

# 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.<sup>1</sup> 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**

**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



“  
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.”

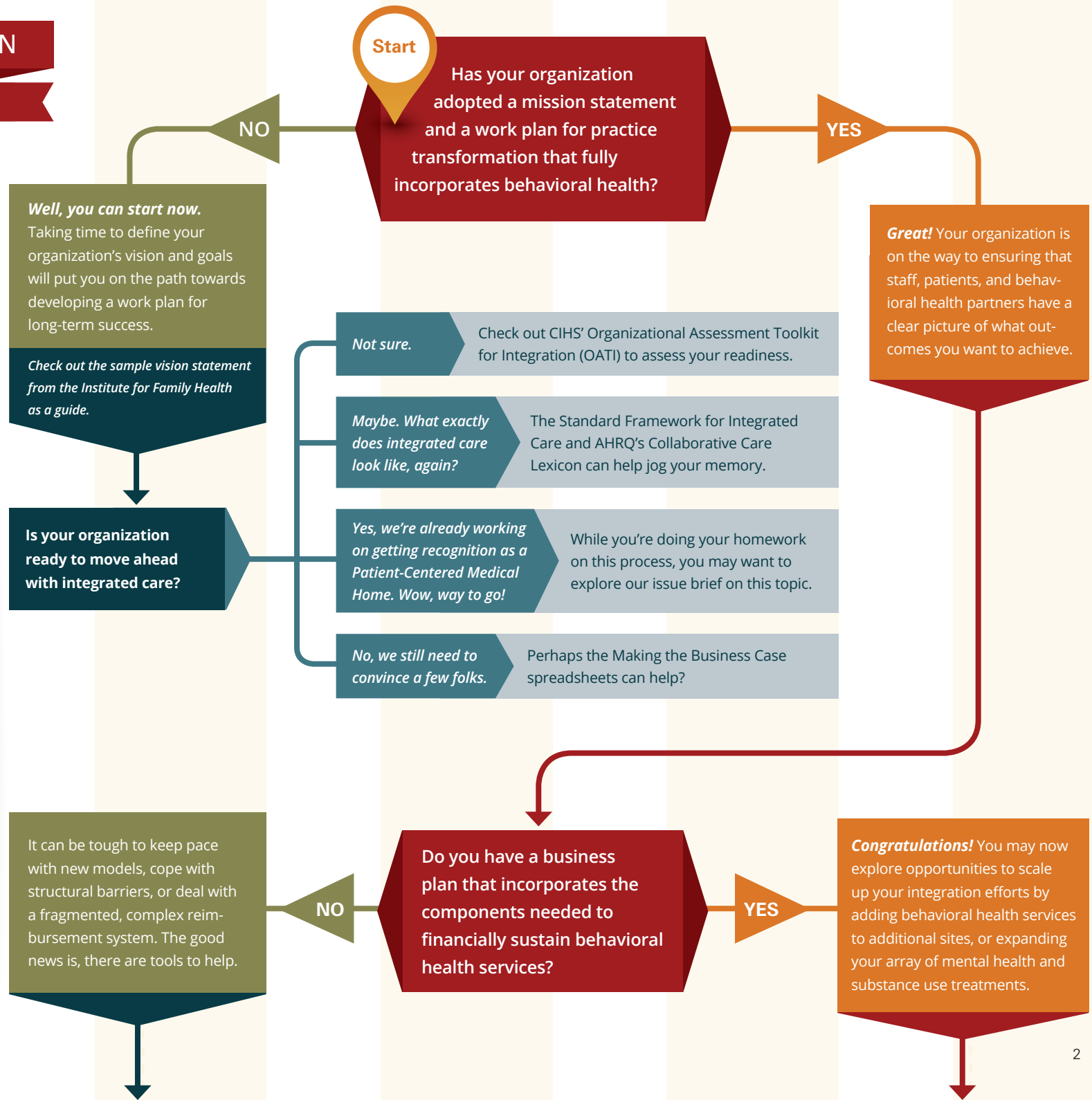
**Cassandra McCallister**  
Board Member, Washtenaw  
Community Health Organization,  
Ypsilanti, MI

1. WHO definition of Integrated Care – [http://www.who.int/healthsystems/service\\_delivery\\_techbrief1.pdf](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*.



