Best Practices in Integrated Behavioral Health

IDENTIFYING AND IMPLEMENTING CORE COMPONENTS

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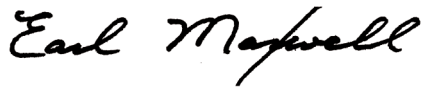
FOREWORD

At St. David's Foundation, we believe that good health returns great benefits to the community. Through a unique partnership, St. David's Foundation reinvests proceeds from St. David's HealthCare to support health programs in a five-county area in Central Texas. Grant funding to more than 60 grant partners supports the work of safety net clinics, agencies serving older adults, health care workforce development, healthy living programs and mental health initiatives.

In 2006, St. David's Foundation began funding integrated behavioral health (IBH), out of the belief that good health requires sound mental health. Though we sensed the promise of IBH to improve mental and physical health outcomes, we knew little about what constituted an effective IBH program. The available research was encouraging but left many questions unanswered as to program design, sustainability and reasonable expectations for health improvements.

During the past decade, through work with evaluators, our grant partners, and key leaders in the field, we have developed a stronger sense of the core components essential to creating an effective IBH program. The research around IBH has correspondingly matured, bringing the field to a pivotal time. We believe the field has reached a point where it is both possible and appropriate to begin defining what factors are important to a successful IBH practice, setting standards for cost effective programs and interventions, and exploring how finance and policy decisions can be shaped to support IBH. Those in the field need practical guidance on creating and sustaining IBH that will be used (and improved upon) by the provider, funder, and policy communities.

As a respected statewide voice on mental health, The Meadows Mental Health Policy Institute is an ideal partner to create this report. We are excited to capitalize on the Institute's expertise to further our knowledge in this area as well as inform and advance the field. It is our hope that this work sparks dialogue and actions that take the promise of IBH and translate it into real health improvements for the state of Texas.



Earl Maxwell
CEO, St. David's Foundation

St. David's Foundation

EXECUTIVE SUMMARY

Integrated behavioral health (IBH) represents a paradigm shift in both primary care and specialty behavioral health settings. IBH entails more routine attention to behavioral health among primary care providers and other medically trained staff, as well as skillful attention to behavioral aspects of what are typically considered "physical" disorders, such as insomnia, diabetes, and obesity. Similarly, in specialty behavioral health (BH) settings that serve adults with serious mental illnesses, IBH has created a new understanding of the overall health of the people being served, offering the potential to extend health, wellness, and life expectancy.

Despite the promise of IBH and its vision of a holistic approach to care, a number of persistent challenges continue to create barriers to IBH implementation. Along with policymakers and payers, providers are not always certain about exactly which models or core components of IBH to adopt or implement. This report offers a guide for providers, funders, advocates, and policy makers interested in promoting IBH and working systematically toward achieving its promise. Much of the literature to date on IBH presents either broad conceptual frameworks or highly detailed descriptions of various aspects of IBH. In this report, we have drawn on a number of sources to propose seven crosscutting core components of IBH, as outlined in the table on the following page.

The purpose of this report is to identify and describe these core components by citing emerging issues and offering examples. By doing so, we hope to facilitate and expedite the adoption of effective IBH programs within Texas health care settings.

Measuring success in IBH is an important element of a successful model. Various systems for measuring performance and outcomes have been developed, including the frequently used Healthcare Effectiveness Data and Information Set (HEDIS) system. Teams implementing IBH should meet regularly (e.g., quarterly) to review outcome indicators and establish priorities for program enhancement.

This report offers a "road map" for providers, funders, advocates, and policymakers interested in promoting IBH and working systematically toward achieving its promise.

Developing a financing approach that can support a successful IBH model is frequently noted as a challenge by providers. Financing integrated care requires a careful examination of the type of insurance coverage connected to the patient population in order to maximize available revenue and identify the ideal partners. When a significant portion of the patient population has Medicaid, using or partnering with a federally qualified health center (FQHC) will help to build a more sustainable revenue base. Additionally, because managed care is the platform on which Texas delivers almost all community-based Medicaid services, exploring the flexibility offered to managed care plans to set different rates or pay for non-traditional services is also an important vehicle for financial sustainability.

CORE IBH COMPONENTS

IBH COMPONENT	DEFINITIONAL OVERVIEW
1. INTEGRATED ORGANIZATIONAL CULTURE	• IBH is highlighted in the organization's vision and mission. • Leadership actively supports IBH by promoting it in all organizational functions.[i] • IBH champions are identified and empowered.
2. POPULATION HEALTH MANAGEMENT	• IBH programs assess and differentiate their patients by their prevalent co-occurring conditions and utilization patterns. • Health information technologies are used to manage outcomes across populations to apply the right interventions at the right time, and to help ensure high quality care and optimal health and wellness outcomes.
3. STRUCTURED USE OF A TEAM APPROACH	• Both physical health (PH) and BH providers are to the fullest practical extent physically located in same space. • A team-based, shared workflow is present, through which continuous communication and collaboration occur to carry out mutually-reinforcing and coordinated physical health and behavioral health care.
4. IBH STAFF COMPETENCIES	• Providers who are part of an IBH team must be able to coordinate care with external specialty providers and social services, collaborate with colleagues, engage patients effectively, and conduct motivational interventions.
5. UNIVERSAL SCREENING FOR THE MOST PREVALENT PH AND BH CONDITIONS	• In primary care, regular and universally applied screening for common mental health and substance use conditions that are both prevalent and associated with the costliest co-occurring illnesses ensures that BH conditions are detected and incorporated into treatment plans. • IBH programs located in BH settings must incorporate screens for common and costly physical health conditions.[ii]
6. INTEGRATED, PERSON-CENTERED TREATMENT PLANNING	• Each person should have a single treatment plan that incorporates all PH and BH conditions, relevant treatment/recovery goals, and intervention plans. • The plan should be person-centered/directed, incorporating pertinent values, lifestyles and social contexts of the people who are obtaining health care.[iii]
7. SYSTEMATIC USE OF EVIDENCE-BASED CLINICAL MODELS	• Successful IBH programs use a systematic clinical approach that targets the specific conditions prioritized for care in that setting. • All providers use well-developed and shared clinical pathways for co-occurring conditions that are rooted in practice guidelines and evidence-based practice. • Evidence-based health/wellness programming is readily accessible to patients.

NOTE: The terms **PEOPLE, PATIENT, CLIENT,** and **CONSUMER** are utilized interchangeably throughout the document. Some terms are utilized more often in certain settings. We acknowledge varying perspectives on these terms.

INTRODUCTION

Integrated behavioral health (IBH) represents a fundamental change in both primary care and specialty behavioral health settings. Over time, IBH implementation efforts may result in behavioral health becoming routinely and seamlessly integrated into primary care services to the point that the distinction between physical health (PH) and behavioral health (BH) is replaced by an understanding that these two areas are fundamentally interdependent, and professionals no longer use the term "integration."[1] To help practice settings make progress toward that goal and promote use of current best practice, providers, payers, and health care systems considering adopting or furthering their integration efforts need information about what works for the populations they serve. This report is intended as a road map for providers, funders, and policymakers. It describes the research to date as well as emerging ideas regarding the core components necessary for an organization to deliver effective integrated behavioral health care.

Among medical staff, IBH entails more routine attention to BH and skillful attention to behavioral aspects of what are typically considered "physical" disorders, such as insomnia, diabetes, obesity, and nicotine dependence. Similarly, in specialty BH settings that serve adults with serious mental illnesses, IBH has created a new understanding of the overall health of people being served and offers the potential to extend health, wellness, and life expectancy. IBH is helping providers and funders move past outdated understandings of health needs, intervention approaches, and limitations on the range of potential settings in which IBH can be successfully implemented. However, this shift to fully embrace IBH will have substantial and complex implications for health care financing, health care services, and workforce training.

THE COMPLEX CHALLENGES OF INTEGRATED BEHAVIORAL HEALTH (IBH) IMPLEMENTATION

Despite the promise of IBH and its vision of a holistic approach to meeting health needs, a number of persistent challenges continue to stall IBH implementation. Along with policymakers and payers, providers are not always certain which models or core components of IBH to adopt or implement. In addition, selecting IBH models and features can be complicated by challenges with sustainable financing.

