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.

> "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, MI

SAMHSA-HRSA
Center for Integrated Health Solutions

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

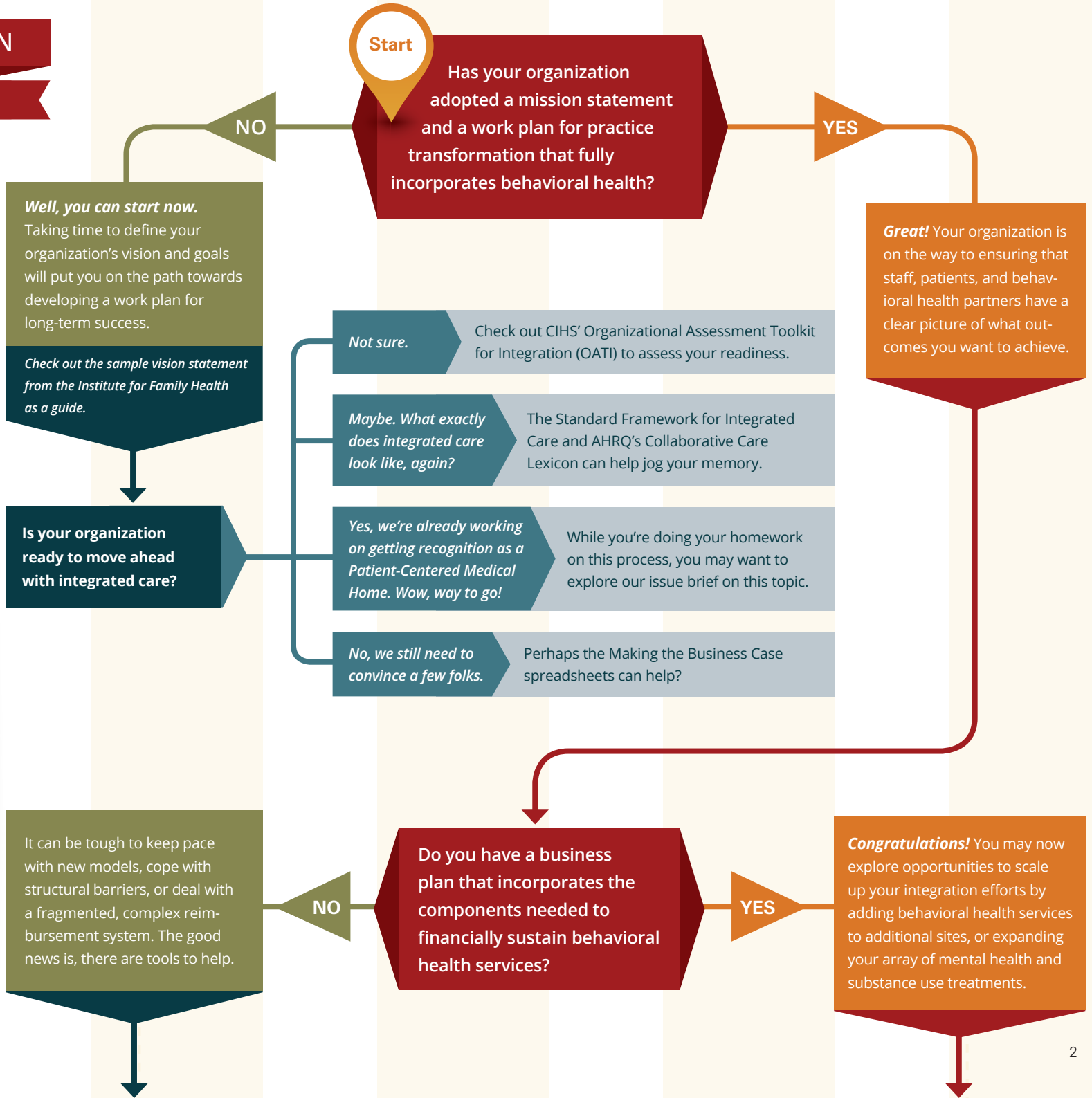
www.integration.samhsa.gov

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.***



What is your biggest hurdle to sustainability?