Section: ADMINISTRATION

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.

Not Quite

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

YES

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!*

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?

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

Yes

**Excellent!**

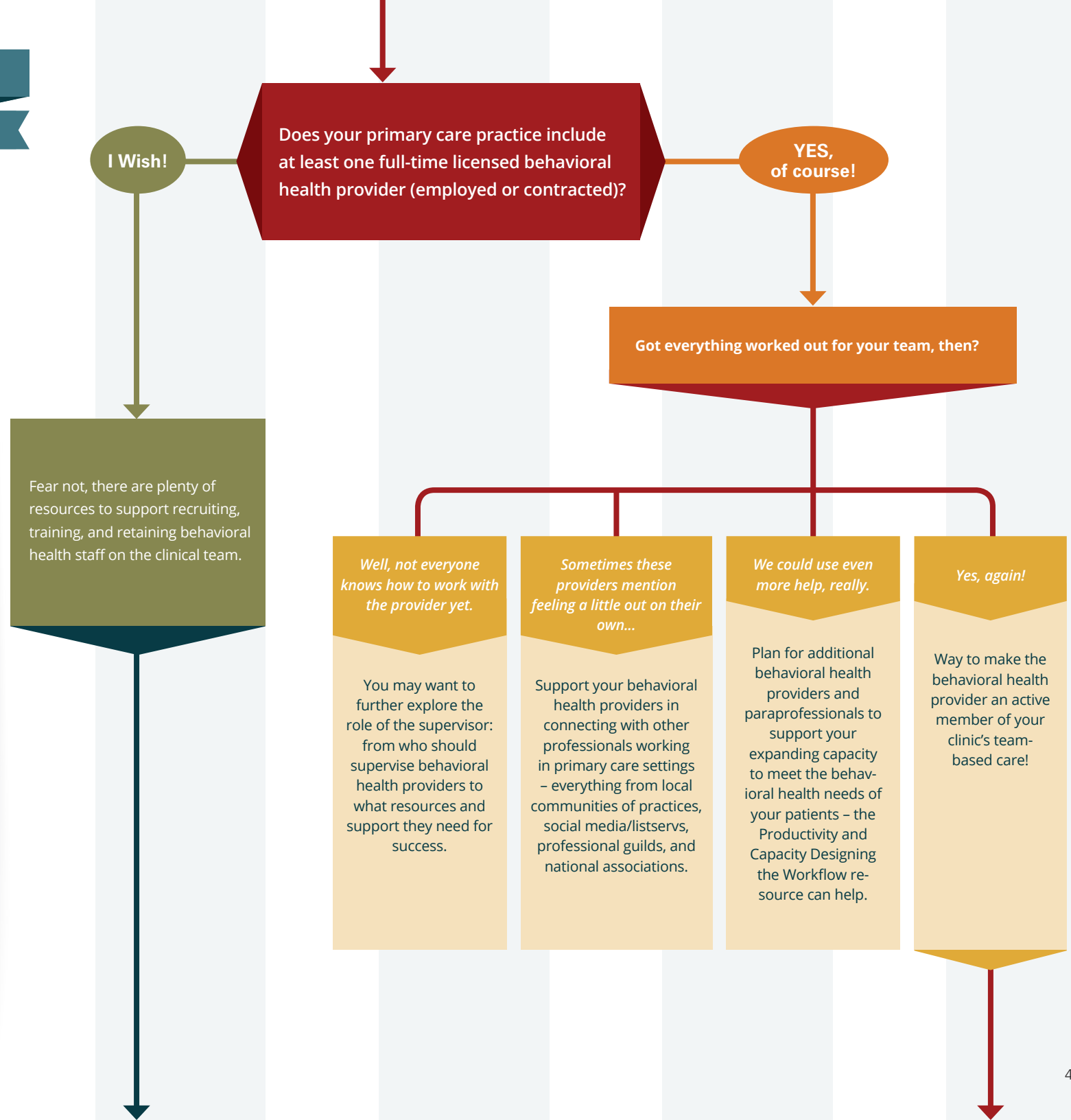
Then you know that this is a great way to keep the change process front and center in everyone's mind.