Additionally, the workforce in both BH and PH settings is rarely sufficiently prepared to deliver integrated care. For all these reasons and more, payers on the primary care side often express uncertainty about the cost-effectiveness of the more intensive (and expensive to deliver) IBH models.[2] Behavioral health providers and policymakers often wish to see IBH implemented but puzzle over how to pay for it. Although successful, sustainable, real-life implementation of IBH can be found in select settings, this remains the exception rather than the rule.

Although successful, sustainable, real-life implementation of IBH can be found in select settings, this remains the exception rather than the rule.

Nevertheless, strong models of IBH are available for both primary care and specialty behavioral health settings. These models can be adopted with confidence once the needs of the groups being served are understood and the organizations implementing IBH are prepared to obtain or create the necessary BH and/or PH resources and supports.

THE CORE COMPONENTS OF IBH

Much of the literature on IBH has focused on the most important clinical and organizational capacities necessary to provide IBH. However, too often this has been presented more in broad, conceptual frameworks than in practical terms. In this report, we have drawn on a number of sources to propose seven crosscutting core components of IBH. The purpose of this report is to identify and describe these core components by identifying critical issues related to each and offering examples. When guided by current practice and research-based wisdom on what constitutes IBH, implementation of IBH models has a better chance of improving the quality and outcomes of care and ensuring a sensible approach to spending health care dollars. In describing these seven components, we drew on two particular authorities: The Center for Integrated Health Solutions' (CIHS) IBH Integration Continuum, and the Agency for Healthcare Research and Quality's (AHRQ) principles concerning how IBH should be provided and supported. See Appendix A for an overview of each. In addition to these primary sources, we drew on several other publications and reports, as well as content experts in the field through key informant interviews. A list of these individuals can be found in Appendix B.

In defining the seven core components, we have attempted to home in on the most important features of IBH that need to be in place in order for providers to achieve its objectives.

Each component is explained in the following sections, and recommended indicators for identifying the presence of each component are summarized in the IBH Implementation Indicators Checklist table at the end of this section on pages 9 through 11.

CORE COMPONENT 1

INTEGRATED ORGANIZATIONAL CULTURE

What Does This Mean?

An integrated organizational culture promotes the delivery of effective and efficient integrated care in all areas of administrative and clinical practice. Organizational leaders communicate a convincing vision of what IBH looks like and what it can achieve in terms of greater health and wellness for the patient population. They inspire, motivate, and equip staff to develop greater IBH expertise.

An integrated organizational culture promotes the delivery of effective and efficient integrated care in all areas of administrative and clinical practice.

Why Is This Considered a Core Component?

Organizational culture is a component that is easily overlooked in discussions that tend to focus on strategy, but, as management consultant Peter Drucker famously noted, *culture eats strategy for breakfast.* At the core of successful and sustainable IBH programs is a culture that believes IBH is critical to achieving improved patient care and facilitates its implementation. A recent study by the AHRQ found that administrative leaders in health provider agencies who were nominated by their peers as exemplary in the area of IBH implementation ensured that the IBH perspective was instilled in all organizational functions.[7] Leaders worked to align clinical, operational and financial activities, and they created "buy-in" with staff at each management and practice level of the organization.[8,9] Unless embedded in organizational culture, IBH implementation may depend only on a few individuals and risks being short-lived and minimally effective.

Applying Integrated Organizational Culture in Practice

Leaders in integrated organizations enhance the agency's vision and mission statements and strategic plans to reflect core IBH values. For example, they often use more inclusive language to reflect goals related to "whole health," or ensuring access to "holistic treatment," or care that is inclusive of patients' "physical, mental, and social health." Successful programs identify champions for IBH development and implementation who can effectively translate the mission and vision or put them into use in

ways that change the culture. Champions may include either *individuals* or existing work *groups,* but they should be situated throughout the organization and empowered to bring about change in specific ways. In addition, IBH is most successful when the agency has a formal training and development plan that includes training specific to IBH practice, and exemplary IBH programs highlight integration in assessing pre-hire readiness, at orientation, and across ongoing staff development. Leaders should also develop plans for incorporating IBH into staff performance evaluation, service delivery design and structure, quality improvement processes, health information systems, and strategic plans for collaboration and partnership.[10] Finally, successful agencies incorporate IBH-related measures into their ongoing continuous quality improvement (CQI) activities. Conversely, failure to include IBH clinical and administrative metrics in program quality review activities has been found to result in failures in IBH implementation.[11]

Additionally, IBH programs often represent collaborations between more than one agency. For example, many IBH programs for people with serious mental illness are jointly developed by community mental health centers and federally qualified health centers (FQHCs). In these and other collaborative arrangements, a successful partnership must have a common or shared mission and vision for IBH that enables both organizations to develop the kind of culture described above.

Implementation Challenges and Considerations

One of the most difficult challenges in developing an integrated organizational culture is creating time for staff, especially direct care staff, to participate in the process of incorporating IBH into the organization's ongoing quality improvement process, clinical guidelines development, staff development, and program development. Many providers are under considerable pressure to maintain productivity and taking time from direct care duties (for example, billable services) is costly. Nevertheless, because IBH is not yet foundational to the way care is delivered, organizations that fail to make the necessary investments to sustain efforts may risk failure.

CORE COMPONENT 2

POPULATION HEALTH MANAGEMENT

What Does This Mean?

Population health management is "a set of interventions designed to maintain and improve people's health across the full continuum of care, from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions."[12] Best practice IBH programs assess and differentiate patients by their prevalent co-occurring conditions and utilization patterns. They routinely identify individuals who have these conditions, introduce the appropriate evidence-based treatment interventions, and track vital PH and BH outcomes. Patient registries and other health information technologies are used to manage outcomes across populations in order to apply the right interventions at the right time and to help ensure high-quality care and optimal health and wellness outcomes.[13]

Why Is This Considered a Core Component?

Implementing population health management is fundamental to realizing the coveted "Triple Aim" of improving the quality and patient experience of care in a cost-effective manner, and it is also essential to the cost-effectiveness and broader efficacy of IBH. Additional information on cost savings in IBH is provided in Appendix C. The importance of population health management within a provider agency is emphasized in the AHRQ research on model examples of IBH as well as in its academic literature review of IBH best practices in primary care settings. [14, 15]

Applying Population Health Management in Practice

Understanding the Patient Population. Effective population health management requires knowing the physical, mental and social needs of the patient population being served in as much detail as possible. However, understanding the prevalence of PH, BH and co-occurring conditions in the population being served is sometimes a challenge for providers because they lack accurate data on the prevalence of BH and PH conditions until they implement universal screening (described under Core Component #5).[16] To get started, providers can draw on national estimates of the overlap in BH and PH conditions. For example, we know that 29% of adults with ongoing medical conditions also have mental health disorders, while 68%

Effective population health management requires knowing the physical, mental and social needs of the patient population being served in as much detail as possible.

of adults with mental health disorders have ongoing PH conditions that require intervention.[17] Collaborating with payers to examine utilization patterns can also help the provider identify patient sub-groups with high need, complex and co-occurring PH/BH conditions (such as persons who overuse emergency room or EMS services).

Matching Patients to Appropriate IBH Models. Strong population health management requires differentiating interventions based on the patient's needs. The Four Quadrant Model is a useful framework with which to organize a providers' understanding of the various combinations of high- and low-severity health and behavioral health conditions, and, ultimately, to plan for the appropriate and efficient implementation of evidence-based IBH models.[18] We modified the model to include high, medium and low severity levels, as noted in the table below. For example, people with serious mental illnesses (SMI) and co-occurring physical health conditions benefit from receiving IBH in the specialty behavioral health settings with which they are familiar (Q-II and Q-IV). However, only some people with SMI need an intensive team-based intervention, such as a multi-disciplinary Behavioral Health Home (Q-IV).

