BEHAVIORAL HEALTH INTEGRATION CAPACITY ASSESSMENT (BHICA)

INTRODUCTION

Purpose

The purpose of the Behavioral Health Integration Capacity Assessment (BHICA) is to assist behavioral health organizations in evaluating their ability to implement integrated care. We define integrated care as "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families[1], using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic health conditions), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."[2] The BHICA allows behavioral health organizations to evaluate their processes related to three approaches to integrated care: develop and coordinate formal or informal relationships with primary care providers, co-locate care, or build primary care capacity in-house. It also allows organizations to assess their existing operational and cultural infrastructure to support greater integration.

After completing the assessment, behavioral health organizations will be better positioned to:

- Consider potential approaches to integration to better serve their population;
- Understand how the current infrastructure of their organization could support greater integration;
- Assess the organization's strengths and challenges in undertaking different approaches to integration; and
- Set and prioritize goals for the organization's integration efforts.

Audience

The audience for the BHICA is behavioral health organizations that are actively planning how to implement or facilitate greater integration of primary care and behavioral health care and want to identify an appropriate approach for their organization. Organizations that have already selected an approach, but want to identify opportunities to improve, will also benefit from this self-assessment. Organizations that have not yet decided whether to pursue integration and want to understand the benefits of an integrated approach may find other tools and resources more useful than the self-assessment. Please see Appendix A for additional resources.

While the focus of this self-assessment is on behavioral health providers, much of the information presented will likely be useful to other types of organizations, as many of the lessons (e.g., culture change, financial barriers) are relevant regardless of context.

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[1] For the purposes of this tool, families refer to immediate family and natural supports identified by the individual.

[2] Peek CJ and the National Integration Academy Council. *Executive Summary*--Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-1-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon_ExecSummary.pdf

How can we best meet an individual's health needs?

Behavioral health and primary care services are typically delivered by different providers in separate settings, often with little coordination. Substance abuse treatment, particularly for opiate dependence, may be even more segregated. For multiple reasons, this fragmented delivery of care can be particularly problematic for individuals seen in community behavioral health organizations.[3,4] Individuals with mental illness or substance use disorders are at greater risk for complex physical health problems and have heightened morbidity and mortality compared with those without behavioral health issues and concerns.[5,6] The side effects of psychiatric medications can produce adverse health outcomes, such as metabolic disorder and weight gain. At the same time, the mental illness or substance use disorder itself may interfere with an individual's ability to receive and participate in appropriate care. Individuals with mental illness or substance use disorders may face barriers in accessing medical care and may feel more comfortable receiving care in a behavioral health setting, but most behavioral health clinics do not provide primary care services.

The Aspirational Model: Fully Integrated Care

Fully integrated care would seamlessly manage each individual's behavioral health and primary care together. An individual would walk into the organization and be cared for by a behavioral health clinician who has already been in touch with the individual's primary care provider. Physical health needs that affect behavioral health would be identified during the initial behavioral health visit, and a joint care plan would be developed. Simultaneously, the individual's behavioral health needs would be communicated to the primary care provider, enabling two-way communication about the individual's holistic health. All needed consents and information sharing would be in place to allow for seamless information sharing. This approach, with warm hand-offs and integrated services, would be optimal for managing the care of individuals with complex behavioral health needs.

Current models of care delivery are not always well-suited to address the health needs of individuals with mental illness or substance abuse diagnoses. While full integration for individuals may be an aspirational goal, organizations can take steps towards addressing individuals' myriad health needs in a coordinated and team-based way.

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[3] Stephens S. Blueprint for Change: Achieving Integrated Health Care for an Aging Population. American Psychological Association, 2007. Retrieved from http://www.apa.org/pi/aging/programs/integrated/integrated-healthcare-report.pdf.

[4] Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/Substance Abuse and Primary Care No. 173. Agency for Healthcare Research and Quality, 2008. Retrieved from http://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf.

[5] Parks J, Svendsen D, Singer P, Foti ME. Morbity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Directors, 2006. Retrieved from http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf.

[6] Piatt, E. E., M. R. Munetz, et al. (2010). "An examination of premature mortality among decedents with serious mental illness and those in the general population." Psychiatr Serv 61(7): 663-668.