- ***Getting reimbursed for services.*** Check to see if there are approved codes for the services you provide - the state billing worksheets outline the latest codes (as of July 2014) for integrated services state-by-state.
- ***I have no idea. I can only choose one?*** Walk through the Sustainability Checklist to get a clearer picture.
- ***Thinking outside of the Medicaid and Medicare box.*** Look into how to get involved in managed care contracting.

Have you integrated behavioral health into the organization's broader infrastructure (e.g. Human Resources, Compliance, Credentialing, Policies and Procedures)?

Not Quite

Establish a core team to begin meeting and identify priority areas: leadership engagement, making the business case, key clinical champions, etc.

Note: the CIHS workforce web pages have sample job descriptions and policies and procedures, too). Be diligent and establish regular ongoing meetings – and keep your eye on the goal!

YES

You're ahead of the game. However, sustaining system change can be even more challenging than making change.

Do you have a formal communication process that regularly (weekly is best, monthly at minimum) covers ongoing integration efforts, highlights positive outcomes, and looks to the future?

Yes

Excellent! Then you know that this is a great way to keep the change process front and center in everyone's mind.

We'll get to it.

The sample Communication Plan can help.

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 at least one full-time licensed behavioral health provider (employed or contracted)?

I Wish!

Fear not, there are plenty of resources to support recruiting, training, and retaining behavioral health staff on the clinical team.

YES, of course!

Got everything worked out for your team, then?

Well, not everyone knows how to work with the provider yet.

You may want to further explore the role of the supervisor: from who should supervise behavioral health providers to what resources and support they need for success.

Sometimes these providers mention feeling a little out on their own...

Support your behavioral health providers in connecting with other professionals working in primary care settings – everything from local communities of practices, social media/listservs, professional guilds, and national associations.

We could use even more help, really.

Plan for additional behavioral health providers and paraprofessionals to support your expanding capacity to meet the behavioral health needs of your patients – the Productivity and Capacity Designing the Workflow resource can help.

Yes, again!

Way to make the behavioral health provider an active member of your clinic's team-based care!

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.

What's the next step to get them in the door?

- ***Learning more about how behavioral health staff will fit on our team.*** Look through the Behavioral Health Consultant Roles & Responsibilities in a Primary Care Setting and the Types of Primary Care Behavioral Services outlined by the Integrated Behavioral Health Project (IBHP).
- ***Getting the position approved and beginning recruitment.*** Refer to sample job descriptions and recruitment and retention resources on the CIHS website.
- ***Preparing behavioral health staff to work with us.*** Training Behavioral Health Professionals: How to Join a Medical Team outlines a plan for shadowing to get team members oriented.

Do you have a plan for accessing the services of a psychiatrist(s)?

NO

Take stock of current gaps and attitudes among staff. Do you see emerging champions? Among your psychiatric connections and referral sources, is there someone with experience or interest in establishing a relationship with primary care, in understanding their environment and culture?

How might you be able to access a psychiatric consultant?

- ***Good question*** — Look into consultation models to learn the different ways primary care providers work with consulting psychiatrists.
- ***We're in a rural area with limited access to psychiatrists.*** — Telehealth may be an option, read more.
- ***We can probably identify some people to work with.*** — Great! Be sure to check out Sample Protocols and resources on Medication Management to get the relationship started.