Patient registries are databases with comprehensive clinical information on patients with long-term or complex PH and BH conditions. Registries can be used to improve treatment engagement (e.g., appointment reminders and health indicator tracking) as well as provide a basis for outcome and quality improvement efforts.

Data Sharing and the Development of Data Portals. Developing the capacity to share clinical data in "real time" with other providers in the health care neighborhood—including hospital and emergency room (ER) providers—is also key. For example, being able to immediately provide (or receive) data on the specific medications a person is receiving when that individual arrives at an ER can help avoid clinical errors and improve care quality. Such data can also inform cost-effectiveness analysis across levels of care, as noted below.

Tracking of Quality and Outcomes. Exemplary IBH programs routinely collect and analyze quality, outcomes, and cost data.[20, 21] Examination of data from screenings, assessments, and re-assessments of vital physical and behavioral health indicators in patients receiving IBH will enhance an agency's understanding of risk/severity

INDICATED IBH MODELS WITHIN A MODIFIED FOUR QUADRANT MODEL FRAMEWORK

CARE SETTING	LEVELS / SEVERITY OF BEHAVIORIAL HEALTH AND PRIMARY HEALTH CONDITIONS	
Primary Care Setting	QUADRANT I (BH: LOW, PH: LOW TO HIGH)	QUADRANT III (BH: MEDIUM, PH: LOW TO HIGH)
	Essential Integrated Care—Primary Care Behavioral Health Model	*Intensive Integrated Care*—Collaborative Care Models
Specialty Behavioral Health Setting	QUADRANT II (BH: HIGH, PH: LOW/MEDIUM)	QUADRANT IV (BH: HIGH, PH: HIGH)
	Essential Integrated Care—Behavioral Health Primary Care Model	*Intensive Integrated Care*—Behavioral Health Home

In primary care settings, the Primary Care Behavioral Health (PCBH) model, which employs a BH consultant embedded with primary care providers, can be used with most patients who have low severity behavioral health conditions (Q-I). But for those who have moderately severe or difficult to treat BH conditions (Q-III), the Collaborative Care Model (CCM), a more intensively staffed team-based approach, may be needed.

Patient Registries. IBH best practice includes the use of patient registries as the hub(s) for tracking and managing the clinical care of people with long-term and/or co-occurring PH and BH conditions that require monitoring.[19]

levels across the patient population, enable it to examine outcomes over time,[22] and improve care for individuals who are high utilizers of emergency and hospital services.[23] Advanced IBH providers can develop a sophisticated understanding of the amount and mix of IBH services needed to achieve reasonable and clinically relevant outcomes, sometimes referred to as "treat-to-target trajectories," for each PH or BH condition, as well as for prevalent co-occurring conditions.[24]

Implementation Challenges and Considerations

The necessary staff expertise for population health management is not always present, and implementing

population health management may require greater investment in CQI/evaluation staff. Larger agencies may be able to develop necessary staff expertise through the training of existing staff, but even training has a cost. Solutions include collaborating with payers and building data collection and analysis into existing clinical and administrative processes. Smaller agencies can band together within a region to develop capacity.

A second challenge is locating and paying for the health information technology (HIT) needed for population health management. In their oversight of the Primary Behavioral Health Care Integration national grant program, SAMHSA found that many grantees did not have the HIT infrastructure to use population health management, so SAMHSA decided to add supplemental HIT grants in order to help providers develop capacity. Electronic health record (EHR) software tends to lag behind IBH developments, so primary care providers often find it difficult to integrate BH fully in the EHR, and vice versa in BH settings. In fact, one of the major challenges for providers to achieve true integration is to have a robust electronic health record (EHR) where all health data are accessible to a provider in real time in a single record. For population health management to be most effective, a single EHR that can be used to track all health conditions must be available.[25]

Electronic health record (EHR) software tends to lag behind IBH developments, so primary care providers often find it difficult to integrate behavioral health fully in the EHR, and vice versa in behavioral health settings.

CORE COMPONENT 3

STRUCTURED USE OF A TEAM APPROACH

What Does This Mean?

A structured team approach means that workflows are shared, that there is a set of working relationships through which the health care team continuously communicates and collaborates in the service of carrying out simultaneous, mutually reinforcing, and coordinated PH and BH care.

Why Is This Considered a Core Component?

Implementing IBH fundamentally involves taking on the complexity of co-occurring PH and BH conditions, and a single provider rarely is capable of effectively addressing it alone. Researchers have identified collaboration in the form of continuous communication and careful integration of BH and PH expertise in planning and delivering care—that is, good teamwork—as an important predictor of good health outcomes.[26]

Applying the Structured Use of a Team Approach in Practice

Two dimensions of collaboration are evident in successful IBH programs: (1) structured provider relationships to promote successful collaboration and (2) a focus on high-performing teams.

Structuring relationships to promote collaboration and teamwork. Successful IBH programs "embed" BH providers within primary care clinics—and PH providers within specialty BH settings—by structuring the workflow and environment to promote ongoing, real-time collaboration. This is done through establishing daily team meetings (e.g., a "morning huddle"); ensuring that the health care team can communicate their assessment findings and person-centered treatment goals through the integrated record; creating protocols for "warm handoffs"; and creating a culture that encourages frequent, informal "water cooler" and "curbside" consultation and conversations.

The characteristics of high-functioning teams. The potential of continuous collaboration is optimized if the characteristics of high-functioning teams are present,[27] including:

1) Sharing the same vision and sets of goals for IBH
2) Understanding each team member's role
3) Enjoying mutual trust
4) Communicating and resolving conflict effectively
5) Regularly reviewing and discussing program outcomes and performance[28]

It is vital that IBH providers periodically assess the extent to which teams are developing these qualities and that management applies tools that help them enhance team functioning in these areas.[29]

Peer/recovery specialists also have an important role to play in IBH, particularly in specialty BH settings and in the person-centered healthcare home (PCHH) model in which they are required team members. Peer-developed and -delivered health and wellness approaches, such as

Whole Health Action Management, are now available and hold great promise for enhancing health and wellness outcomes in IBH.[30]

Implementation Challenges and Considerations

Hiring or appointing the right personnel for IBH is one of the most difficult challenges to maintaining high-functioning integrated care teams.[31] Often, agencies find that training and developing team members who are relatively new to their profession is more effective in establishing an IBH-orientated culture and instilling collaborative care practice habits. Other methods include using targeted training and recruitment of IBH-ready clinicians from academic programs with curricula and degrees tailored to integrated care/collaborative care practice, and collaborating with local universities to develop such programs.

Another challenge is the development of a shared language for care that bridges the PH and BH worlds. In practice, this often means that BH providers in primary care settings need to adopt the language of the PH world (e.g., use of the term "patient") and vice versa. However, successful IBH providers also explicitly develop a common IBH language that facilitates clinical interaction and collaboration.[32]

CORE COMPONENT 4

IBH STAFF COMPETENCIES

What Does this Mean?

Successfully implementing IBH requires "distinctive knowledge, skills, and attitudes, with specific training required for their attainment."[33] These include, for example: the ability to quickly establish rapport with consumers/patients and their families; the capacity to function as a member of a multidisciplinary team and to skillfully coordinate care within the team and with external specialty and social service providers; and the knowledge and skills necessary to assess the patient's stage of change and create interventions that correspond to the patient's current state of readiness.

Why Is This Considered a Core Component?

The concept of team was emphasized in the last component. However, a team is only as good as its members and the *blend* of players who make up the team. It is important to invest in the right people and continue to support their ability to effectively carry out IBH. Kathol and colleagues warn, "low-cost but undertrained clinicians are a poor investment unless linked to ways in which they can support application of evidence-based approaches to treatment in those with behavioral health conditions."[34]

Applying IBH Staff Competencies in Practice

SAMHSA-HRSA's Center for Integrated Health Solutions' *Core Competencies* document for IBH notes that the ability to quickly establish rapport with consumers/ patients and their families and the capacity to function as a member of a multidisciplinary team (that includes consumers/ patients and family members as well as other providers) are two "core competency categories."[35] Because behavior change and developing the capacity for managing their illnesses are primary needs for people presenting with PH and BH conditions, whether or not a primary care setting is staffed with a behavioral health consultant (BHC), all staff members should also develop the basic ability to assess the patient's stage of change and match planned interventions to that stage. Motivational interviewing, an evidence-based intervention that incorporates an understanding and acceptance of a patient's stage of readiness for change, is an approach that all staff should know how to use, particularly with patients who are in early stages of change (e.g., pre-contemplation, contemplation). This approach to assessing and motivating behavior change dovetails with person-centered planning because it draws on patients' own goals to inform treatment decisions.