*We'll get to it.*

The sample Communication Plan can help.

## Section: WORKFORCE

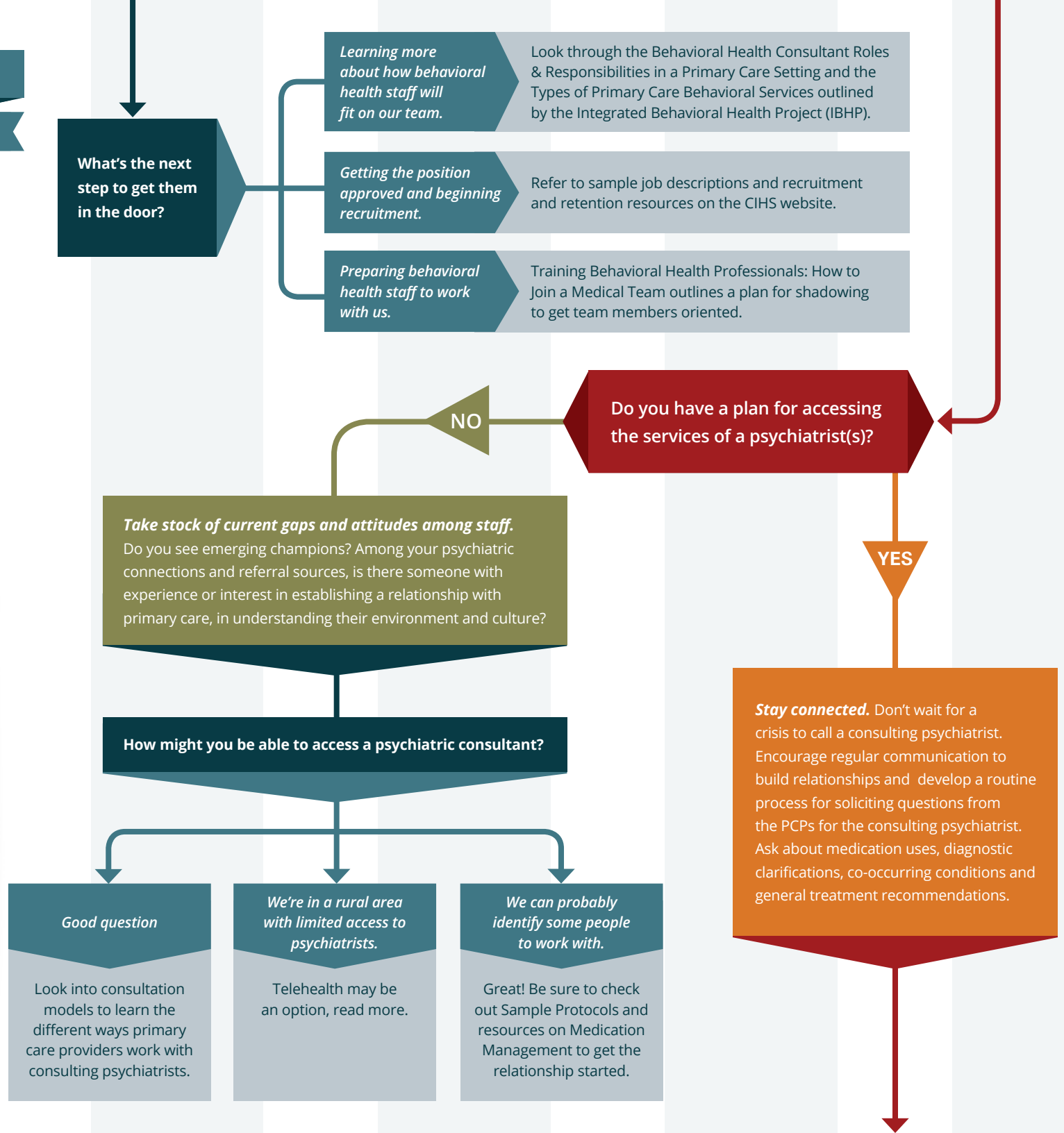
Integrated care involves a *patient-centered care team* providing evidence-based treatments for a defined population using a measurement-based treat-to-target approach. In integrated settings, a behavioral health general practitioner works as part of the medical team to meet a wide range of needs. **Behavioral 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.<sup>2</sup> It's about finding the right person, setting the right expectations and providing the right support.



2. Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobbmeyer 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.

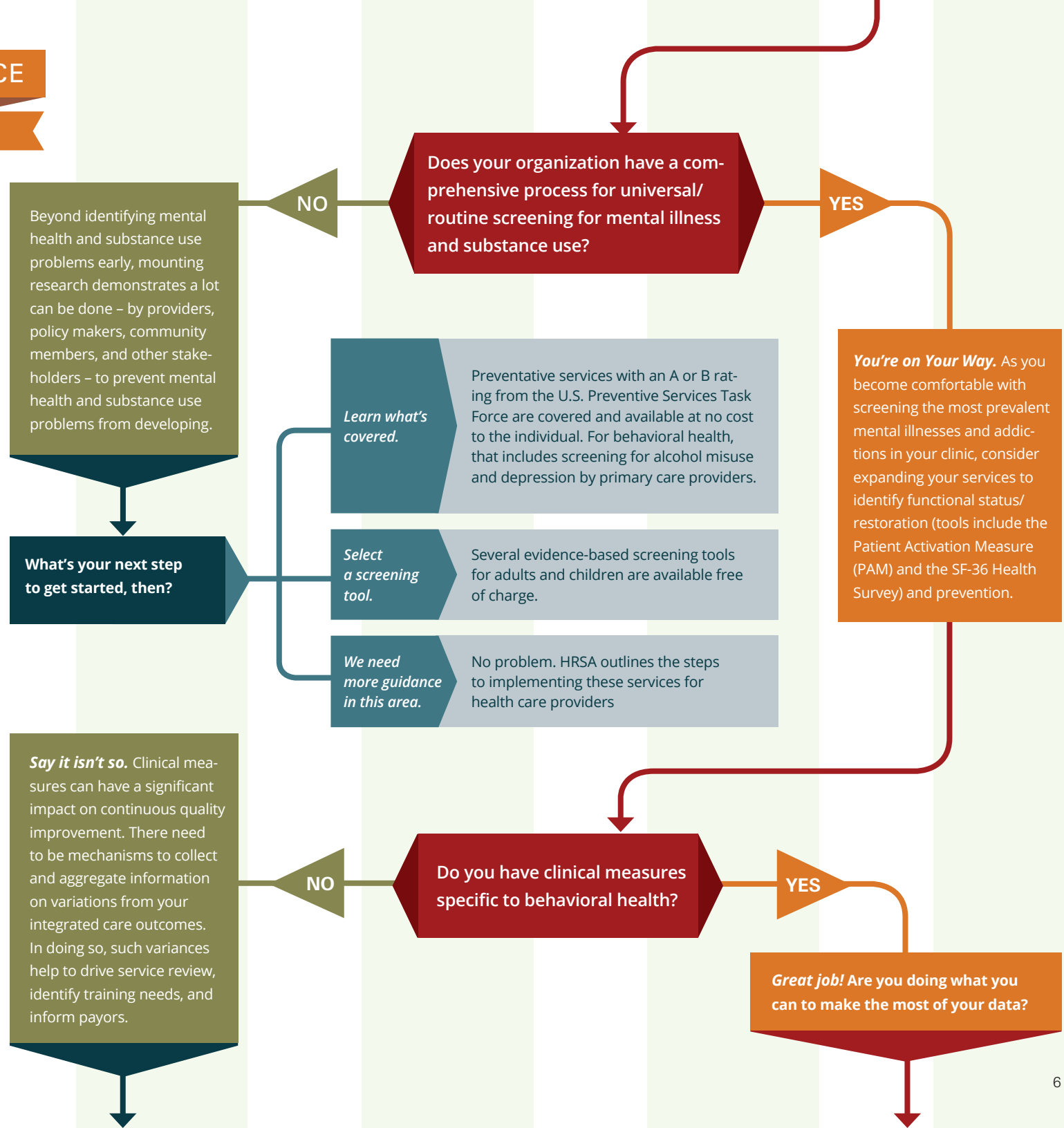


## Section: CLINICAL PRACTICE

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,