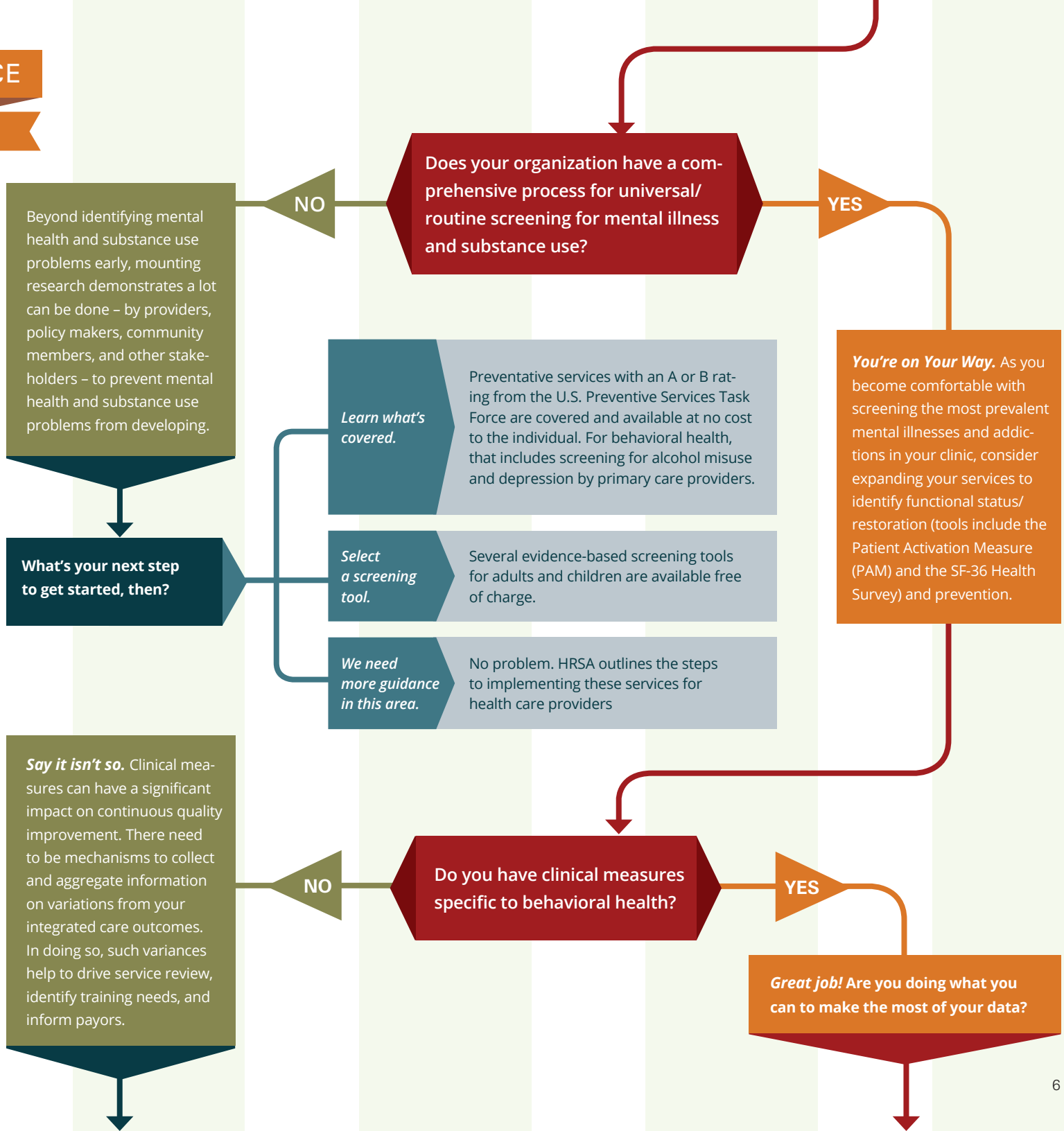
YES

Stay connected. Don't wait for a crisis to call a consulting psychiatrist. Encourage regular communication to build relationships and develop a routine process for soliciting questions from the PCPs for the consulting psychiatrist. Ask about medication uses, diagnostic clarifications, co-occurring conditions and general treatment recommendations.

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,



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.

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

NO

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?

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.