Behavior change and developing the capacity for managing their illnesses are primary needs for people presenting with physical health and behavioral health conditions.

Additionally, because many IBH patients, particularly those in safety net settings, have multiple health conditions as well as social services needs (e.g., finding safe and affordable housing or child care), the skills and training of the IBH team should intentionally include the ability to provide coordination of needed medical and social services.

Implementation Challenges and Considerations

It can be difficult for practitioners of all professions to unlearn the habits they have accrued from years of training in non-integrated models and from working in isolation from other providers. It can also be a challenge to change perceptions of fellow providers' roles and beliefs about one's own "turf." Often, reward structures and staff

incentives are based on individual performance, not team performance, and productivity, not value and positive outcomes for consumers/patients. Reinforcing the desired IBH staff competencies may require change across many facets at the organizational level even after the right people are hired and trained.

CORE COMPONENT 5

UNIVERSAL SCREENING FOR PH AND BH CONDITIONS

What Does this Mean?

Just as vital signs such as blood pressure and body temperature help detect and monitor medical problems, behavioral health screening tools can act as "vital signs," helping to detect and monitor behavioral health problems. Like physical health vital signs, they should be universally used. Universal application of screening for the entire population for which the tool is indicated removes the requirement that patients take the initiative to disclose and reduces the risk of providers failing to identify patients in need of behavioral health services. At a basic level, effective integrated care means regularly screening all patients for behavioral health issues in primary care settings and for physical health issues in behavioral health settings.

Why Is This Considered a Core Component?

Early detection and intervention is an important factor in the successful treatment of behavioral health conditions. In many IBH settings (particularly primary care), the behavioral health needs of clients are typically in the mild to moderate range, often involving depression and/or anxiety. Universal screening is a key tool in identifying these behavioral health needs, because mild to moderate conditions often go unnoticed by providers (even those who consider themselves adept at spotting these issues), and primary care patients rarely describe themselves as anxious or depressed and instead tend to present with complaints such as fatigue, headache, or backache. Because patients with mild to moderate behavioral health disorders rarely self-report, providers need to proactively identify behavioral health needs in their patients if they are to succeed in early detection and intervention to prevent conditions from becoming more severe. The use of universal screening tools for behavioral health issues helps to normalize and de-stigmatize behavioral health conditions among both patients and providers by regularly asking questions about mental health needs.

Applying Universal Screening in Practice

Universal screening tools identify the patients that may need further assessment and possible treatment. The selection of which tool(s) to use is driven by client age and clinical profile. Frequently used universal screening tools include the Patient Health Questionnaire 9 (PHQ-9), or the Generalized Anxiety Disorder 7 (GAD-7), or simplified versions of those tools. While universal screening tools assist with identification, they can also be used for ongoing monitoring to measure response to treatment, which is critical in the goal of *treating to target*. Once completed, if the scores exceed an established threshold (e.g., a score of 10 or greater for the PHQ-9), then further assessment is done to determine whether treatment is warranted.

IBH settings can employ universal screenings in a variety of ways. The PHQ-9 can be completed by patients in the waiting room prior to each visit. Additionally, the PHQ-9 can be used as both an identification and an ongoing tracking tool. Alternatively, some IBH settings include a shortened version of the PHQ-9, either the PHQ-2 or the PHQ-4, as part of each primary care visit, the results of which are collected and tracked like traditional vital signs are. Positive responses trigger the use of the more extensive PHQ-9 and then additional assessment as necessary.

In specialty behavioral health settings that serve people with serious mental illness and related conditions, providers need to routinely screen for prevalent PH conditions. The nationwide Primary and Behavioral Health Care Integration grant program, promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) uses a robust screening regimen that includes screens for hypertension, hyperlipidemia, smoking (and breath CO2), obesity, substance use, and elevated blood glucose (e.g., A1c) levels, among others.

Implementation Challenges and Considerations

To ensure that a clinical practice embraces the use of universal screening tools, clear expectations must be set with the staff charged with administering the tool. If the tool is completed in the waiting room, the workflow of support and clinical staff needs to account for the administration, collection, and follow-up of this information. Clinic leadership plays a key role in establishing expectations and promoting the culture around this component. In considering the role of screening tools in measuring the vital signs of behavioral health, a clinic's quality program should incorporate and track the appropriate use of BH screening tools as a key metric. Findings of sub-par performance should serve as triggers for en-

hanced provider education. For example, a clinical quality strategy would require regular chart reviews that evaluate the completeness of all recommended elements of a visit, including BH screening tools. Screening can also influence the interaction between providers and patient, as providers will need to actively communicate with patients about when, how much, and whether active treatment is the best course of action.

A positive screen does not always indicate the need to intervene. Like physical health care, a "watch and wait" stance is sometimes an appropriate response when there is low acuity/risk and when this is consistent with the patient's desires. Additionally, positive screens are sometimes chiefly related to situational issues (e.g., domestic violence or unsafe housing). In these cases, the intervention may take the form of helping to connect the client to resources that remedy the situational issue before considering a medical intervention.

CORE COMPONENT 6

INTEGRATED, PERSON-CENTERED TREATMENT PLANNING

What Does This Mean?

Integrated, person-centered treatment planning means that patients receiving IBH have only one treatment plan that incorporates all PH and BH conditions, treatment/recovery goals, and intervention plans. The plan should incorporate the values, lifestyles, and social contexts of the person obtaining health care; it should reflect the fact that providers are "doing things *with* people, rather than *to* them."[36]

The treatment plan should reflect the fact that providers are "doing things with *people, rather than* to *them."*

Why Is This Considered a Core Component?

Shared decision-making and person-centered planning are emerging as important components of best practices in behavioral health care.[37] In part because difficulty talking about BH among both providers and patients (related to stigma or other barriers) tends to cause many patients to avoid seeking needed behavioral health care, engaging patients in the processes of defining their clinical needs, identifying goals for treatment, and choosing treatments becomes a vital aspect of ensuring active and ongoing participation in care.[38]

Applying Integrated Person-Centered Treatment Planning in Practice

IBH best practice includes the development of fully integrated treatment plans that are housed in one electronic health record. As the AHRQ noted, best practice for patients with co-occurring conditions is to have one PH/BH treatment plan (not two or more).[39] A person-centered treatment planning process also offers an opportunity to empower both the patient and the provider. Engaging patients in the process of producing the precise phrasing of goals and objectives validates and elevates their roles so that they are seen as critical members of the care team. Other specific person-centered practices may include a treatment plan that includes a signature page that confirms the patient's agreement with the plan. Some practices have found sharing the EHR screen with patients to be an effective way to enhance engagement in the treatment process and promote activation. Patients and their providers can also collaboratively review assessment and laboratory results, along with other aspects of care and treatment, in addition to the treatment plan.

Implementation Challenges and Considerations

Person-centered planning sometimes requires a shift in mindset, from an implicitly hierarchical understanding of the clinical relationship to a partnership model that is capable of activating the patient to pursue optimal health, wellness, and quality of life outcomes. For this reason, training on such topics as "person-centered planning," "patient activation," and "motivational interviewing" in a formal IBH training and staff development plan will be vital to supporting actual implementation of person-centered approaches, versus mere lip service to the notion of a more collaborative model.

CORE COMPONENT 7

SYSTEMATIC USE OF EVIDENCE-BASED CLINICAL MODELS

What Does This Mean?

