_techbrief1.pdf

Section: ADMINISTRATION

Integration is more than providing mental health and substance use services. Building and sustaining integrated care means all facets of the organization must reflect the values of whole health, collaborative care, and the understanding that successful clinical outcomes are everyone's responsibility. It's developing an infrastructure that allows for the inclusion of the behavioral health system in your practice transformation; mapping out the financial costs and revenue sources for behavioral health integration.

Organizations offering integrated care need to be sure that behavioral health is fully embedded into the practice – including a *mission statement* and *work plan* that addresses these services. The answer to "How are we going to pay for this?" is a strong *business plan*.

Start Has your organization adopted a mission statement NO and a work plan for practice YES transformation that fully incorporates behavioral health? Well, you can start now. Taking time to define your **Great!** Your organization is organization's vision and goals on the way to ensuring that will put you on the path towards staff, patients, and behavdeveloping a work plan for long-term success. clear picture of what out-Check out CIHS' Organizational Assessment Toolkit Not sure. comes you want to achieve. for Integration (OATI) to assess your readiness. Check out the sample vision statement from the Institute for Family Health as a guide. Maybe. What exactly The Standard Framework for Integrated does integrated care Care and AHRQ's Collaborative Care look like, again? Lexicon can help jog your memory. Yes, we're already working Is your organization While you're doing your homework on getting recognition as a ready to move ahead on this process, you may want to Patient-Centered Medical with integrated care? explore our issue brief on this topic. Home. Wow, way to go! No, we still need to Perhaps the Making the Business Case convince a few folks. spreadsheets can help? It can be tough to keep pace **Congratulations!** You may now Do you have a business with new models, cope with explore opportunities to scale plan that incorporates the structural barriers, or deal with up your integration efforts by NO YES components needed to a fragmented, complex reimadding behavioral health services bursement system. The good financially sustain behavioral to additional sites, or expanding news is, there are tools to help. your array of mental health and health services? substance use treatments.



Section: WORKFORCE

Integrated care involves a patient-centered care team providing evidence-based treatments for a defined population using a measurement-based treat-to-target approach. In integrated settings, a behavioral health general practitioner works as part of the medical team to meet a wide range of needs. Behavioral *Health generalists* – such as psychologists, social workers, psychiatric nurses and peer support specialists - are trained to use evidenced-based strategies to promote behavior change across a broad range of populations, and behavioral and physical health conditions.2 It's about finding the right person, setting the right expectations and providing the right support.

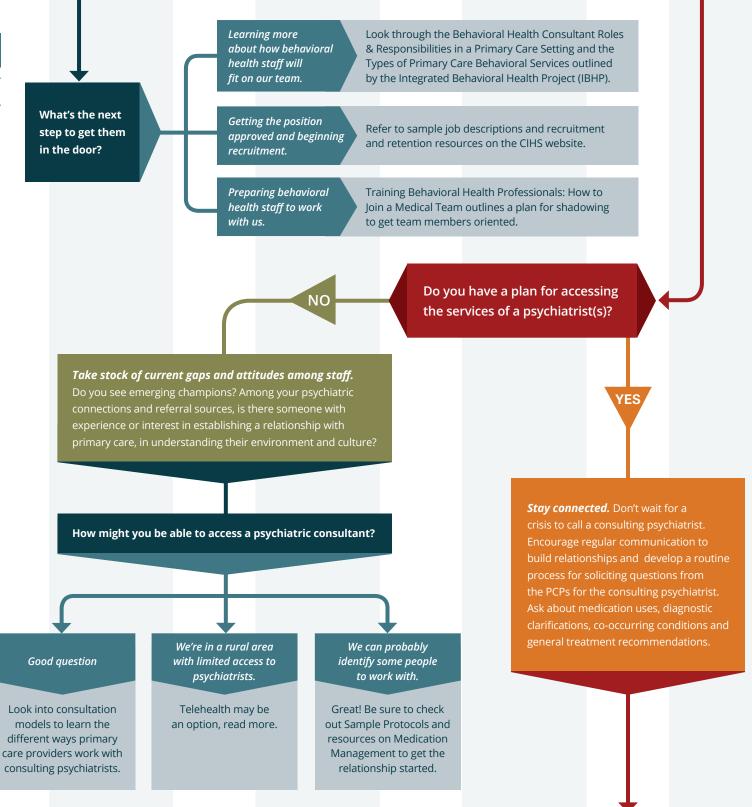
Does your primary care practice include YES, l Wish! at least one full-time licensed behavioral of course! health provider (employed or contracted)? Got everything worked out for your team, then? Fear not, there are plenty of resources to support recruiting, training, and retaining behavioral health staff on the clinical team. Well, not everyone We could use even knows how to work with the provider yet. Plan for additional Way to make the behavioral health behavioral health You may want to Support your behavioral providers and provider an active further explore the health providers in paraprofessionals to member of your role of the supervisor: connecting with other support your clinic's teamfrom who should professionals working expanding capacity based care! supervise behavioral in primary care settings to meet the behavhealth providers to - everything from local ioral health needs of what resources and communities of practices, your patients - the support they need for social media/listservs, Productivity and professional guilds, and success. **Capacity Designing** national associations. the Workflow resource can help.

2. Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer A.C., (2009), Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention. Washington, DC: American Psychological Association.

Section: WORKFORCE

A common barrier to integrated care is a lack of knowledge and comfort with prescribing psychiatric medications.

Many primary care physicians have gained foundational prescribing competence, yet PCPs are reluctant to proceed without input from a psychiatrist as more people turn to their PCPs for psychiatric medication. Good prescribing practices involve consistently building new knowledge and skills over time.



Integrated care begins with screening all patients for other health (including behavioral health) conditions in addition to the presenting problem. Similar to hypertension, behavioral health conditions can be "silent killers" in that the patient may not lead with this problem, but these conditions can drive and complicate other health concerns. If not proactively addressed, mental illness can quietly undermine efforts to improve health status. Routine screening leads to an organized collection of data.

Measuring the quality and outcomes of care are central components to all integration initiatives. Most health care providers have a performance improvement system in place that tracks the outcomes of core health indicators. These outcomes not only tell us whether our care is effective and efficient, this data can make the case for integrated care.

Care coordination is a function that supports information sharing across providers,

Does your organization have a comprehensive process for universal/ NO YES Beyond identifying mental routine screening for mental illness health and substance use and substance use? problems early, mounting research demonstrates a lot can be done – by providers, policy makers, community members, and other stake-**You're on Your Way.** As you Preventative services with an A or B ratholders – to prevent mental become comfortable with ing from the U.S. Preventive Services Task health and substance use Learn what's Force are covered and available at no cost problems from developing. mental illnesses and addiccovered. to the individual. For behavioral health, tions in your clinic, consider that includes screening for alcohol misuse and depression by primary care providers. expanding your services to identify functional status/ restoration (tools include the Patient Activation Measure Select Several evidence-based screening tools What's your next step (PAM) and the SF-36 Health a screening for adults and children are available free to get started, then? Survey) and prevention. tool. of charge. We need No problem. HRSA outlines the steps more guidance to implementing these services for in this area. health care providers Say it isn't so. Clinical measures can have a significant impact on continuous quality improvement. There need to be mechanisms to collect Do you have clinical measures and aggregate information NO specific to behavioral health? on variations from your integrated care outcomes. In doing so, such variances help to drive service review, **Great job!** Are you doing what you identify training needs, and can to make the most of your data? inform payors.

patients, types and levels of service, sites and time frames (NCQA).

Clinical pathways are one of the main decision-support and quality management tools used in healthcare settings. The implementation of clinical pathways helps to standardize care and to provide efficient, evidence-based treatment. Because more than 68 percent of adults with a mental disorder reported having at least one general medical disorder, and 29 percent of those with a medical disorder had a comorbid mental health condition,³ it is critical that behavioral health consultation and treatment be incorporated into all clinical pathways for treating chronic medical conditions.

One of the most significant cultural shifts when providing integrated care is moving from a focus on individual patient outcomes to *population-based care*. In primary care, the emphasis is on targeting populations (all people with diabetes, all people with depression), applying evidence-based

What's stopping you?

I'm not sure our EMR system would support it.

See how others have navigated this issue in A Resource Guide for Health Information Technology I'm not sure what to measure.

There are plenty of resources to help. NQF outlines suggested clinical measures, as does AHRQ in their Atlas of Care Coordination Measures.

I'd like to find out what our patients think about our service.

AHRQ's Consumer
Assessment of Healthcare
Providers and Systems
(CAHPS) clinician and
group surveys ask patients
to report on and evaluate
their experiences with
health care.

What do you suggest? Communicate your findings to all staff, patients, and to external stakeholders. Help staff make the connection between data and actions. Make sure you have a plan for regularly reviewing and discussing data findings in relation to successes and challenges and the role of team care in moving the integration process forward.

Using process mapping early on in the development of your integration work can support the development of clinical pathways. Process mapping helps to identify and examine existing journeys of care from the perspective of patients and staff. Teams can begin to see where changes or improvements need to be addressed.