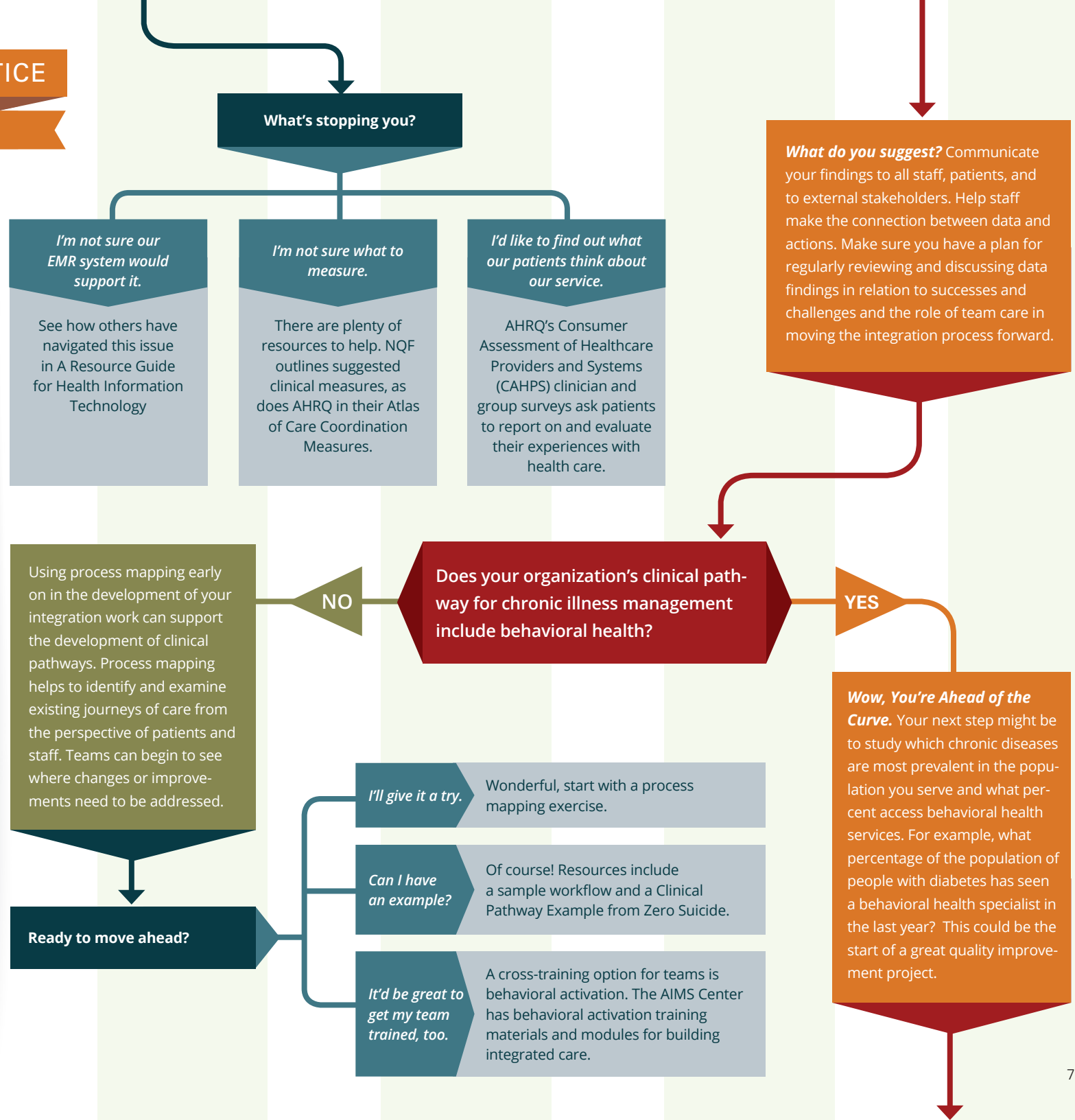


## Section: CLINICAL PRACTICE

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,<sup>3</sup> 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