Successful IBH programs use a systematic clinical approach with shared clinical protocols and guidelines that incorporate BH and PH conditions. Models vary, but the common component is that providers use well-developed and shared clinical pathways for co-occurring conditions that are rooted in practice guidelines and evidence-based practice. Evidence-based illness management interventions and health and wellness programming, which help people gain more control over their lives and make behavior changes, are readily accessible to patients.

Why Is This Considered a Core Component?

Fundamental IBH practices, such as co-location and collaboration among staff and implementation of an integrated treatment record, pave the way for more effective care and better outcomes. However, unless IBH programs use evidence-based and best practice PH and BH interventions, and adhere to the best practice guidelines and elements of those evidence-based models, better outcomes and more cost-effective care will not be achieved.

Applying Evidence-Based and Practice-Based Interventions in Practice

There are at least two levels of evidence-based practice in the implementation of IBH. First are the evidence-based *models* of IBH, such as the Primary Care Behavioral Health model[40] and Collaborative Care Model.[41] Second, there are specific, often overlapping, practices utilized within the models. For example, in primary care, IBH approaches such as the Primary Care Behavioral Health model incorporate brief interventions that are consistent with the culture and productivity demands of primary care. Drawing solution-focused techniques from cognitive-behavioral therapy, motivational interviewing, and illness management, BH specialists meet with patients in 20- to 30-minute sessions to help them experience rapid relief from symptoms, develop their own capacities to gain control over their illnesses, and achieve higher levels of functioning and quality of life.

IBH care in the specialty behavioral health setting overlaps with the implementation of behavior-related interventions for physical health problems. PH and BH specialists work together to help the entire organization develop a way to simultaneously implement evidence-based health and wellness interventions that promote behavior and lifestyle changes associated with greater activity and exercise, weight reduction, nutritious diets, and reduced tobacco use. Overlapping interventions, which would also include motivational interviewing and illness management, should be available in both settings. However, in specialty behavioral health settings, providers draw on evidence- based and best practice interventions, such as Wellness Recovery Action Planning and Whole Health Action Management that were developed specifically for people with serious mental illnesses.[42]

Implementation Challenges and Considerations

It is one thing to adopt evidence-based practices, but it is another thing altogether to implement them with fidelity to the core elements that are known to be clinically effective. The need for fidelity assessment was highlighted by SAMHSA's evaluation of IBH in behavioral health settings. Many grantees in SAMHSA's program used smoking cessation and weight-related evidence-based practices, but they failed to show improvement compared with control groups, which suggests that they did not implement these practices consistently.[43] Implementation of evidence-based practices requires a commitment to training staff and periodically assessing fidelity. The latter will cost organizations either time or money, but if not used, outcomes will be weaker. IBH programs can find creative ways to partner with trainers and evaluators (e.g., obtaining grants, engaging in practice-based research, etc.) or they can utilize inexpensive self-assessment tools such as the COMPASS PH/BH.[44]

It is one thing to adopt evidence-based practices, but it is another thing altogether to implement them with fidelity to the core elements that are known to be clinically effective.

IBH IMPLEMENTATION INDICATORS CHECKLIST

1. INTEGRATED ORGANIZATIONAL CULTURE

- Is IBH integrated into the organization's most important documents (vision, mission and value statements; strategic plans)?
- Do program descriptions describe the quality and access to services for patients with complex needs, including co-occurring BH/PH conditions?
- Do promotional materials and signage use inclusive language and images for patients with complex physical and behavioral health needs?

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1. INTEGRATED ORGANIZATIONAL CULTURE [CONTINUED]

- Does the documentation of administrative policies and procedures reflect IBH (billing instructions for staff, confidentiality statements, communication with external partners)?
- Has the organization established an IBH quality improvement team, which ideally includes multilevel, multidisciplinary staff and collects quality and milestone data related to IBH?
- Do staff development, hiring practices, and performance evaluations explicitly include robust attention to IBH?

2. POPULATION HEALTH MANAGEMENT[45, 46]

- Does the IBH provider have a quantitative understanding of the patient population—its BH and PH conditions and utilization patterns and costs?
- Does the provider match patients to appropriate interventions, including intensive, team-based interventions for those people with more severe conditions and/or high utilization of costly services?
- Does the provider use an integrated treatment plan, housed in an electronic health record (EHR)?
- Does the provider maintain a patient registry, ideally linked to its EHR, that allows for individual- and group-level tracking and analysis of services?[47, 48]
- Does the provider use data portals and other mechanisms to share data with other providers in the health care neighborhood (emergency rooms, hospitals, specialty providers)?
- Does the provider use ongoing analyses of carefully selected quality, outcome, and cost metrics within a continuous quality improvement (CQI) paradigm?
- Does the provider include staff (and, ideally, consumers/patients) in the CQI process?
- Does the provider incorporate population health management reports (produced from patient registries) into regular IBH quality improvement team meetings?

3. STRUCTURED USE OF A TEAM APPROACH

- Does the IBH program structure and organize provider relationships and communication to promote successful collaboration and care coordination?
- Do PH or BH providers continuously communicate at every stage of treatment, from assessment to planning and the ongoing provision of care?
- Are the characteristics of high-functioning teams manifested in PH and BH providers' attitudes and behaviors?
- Do providers who serve people with more severe and complex co-occurring conditions use intensive multidisciplinary teams, including peer specialists, to meet their needs and reduce high utilization?

4. IBH STAFF COMPETENCIES

- Does the provider have the capability to quickly build rapport with consumers/patients?
- Does the provider have the ability to work effectively as part of an inter-professional team and successfully coordinate care with external providers?
- Do all clinicians have the basic ability to assess the patient's stage of change and match planned interventions to that stage?
- Do all clinicians have basic proficiency in motivational interviewing?

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5. UNIVERSAL SCREENING FOR PH AND BH CONDITIONS

- Do primary care clinicians use widely accepted BH screens, such as the PHQ, with all patients?
- Do specialty behavioral health clinicians universally screen people with mental illnesses on core health indicators, such as BMI, tobacco use, blood pressure, and blood glucose?
- Does the IBH provider have policies, procedures, and training mechanisms in place that clarify universal screening methods and ensure they are used in clinically accurate and effective ways?

6. INTEGRATED PERSON-CENTERED TREATMENT PLANNING

- Is the provider's treatment plan completely integrated, with BH and PH conditions, goals, and planned treatments included in the same record?
- Do the provider's policies promote the use of person-centered and shared-decision making models of care and invite the person into an active treatment partnership?
- Does a representative sample of records indicate that BH and PH goals are chosen by patients and articulated in their own words? (Is "boilerplate" language used only sparingly?)

7. SYSTEMATIC USE OF EVIDENCE-BASED CLINICAL MODELS - INDICATORS

- Are staff trained in evidence-based practices and do they regularly implement them in response to patients' BH and PH needs?
- Do integrated treatment plans regularly reflect the use of evidence-based practices (EBPs) for the appropriate PH and BH conditions and match interventions to patients' stages of change?
- Are best practice guidelines, including medication algorithms, psychosocial EBPs, and wellness EBPs, incorporated into the EHR so that they are universally available to all staff?
- Does the provider periodically assess the fidelity of its EBP implementations?

Assessment of IBH Outcomes

The ultimate goals of IBH include improving outcomes for people served while lowering or containing costs. The number and variety of potential outcome measures is vast. Given that programs do not have unlimited resources, they should focus on two key questions: *Which outcomes do our payers and other key constituents want to see (accountability focus)?* And, *which outcomes do we need to track in order to gauge how well we are doing and make program enhancements (quality improvement focus)?* The former question refers to the need to establish accountability and the latter to the need to inform a continuous quality improvement process.

Various systems for measuring performance and outcomes have been developed, including, for example, the frequently used Healthcare Effectiveness Data and Information Set (HEDIS) system.[49] Most approaches over-emphasize process measures, even though they do often include some outcome measures. Although process measures can be useful (in particular, certain administrative metrics and measures of fidelity to the chosen IBH model), whenever possible, scarce resources should primarily focus on developing ways to measure health/wellness and cost-effectiveness outcomes.