THREE APPROACHES TO INTEGRATION

The Agency for Healthcare Research and Quality (AHRQ) lexicon[7] outlines three basic integration approaches designed to improve care delivery processes and outcomes:

a. Coordinate care

b. Co-locate

c. Build primary care capability in-house

Regardless of the approach, achieving integration will take time, require building relationships, and require modifying administrative and operational functions. The approach that best fits an organization will depend on its available resources and goals. The approaches outlined in the BHICA are not mutually exclusive implementation strategies. Rather, they represent different ways in which organizations can bring primary care services into their organization. Organizations may select components from different approaches based on what works best for them.

Coordinate Care

Behavioral health organizations regularly collaborate and consult with other providers to address the health needs of their population through better coordinated care. To accomplish this, organizations may build formal relationships through contracts with primary care providers or build informal networks of primary care and specialty providers. Organizations share as much data and information between providers as possible, consistent with federal or state information-sharing laws. Organizations may build relationships with community organizations that address the health, wellness, or social needs of individuals in their practice (e.g., YMCA, peer support centers, low-income housing advocates).

Co-locate

Behavioral health organizations may also integrate care by being on the same site or campus with a primary care provider such as a federally qualified health center. In this approach, organizations provide team-based care with referrals between behavioral and primary care providers and, when possible, warm hand-offs—direct introductions to the other provider at the time of the individual's visit. Organizations share as much data and information between providers as possible, consistent with federal and state information-sharing laws. Some integrated practices maintain an integrated record-keeping system.

Build Primary Care Capability In-house

Behavioral health organizations bring primary care providers on-site to address the needs of individuals in their organization. General screening (e.g., blood pressure, blood work for basic labs) and wellness activities (e.g., classes on nutrition and smoking cessation) are offered on-site and targeted specifically to individuals and families with behavioral health

[7] http://integrationacademy.ahrq.gov/lexicon

issues and concerns. Walk-in and advance appointments are accepted, and the behavioral health and primary care providers work together to address the needs of the population.

A note about financing: Finding sustainable financing is an important part of making integration work. Some may argue that it is the most critical component. In a changing health care environment, new models and demonstrations are opening up new financing options for behavioral health organizations to further integrate primary care services. Because these models are changing and may be state- or area-specific, we have included a few general questions about financing and the business case for integration in this self-assessment. Additionally, we have linked to some useful resources on financing that may help organizations identify possible pathways for funding this work. Engage financial staff in discussions when deciding on a potential model and assessing the organization's readiness from a financial perspective. Though this assessment includes a section that prompts consideration of the financial aspects of integration, it is important to note that this is not a comprehensive resource for selecting an organization's financial approach.

How to use the self-assessment

This self-assessment is designed to facilitate a candid analysis of the current practices and processes within your organization that support integration. The accompanying scoring tool will help you understand how your current practices and processes map to the different integration approaches. The scoring tool will also help you to identify possible next steps in your integration work.

Pre-work:

Prior to beginning the assessment, it will be helpful to work with staff in your organization on the following:

(a) Collect data on demographics, service utilization, and other characteristics of your current population (whom you serve, what you deliver, and how often). Your organization may find these data through a variety of sources, such as individuals' electronic health records, claims data, conversation with individuals and providers, and other sources.

(b) Gather information on current clinical, operational, and cultural practices and processes (the organization's infrastructure).

(c) Decide whether you want to assess processes related to one particular approach or all approaches. A high-level description of each approach is available here.

(d) Collect information about how existing services are paid for (e.g., Medicare and Medicaid reimbursement, commercial insurance, grants) and where there may be flexibility to add or change services your organization provides.

Self-Assessment:

The self-assessment comprises five sections:

a. Section I: Understanding Your Population

   This section of the self-assessment is intended as a reflection tool for your organization. Organizations may find it useful to think through the characteristics of the population and review considerations for how these characteristics affect their choices of how to integrate. Organizations that have already selected an approach or done similar analyses in the past do not need to complete this section.

b. Section II: Assessing Your Infrastructure

   This section is intended to help you evaluate your organization's current operational and cultural practices in order to identify specific recommendations for continued improvement.

c. Section III: Identifying the Population and Matching Care

   This section is intended to help you examine processes to identify the target population and match identified individuals with appropriate care.

d. Section IV: Assessing Three Approaches to Integration

   This section outlines three approaches to integration: formal or informal relationships with primary care providers and community organizations, co-located care, or in-house primary care capability. Organizations can answer the questions in all sections or just the sections that are most relevant for their organization. Please note that there is some repetition across sections, as there are common elements required for each approach.

e. Section V: Financing Integration

   This section identifies a few questions that may be helpful for organizations to consider as they think about financing and building a business case for integrating care.