Ready to move ahead?

NO

Does your organization's clinical pathway for chronic illness management include behavioral health?

I'll give it a try.

Wonderful, start with a process mapping exercise.

Can I have an example?

Of course! Resources include a sample workflow and a Clinical Pathway Example from Zero Suicide.

It'd be great to get my team trained, too. A cross-training option for teams is behavioral activation. The AIMS Center has behavioral activation training materials and modules for building integrated care.

Wow, You're Ahead of the

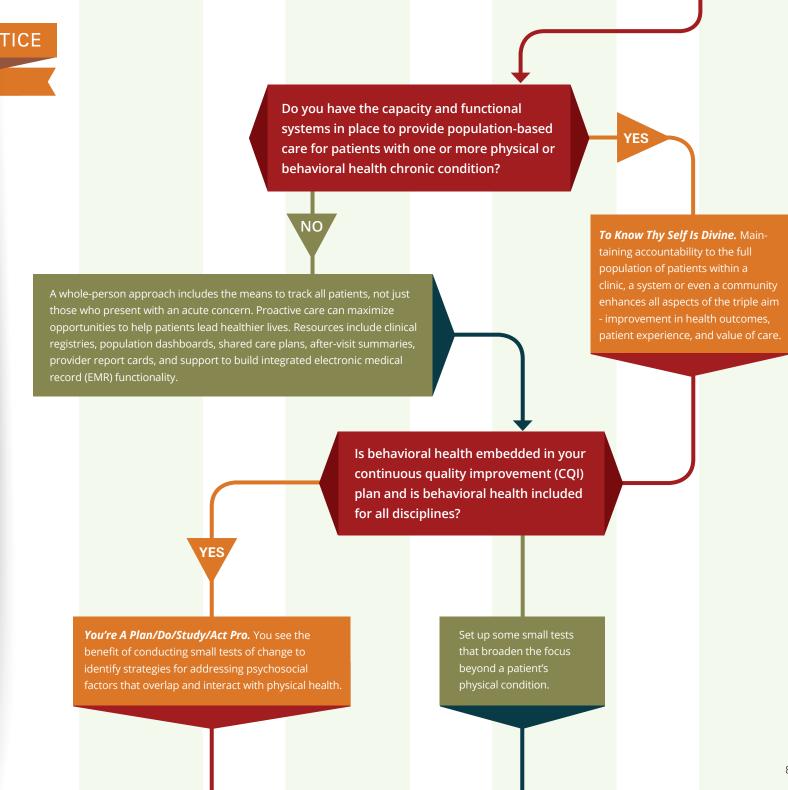
YES

Curve. Your next step might be to study which chronic diseases are most prevalent in the population you serve and what percent access behavioral health services. For example, what percentage of the population of people with diabetes has seen a behavioral health specialist in the last year? This could be the start of a great quality improvement project.

standards of care, and tracking the outcomes of these efforts using disease registries to collect, aggregate, and analyze results. This is a powerful way of holding providers accountable for standards of care and outcomes.

However, in behavioral health, because of the emphasis on the uniqueness of each individual's treatment plan, this can be a difficult concept to embrace and incorporate. Population-based care is tied directly to quality improvement (QI) efforts when targeted outcomes are not being met. Given that all chronic medical conditions have a behavioral health component (behaviors and conditions), it is important to ensure that QI projects are inclusive of behavioral health.

While population-based care is a critical component to integration, each patient is expected to carry out a care plan that is uniquely tailored to their needs, often involves multiple recommendations (changes in diet, exercise, medication) and requires input from specialists. A *coordinated plan* of care and services,



overseen by a member of the health care team, ensures support in following these recommendations. *Self-care* is at the center of chronic disease management, and a formal, interdisciplinary communication process and tool is needed to support follow through on short-term steps and long-term goals. The tool should promote patient engagement and be aimed at producing an informed and activated patient.

The *medical record* is the centerpiece for communicating findings and treatment recommendations. The behavioral health provider's assessment, plan and documentation of progress need to be easily accessible by the PCP, who is co-treating the patient and, in certain cases, may be the provider implementing and supporting behavioral health recommendations.

3. Kessler RC, Berglund P, Chiu WT, Demler O, Heeringa S, Hiripi E, Jin R, Pennell BE, Walters EE, Zaslavsky A, Zheng H. "The US National Comorbidity Survey Replication (NCS-R): Design and Field Procedures." International Journal of Methods in Psychiatric Research, vol. 13, no. 2, 2004