Teams implementing person-centered health homes in specialty BH settings and person-centered medical homes in primary care should meet regularly (e.g., quarterly) to review outcome indicators and establish priorities for program enhancement. The key is that data are actually reviewed and program enhancements identified and implemented. For example, targeted changes (e.g., moving toward personal coaching for health and wellness instead of an exclusive emphasis on educational interventions) can often be instrumental in achieving better outcomes and can only be identified through regular review of program results.[50]

Additional detail on measuring outcomes and assessing fidelity can be found in Appendix D.

FINANCING INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH CARE PRACTICES

OVERVIEW

As practices consider restructuring to offer integrated physical and behavioral health care, it is important to understand the context of the financing environment. The rules, challenges, opportunities, and threats to financing integrated care practices often vary by payer environment and practice model.

Any discussion on financing must take into consideration the setting, whether it is based in behavioral health care or primary care, either at a federally qualified health center (FQHC) or a non-FQHC primary care practice. The type of entity billing for integrated care impacts the reimbursement strategies and options available to the provider. Integrated care practices are most commonly led by FQHCs, primary care practices, or community mental health centers (CMHCs). Despite some promising emerging models, the historical financing of these distinct entities, particularly in Medicaid, impacts the process and price for reimbursement and continues to perpetuate in most instances a fee-for-service model and traditional delivery patterns.

There are increasing opportunities for integrated practice sites to enhance the financial sustainability of the clinical model through new contractual arrangements with managed care organizations. While the shift away from fee-for-service of Texas Medicaid and Healthcare Partnership-specified services has been slow in the managed care environment, the requirements for this type of innovation are included in Texas Medicaid managed care contracts today. A concerted effort on the behalf of well-educated and well-organized providers is needed to move the system forward in a way that supports integrated care.

Many of the technical glitches around financing that existed in the early days of integrated care have been resolved through coordinated work of the state, providers, and managed care organizations (MCOs). The next level of integrated financing is likely to be more difficult to achieve and will require a clear understanding of the existing barriers and creative solutions to move to integrated, holistic payment models.

STRATEGIES FOR FINANCING IBH IN TEXAS

In Texas, the majority of Medicaid beneficiaries are covered through the Medicaid managed care program. Although the framework for the program is based on a fee-for-service (FFS) model—in which services are unbundled and paid for separately, and payment is dependent on the *quantity* of care, not the *quality*—the program is not restricted to operating on FFS policies or rates. As we discuss the rules for the Medicaid program, it is important for payers and providers to remember the managed care program allows for great flexibility to meet the needs of its members.

Since financing options depend upon the setting in which IBH is delivered, either at a FQHC or a non-FQHC primary care practice, we discuss these issues by setting. This discussion also is framed in terms of what is typical, knowing that sometimes there are exceptions.

HOW DOES THE PROVIDER TYPE IMPACT FINANCING OF INTEGRATED PRACTICES?

The type of entity billing for integrated care impacts the reimbursement strategies and options available to the provider. Integrated care practices are most commonly led by FQHCs, primary care practices, or CMHCs. The historical financing of these distinct entities, particularly in Medicaid, impacts the process and price for reimbursement for what is often the same service.

Federally Qualified Health Centers

FQHCs are designated to receive Medicare and Medicaid payments through the federal Prospective Payment System (PPS), a methodology based on the average of each FQHC's reasonable costs. This model pays a PPS or flat minimum rate per person per day of service regardless of the number of services offered in the encounter. These PPS payment rates are higher (often significantly) than the Texas Medicaid and Healthcare Partnership (TMHP) fee schedule for like services provided by an entity other than an FQHC. In addition to the PPS rates, FQHCs have specific billing rules that allow for an additional BH encounter in an FQHC on the same day that a PH encounter is billed.[51]

When patients have Medicaid coverage, the FQHC PPS system provides a significant source of funding that is designed to cover the complete costs of care. For the uninsured, FQHCs have access to federal grants and discounted medication pricing. This makes FQHCs an ideal partner in collaborations around integration if the patient population has a large percentage of Medicaid or uninsured clients.

Community Mental Health Centers[52]

For Medicaid/Children's Health Insurance Program (CHIP) patients, CMHCs bill primarily through MCOs per negotiated contracts and to a diminishing degree through TMHP per the state's fee schedule. CMHCs are considered comprehensive service providers; therefore, they have access to funding for mental health rehabilitative services and targeted case management when the patient's acuity meets certain requirements. These services can help support an office-based team through care coordination and home-based visits.

For the uninsured or under-insured, CMHCs receive state general revenue funding for behavioral health services when a person meets the state's clinical criteria. This does not provide an option for primary care funding. Some CMHCs do receive funding that includes both primary and behavioral health services for low-income uninsured individuals through the Texas 1115 Waiver. The 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) program has been a primary source for expanding IBH for adults with serious mental illness.

Community Primary Care Physicians

Primary care physicians based in the community without FQHC status or affiliated with a public hospital only have access to Medicaid funding available through negotiated MCO contracts (primarily) or the TMHP FFS schedule. This creates a financing disadvantage when attempting to establish integrated care.

HOW DOES THE TEXAS MEDICAID PROGRAM IMPACT FINANCING OF INTEGRATED PRACTICES?

Texas Medicaid rules for reimbursement for covered services vary by the type of Medicaid program, whether FFS or managed care, and within managed care, where rules and rates may vary by MCO. These differences create opportunities and challenges for operating integrated practice sites. Within the Texas Medicaid program, the state operates the TMHP, a traditional fee-for-service program. This program now accounts for less than 15% of all Medicaid beneficiaries, and that number is expected to decline. In this program, the Health and Human Services Commission (HHSC) sets the fee schedule and reimbursement rules for providers.

The majority of Medicaid beneficiaries are served by the Medicaid managed care program, where HHSC contracts with an MCO. The MCO then sets rates and rules for reimbursement directly with providers. MCOs for the most part continue to follow the TMHP fee schedule and reimbursement rules, which significantly limits the capacity to provide IBH (and to an increasing degree, care more broadly). However, MCOs have the flexibility to create their own fees and rules through negotiation with providers. Although not exhaustive, the following information outlines some financing issues providers should consider if they intend to operate an integrated care site for Medicaid beneficiaries in Texas.

If the MCO has an integrated plan (meaning one contract for both physical and behavioral health), one potential issue involves system checks to prevent duplicate billing. As long as the specialty type of provider (e.g., primary care provider versus BH provider) and diagnosis of the member differ, billing two of the same codes on the same day should not cause denials. In order to prevent denials and potential billing issues, the provider should proactively discuss the integrated site's program model with the MCO and work with the MCO to define appropriate billing criteria prior to accepting the MCO's members.

When the MCO subcontracts with a behavioral health organization (BHO), the provider must negotiate two separate contracts. This decreases the potential issues with duplicate billing for PH and BH, but requires more time on the front end to negotiate contracts and rates given that there are two contractually linked, but separate, entities managing the care. In addition, there is potential for issues in which the BHO denies a claim as medical, and the MCO denies the claim as behavioral health. As an example, reimbursement for injectable medications has been a problem with some MCOs. When this occurs, providers should request a joint meeting with both the MCO and BHO to discuss such crossover claim issues.

Additionally, HHSC has added a set of Health and Behavior Assessment and Intervention (HBAI) services to the Medicaid State Plan. HBAI services are used to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to the treatment and management of physical health problems. HBAI is an established intervention designed to enable the consumer to overcome the perceived barriers to self-management of his/her chronic disease(s) and can be an integral part of an

effective IBH program. The HBAI services are a covered benefit for children who are 20 years of age and younger. This benefit was implemented by TMHP and MCOs in 2014. HBAI services are provided by a licensed therapist, who is co-located in the same office building or complex as the client's primary care provider.[53] Integrated practice sites should determine the appropriate use of these services to support the practice. In addition, MCOs can choose to cover these services for adults in order to appropriately manage care. Providers serving adults who have Medicaid coverage in an IBH program should include in their discussion and contract negotiations with MCOs a request to receive reimbursement for HBAI services.