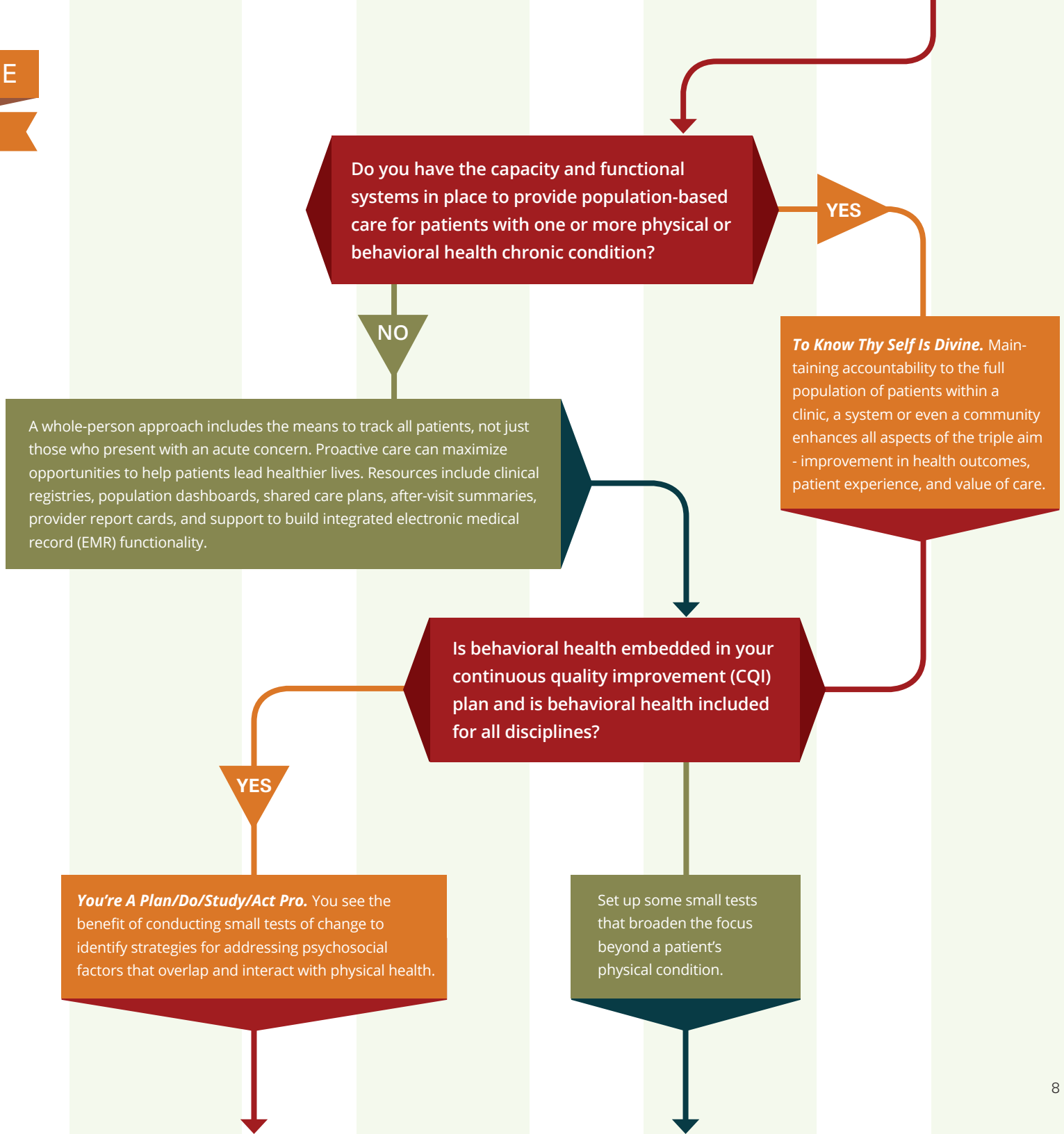
YES

Wow, You're Ahead of the 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.