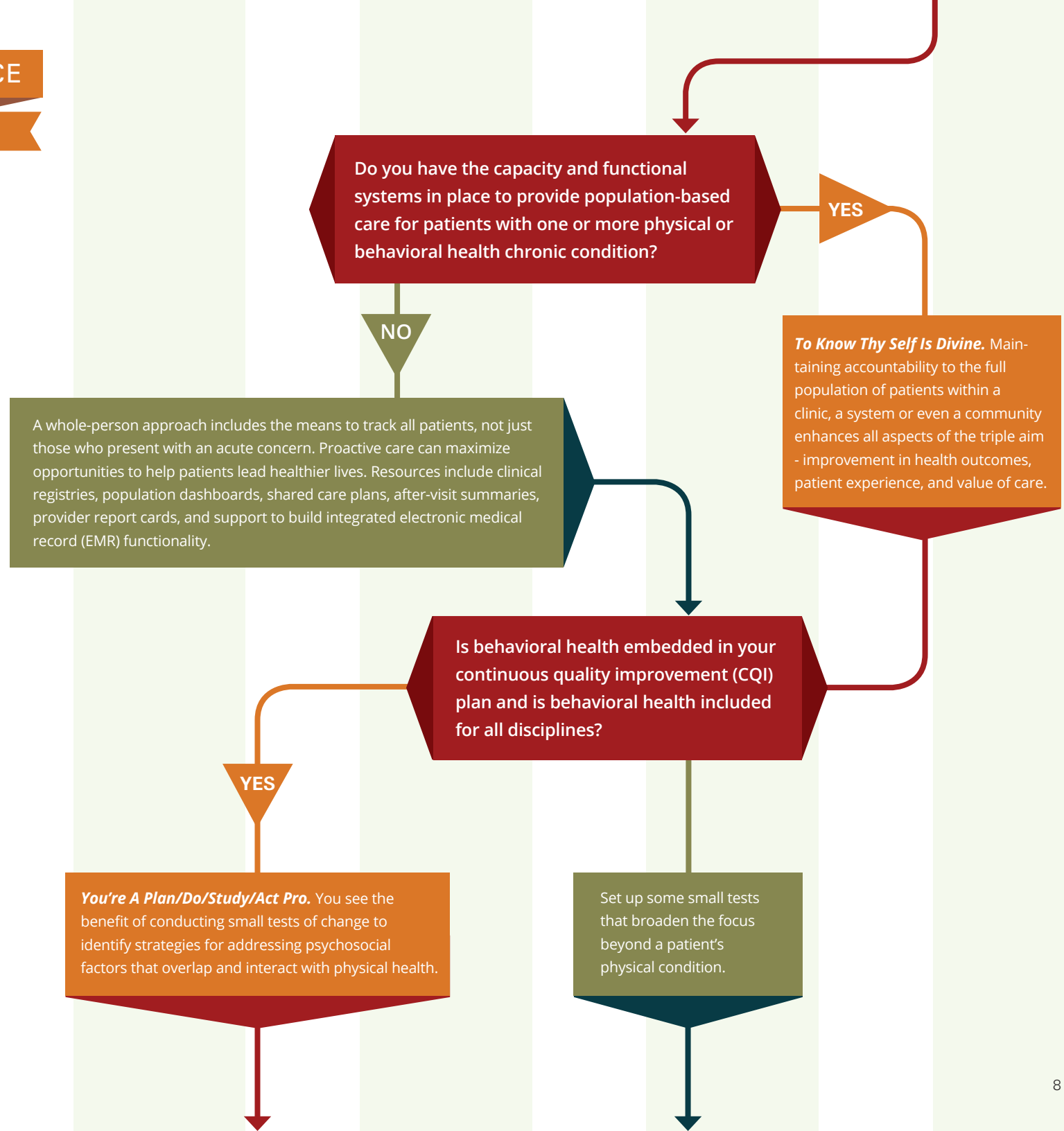


## Section: CLINICAL PRACTICE

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,

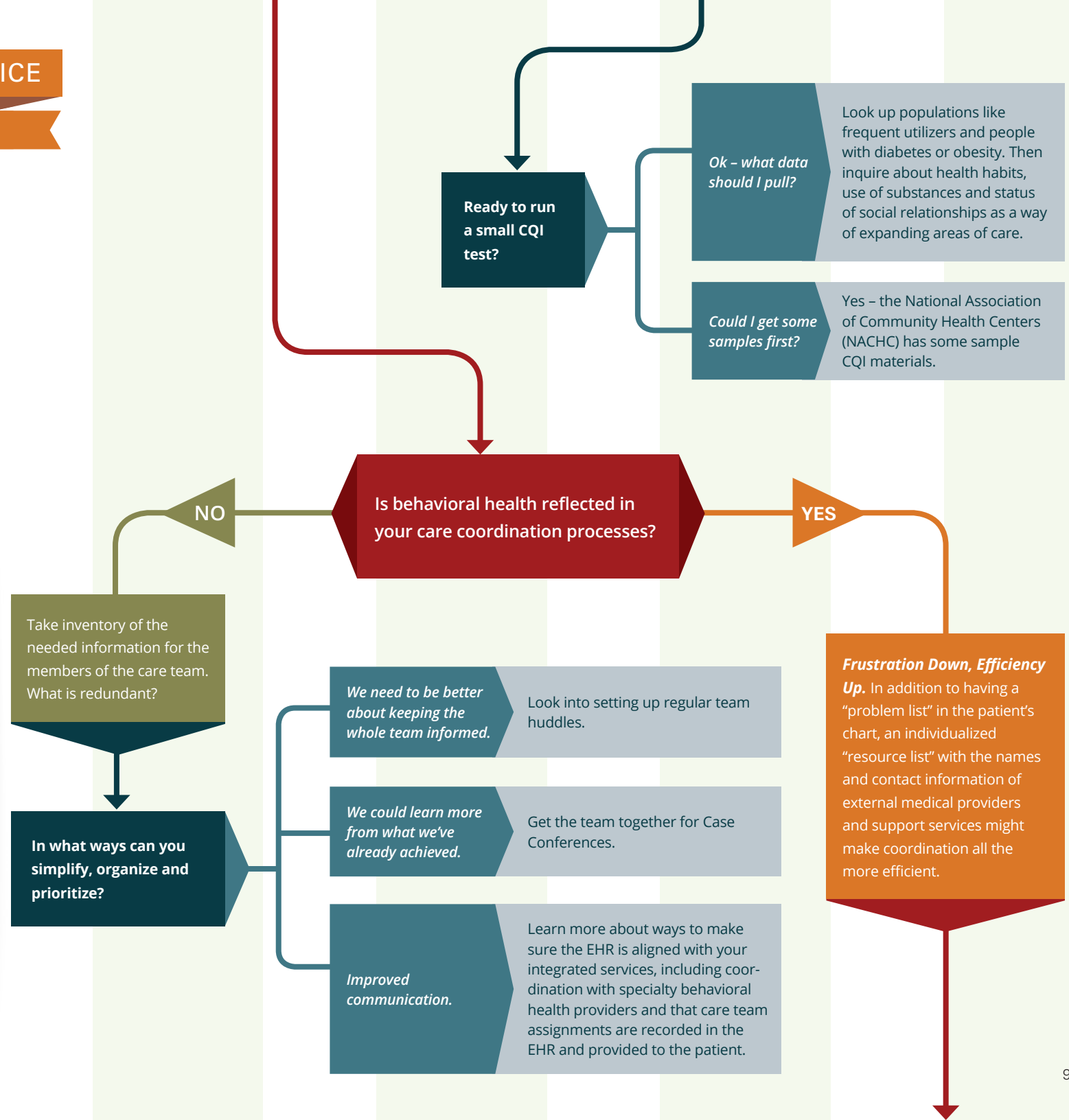




## Section: CLINICAL PRACTICE

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

**Establish some first steps.** For example, if your population focus is patients with diabetes and depression, you will need easy access to A1c levels, a depression screening tool and a current medication list. Small steps are better than no steps – keep implementation moving forward even if you have only a paper document of a required tool and have to scan it into the electronic system.

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.