Providers serving adults who have Medicaid coverage in an IBH program should include in their discussion and contract negotiations with MCOs a request to receive reimbursement for Health and Behavior Assessment Intervention services.

Typical payments by TMHP and MCOs do not cover many important elements of integrated care sites such as doctor-to-doctor consultation, wellness programs, patient education, and care coordination. The concept of health homes, which has been included in the MCO contracts with HHSC, offers a model of care and financing to support these critical ancillary functions. However, to date, few (if any) integrated care sites have been successful in creating health home payment structures with Texas MCOs.

Care coordination is also a critical component in an integrated practice, but it is difficult to receive payment for this service in the TMHP environment. In both TMHP and MCOs, comprehensive service providers can bill targeted case management for specified individuals based on the outcome of a required assessment, but for most Medicaid enrollees, the MCOs have the flexibility (as well as the direction) from HHSC to reimburse health homes through value-based payments, which can include a care coordination fee for the integrated practice.[54] It is unclear the extent to which MCOs are currently using value-based payments with integrated care sites, but interviews with key informants suggest that it is highly limited and more theoretical than actual.

The Texas STARKids program becomes operational in September 2016 for children who receive supplemental security income (SSI) or are enrolled in the Medically Dependent Children Program (MDCP). In STARKids, the MCO must develop incentive programs for designated providers who meet the requirements for patient-centered medical homes.[55] STARKids also requires health homes be provided to all members.[56] These requirements have the potential to more fully support the scope of work necessary for successful integrated practice sites, compared with the existing financing models. However, MCOs and providers must work together to develop the IBH capacity and funding models to support them.

In summary, financing of integrated care requires a careful examination of the type of insurance coverage connected to the patient population in order to maximize available revenue and identify ideal partners. As noted earlier, if a significant portion of the patient population has Medicaid, then using or partnering with an FQHC will help to build a more sustainable revenue base. Additionally, because managed care is the platform on which Texas delivers almost all community-based Medicaid services, exploring the flexibility offered to managed care plans to set different rates or pay for non-traditional services is also an important vehicle for financial sustainability.

APPENDIX A:
AUTHORITIES INFORMING SEVEN CORE COMPONENTS OF IBH

THE SAMHSA/HRSA CIHS INTEGRATION CONTINUUM

In 2013, SAMHSA developed the "Standard Framework for Levels of Integrated Healthcare" for the agency's Center for Integrated Health Solutions (CIHS). The framework identifies six different levels of implementation that follow a continuum from collaboration to integration.[57] The following table summarizes the six key levels of implementation and "key differentiators" of the Standard Framework. Following this, the table also summarizes five cross-cutting domains of clinical and organizational functioning that should be considered in addressing integration, each of which can reflect varying degrees to which a provider has implemented or supported a collaborative, integrated model.

The framework groups the developmental levels within three overarching categories—coordinated, co-located, and integrated care—and then further refines each category into two levels to create a six-level continuum of integration. For instance, *frequency of communication* is described as a critical distinction within levels of coordinated care. As communication frequency increases, *physical proximity* becomes the critical distinction for practices moving from coordinated care (levels 1 and 2) to co-located care (levels 3 and 4). Lastly, *practice change* (integration orientation by all systems, leadership and providers) is the hallmark of integrated care levels 5 and 6.

At this time, there is insufficient evidence to associate specific health outcomes to a particular level of integration,[58] which may be due to the fact that IBH is still relatively new, and it represents a broad range of interventions that are difficult to examine with rigorous methodologies.

SAMHSA-HRSA CIHS STANDARD FRAMEWORK FOR LEVELS OF INTEGRATED HEALTH CARE

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	LEVEL 6
Minimal Collaboration	**Basic Collaboration at a Distance**	**Basic Collaboration Onsite**	**Close Collaboration Onsite with Some System Integration**	**Close Collaboration Approaching an Integrated Practice**	**Full Collaboration in a Transformed/ Merged Integrated Practice**
BEHAVIORAL HEALTH PRIMARY CARE AND OTHER HEALTH CARE PROVIDERS WORK (System Integration, Communication Frequency, Collaboration, and Roles & Culture)					
CLINICAL DELIVERY (Screening, Collaborative Treatment Planning, Implementation of EBPs)					
PATIENT EXPERIENCE (Experience with Care Team, Attention to Whole Health Care)					
PRACTICE / ORGANIZATION (Leadership Support and Provider Buy-in)					
BUSINESS MODEL (Funding Integration, Sharing of Resources & Integrated Billing Structures)					

AHRQ IBH EXPERT CONSENSUS LEXICON

The Agency for Healthcare Research and Quality (AHRQ), a key governmental authority in identifying standards for integrated care, developed a summary of principles concerning how integrated care should be provided and supported.[59] When combined with the SAMHSA-HRSA CIHS standard framework, the AHRQ model helps us begin to paint a picture of what it looks like when providers are implementing integrated behavioral health.

IBH FEATURES THAT MAP SIMILARITIES AND DIFFERENCES AMONG IBH PROGRAMS[60]

HOW CARE IS PROVIDED	CORRESPONDING PARAMETERS
Practice team tailored to the needs of each patient situation	• Range of care team functions and expertise that can be mobilized to address needs of particular patients and target populations • Type of spatial arrangement employed • Type of collaboration employed
Clear, shared understanding of patient population and mission	• Clear definition of patient panel with total health outcomes and a method for Identifying individuals
Systematic clinical approach	• Protocols are established for engaging patients in integrated care • Degree to which protocols for initiating integrated care are followed • Proportion of patients in target groups with shared plans • Degree that care plans are implemented and followed
HOW CARE IS SUPPORTED	**CORRESPONDING PARAMETERS**
Community, population, or individuals expecting IBH as standard care	• Level of community expectation for IBH as standard care
Support by office practice, leadership alignment, and business model	• Level of office practice reliability and consistency • Level of leadership/administrative alignment and priorities • Level of business model support for integrated behavioral health
Continuous quality improvement (CQI) and measurement of effectiveness	• Scale / extent of practice data collected and used to improve the practice

APPENDIX B:
KEY INFORMANT INTERVIEWEES

INTERVIEWEE	AGENCY/ORGANIZATION	AREA OF EXPERTISE
Avery, Mark	University of Washington AIMS Center	Collaborative Care Model
Capobianco, Jeff	Center for Integrated Health Solutions; National Council for Behavioral Health	IBH implementation; administrative and outcome metrics in IBH
Jarvis, Dale	Dale Jarvis Associates; Consultant to National Council for Behavioral Health	IBH models and financing of IBH
Kessler, Rodger	University of Vermont, Department of Family Medicine	IBH implementation, policy and research
Khatri, Parinda	Cherokee Health Systems	Hybrid IBH model—the Cherokee Model
Medrano, Martha	CommuniCare Health Centers	Implementation, primary care setting
Reynolds, Kathleen	Reynolds Associates	IBH implementation, financing, and evaluation
Rowan, Melissa	Wertz & Rowan	IBH implementation and financing in Texas
Steiner, Leigh	Care Management Technologies	IBH best practices, clinical/system decision supports, and analytics
Strosahl, Kirk	Mountainview Consulting	Developer of the PCBH model of IBH

APPENDIX C:
COST SAVINGS FROM INTEGRATED HEALTH CARE

It is beneficial for those funding or implementing integrated health care to have some understanding of the cost implications. Will implementing the core components outlined here save money? The answer is more complicated than we might hope, but critical to widespread implementation. In identifying the potential for cost savings from integrated care, it is important to understand how the distribution of costs varies between behavioral and physical health costs, and how the combined costs vary among individuals.

INDIVIDUALS WITH BEHAVIORAL HEALTH ISSUES HAVE HIGHER HEALTH CARE COSTS

For individuals with a mental health or substance use disorder, health care treatment costs for behavioral and physical health conditions are two to three times higher ($1,085 versus $397 per member per month in one national study).[61] The greater proportion of additional cost is for PH, not BH, conditions. The distribution of per person costs contains many individuals with low to moderate use of medical and behavioral health services, and a much smaller number of individuals with very high costs (super-utilizers). These facts suggest two related strategies: (1) target the small number of super-utilizers of expensive emergency department and inpatient services (often served in community behavioral health settings) with interventions that allow them to address their physical health crises more effectively, and (2) prevent the much larger number of low utilizers of emergency department and inpatient services (often served in primary care settings) from becoming super-utilizers.