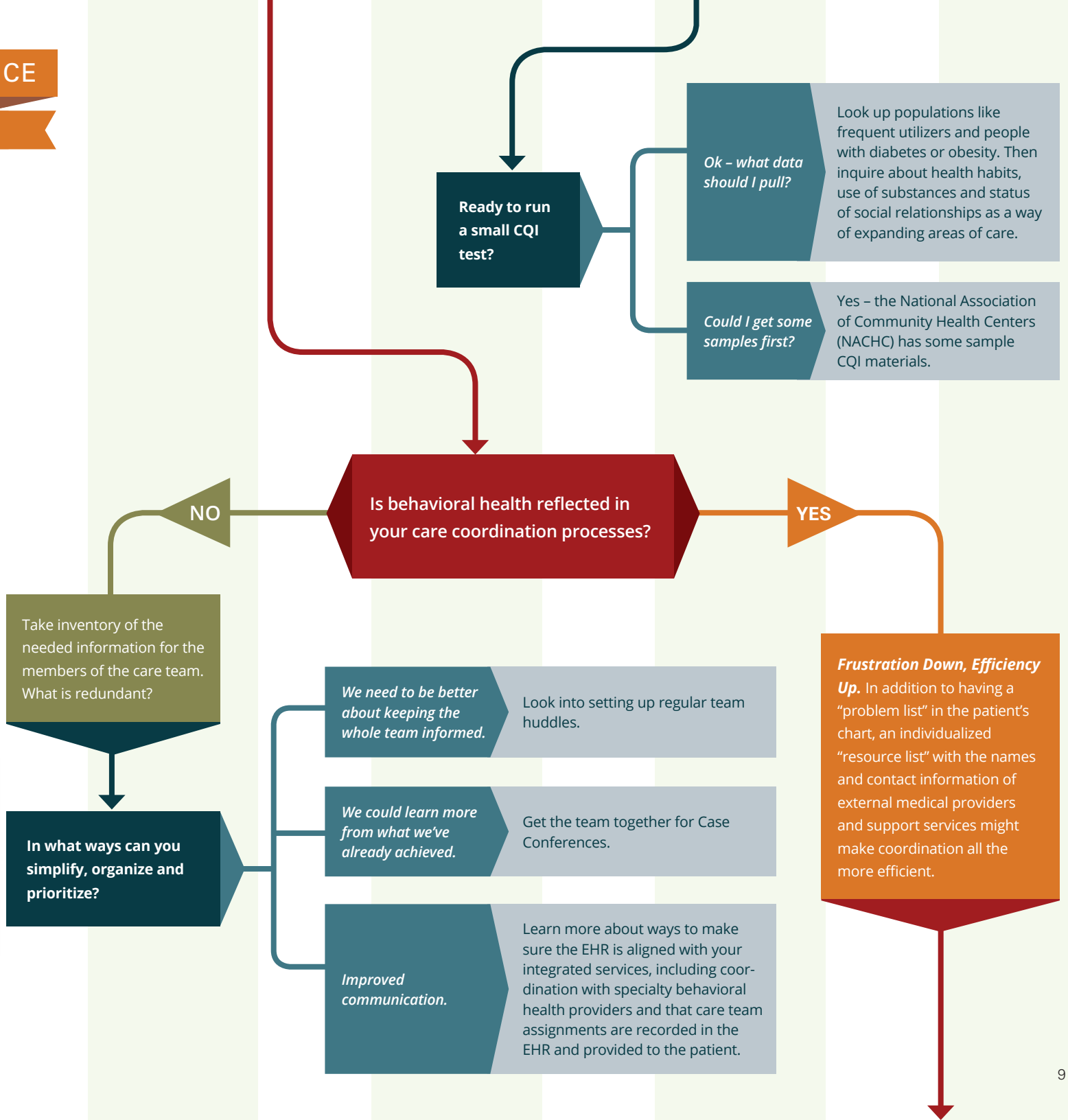
However, in behavioral health, because of the emphasis on the uniqueness of each individual's treatment plan, this can be a difficult concept to embrace and incorporate. Population-based care is tied directly to quality improvement (QI) efforts when targeted outcomes are not being met. Given that all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

Resources and organizations are available to help your integration efforts succeed! Browse CIHS' website, as well as AHRQ's Integration Academy, the Institute for Healthcare Innovation, and CMS' Center for Medicare and Medicaid Innovation for the latest tools to support your work.