The literature does not yet contain a rigorous meta-analysis of cost studies targeting super-utilizers who use integrated health care. However, in one promising intervention, Missouri enrolled Medicaid clients with mental illness (and at least $10,000 in Medicaid claims during the previous year) into health care homes, and expenditures on emergency department and inpatient hospitalizations declined in a before-and-after comparison. Because a control group was not used in evaluating this program, it is not clear how much of this reduction was due to the intervention itself.

COST SAVINGS OF INTEGRATION OF PRIMARY CARE INTO BEHAVIORAL HEALTH CARE

For interventions not limited to super-utilizers, recent meta-analysis results[62] of the provision of primary care services in outpatient behavioral health settings (community mental health centers and substance use disorder clinics) found no significant changes in health care costs. Small declines in hospitalization were offset by small increases in emergency department use. These disappointing results may be driven by the more severe BH and PH conditions of the population served in community mental health settings.

The lack of cost savings from health care integration in behavioral health settings should be a cautionary note to policymakers and administrators seeking to fund integration through health care savings. Short-term costs may rise as individuals with mental illness receive better primary care screening and expensive-to-treat conditions are identified.

COST SAVINGS OF INTEGRATION OF BEHAVIORAL HEALTH INTO PRIMARY CARE

Meta-analysis results of integration in primary care settings do yield significant results. Analysis of collaborative primary care for depression performed by the Washington State Institute for Public Policy (WSIPP) estimated that per person lifetime savings in health care costs from this type of integration is $1,805, while the per person cost of integration is $797. Similar results occur for anxiety conditions.[63]

Although improved PH care should in the long run result in reduced use of expensive emergency department and inpatient services, more evaluation work needs to be completed to find out the nature and timing of this savings. Integration in primary care settings is more likely to yield savings in health care costs, and it is feasible to plan for these savings in developing these programs.

APPENDIX D:
IBH FIDELITY, READINESS AND SELF-REVIEW TOOLS AND MEASUREMENT STRATEGIES

MEASURING OUTCOMES IN PRIMARY CARE

Measures used in a primary care-based program will typically include standard and brief BH measures such as the Patient Health Questionnaire-9 (PHQ-9) that can serve both as a screening/assessment instrument and as an indicator of IBH treatment progress.[64] Health indicators associated with prevalent PH conditions, including blood pressure, body mass index, cholesterol levels, and the like, can also be easily tracked, and they often are already incorporated within (or readily added to) typical electronic health records (EHRs). Cost-related outcomes of concern, especially for intensive programs serving people with high utilization, will include at a minimum emergency room visits and hospitalization days, but in some programs should also include expensive treatments associated with disease complications, such as amputations for people with diabetes.

The above-mentioned outcomes can be considered "ultimate" outcomes, but sophisticated programs also will assess intermediary outcomes that they know are precursors to the ultimate outcomes, as well as cost measures associated with their own outpatient/community-based service delivery to specific key sub-groups of patients. A prime example of an intermediary outcome is the use of the Patient Activation Measure (PAM) as a tool to track the degree to which patients are becoming actively engaged in their care and illness management,[65] because active patient engagement is associated with better ultimate outcomes.[66] Cost measures include, for example, the unit cost to help people with a specific, prevalent clinical condition such as major depressive disorder or diabetes (or co-occurring major depressive disorder and diabetes) to reach treatment targets.[67]

Two additional key issues need to be kept in mind: 1) the particular PH and BH outcomes used should address the highest-priority needs of people served and the concerns of payers with whom the provider needs to establish accountability; and 2) the program needs to establish methods for extracting and combining person-level baseline and follow-up data in order to examine changes over time. This can include, for example, conducting simple before-and-after statistical tests of health measures. The follow-up data should be obtained at the point in treatment when most people tend to show change. For example, hypertension tends to respond more quickly to treatment than does body mass index (BMI).

MEASURING OUTCOMES IN SPECIALTY BEHAVIORAL HEALTH CARE

The guidance for measuring outcomes in specialty behavioral health care is nearly identical, but for people with SMI, it should also include attention to indicators of community integration, including independent living and employment, as well as highly prevalent conditions such as tobacco addiction/dependence and substance use-related outcomes (e.g., use of detoxification and stage of recovery).

ASSESSMENT OF IBH IMPLEMENTATION FIDELITY

Before examining outcomes, programs need to measure the extent to which they are consistently implementing core aspects of their particular IBH model. If it turns out that IBH is not being implemented as outlined by the evidence-based model that has been selected, the ability to measure outcomes such as changes in health and well being over time is diminished. In terms of timing, any time an evidence-based model is being implemented, baseline measures of fidelity to the model and key outcomes (e.g., health and well-being) should be obtained in order to establish the starting point for measuring change. For fidelity, initial measurement mid-way through year one (to allow time for implementation to progress sufficiently to measure) and then annually thereafter can help facilitate progress. Fortunately, several well-organized fidelity instruments have been developed, although often they are conceptualized as "capacity" or "readiness" assessments. While programs can use them to self-assess, it is often beneficial to have external reviewers conduct collaborative fidelity assessments to maximize learning.

Below are some specific tools and instruments that behavioral health centers may use to assess agency capacity and/or readiness.

Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration (OATI)[68]

The OATI is currently the most comprehensive set of measures for establishing or improving integrated care services. The OATI is composed of four (4) primary OATI tools: the Partnership Checklist, the Executive Walkthrough, the Administrative Readiness Tool, and the COMPASS Primary Health-Behavioral Health Tool.

Specific tools associated with the OATI can be accessed from: **http://www.integration.samhsa.gov/operations-administration/assessment-tools#OATI**

including Partnership Checklist:
http://www.integration.samhsa.gov/operations-administration/OATI_Tool1_Partnership_checklist.pdf

Executive Walkthrough:
http://www.integration.samhsa.gov/operations-administration/OATI_Tool2_Executive_Walkthrough.pdf

Administrative Readiness Tool:
http://www.integration.samhsa.gov/operations-administration/OATI_Tool3_ART.pdf

COMPASS Primary Health-Behavioral Health Tool:
http://www.integration.samhsa.gov/operations-administration/OATI_Tool4_COMPASS.pdf

Behavioral Health Integration Capacity Assessment (BHICA)[69]

The BHICA is a readiness tool that emphasizes three key integrated care areas: coordinated care, co-location, and on-site primary care capability. Created as a self-assessment, a provider assembles an interdisciplinary work group to answer questions associated with the three key integrated care areas, including provider infrastructure. The burden to complete the assessment is relatively low and can be completed over the course of several meetings.

Behavioral Health Integration in Medical Care (BHIMC)[70]

Designed for FQHCs, this is an advanced checklist style assessment tool for assessing the degree of primary care and behavioral health integration as it relates to the provider's capacity to treat dual diagnosis conditions. Primary domains include organizational characteristics, treatment characteristics, and care coordination/management characteristics.

Integrated Practice Assessment Tool (IPAT)[71]

The IPAT is a simple tool that includes a stepped series of yes/no questions to help providers understand the level of integrated care at which they currently operate. Drawing on the SAMHSA framework described in Appendix A, the IPAT uses a decision-tree structure to reveal an overall IBH implementation rating from one to six.

END NOTES

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[25] At the inception of IBH in Texas, most EHRs did not have the functionality to collect and manage behavioral health data. Registries were developed by many providers to address this gap, but they still required providers to work in a two-record system (a registry and EHR). To date, there is a movement to have a "single record" for all health data. EHR vendors have now begun adding functionality and templates for mental health screening (depression), aggregation of health data from an individual and population perspective, and access to all health data, including behavioral health data, in real time. Again, the ultimate goal is to

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