Process for completing the self-assessment:

1. We recommend that you select a group of leaders and staff who collectively have expertise on all levels of the organization (e.g., finances, operations, clinical processes, leadership practices, staff practices) to complete the self-assessment. The time needed to complete the assessment will vary depending on how many sections are completed. It could take between 90 minutes for a more cursory review or a full day or more for in-depth analysis and conversations. You may ask specific individuals to complete specific sections of the assessment, or you may ask a few individuals to complete as much of the assessment as possible. Some examples of staff who may help complete the assessment include senior leadership, office/program managers, referral coordinators, behavioral health providers, nurses, and any staff providing primary care (if applicable).

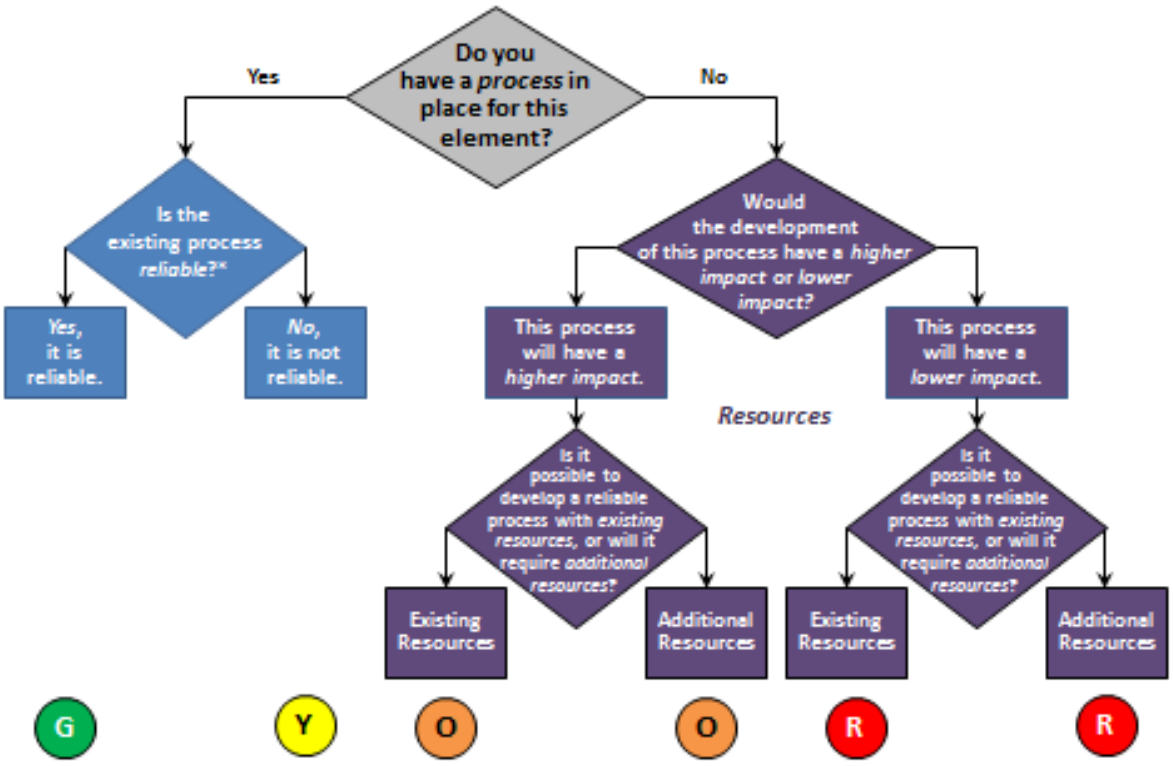
2. When you finish, we recommend that you come together as a team to discuss discrepancies between answers.

3. After you complete the self-assessment and accompanied scoring tool, we suggest setting up time to debrief with key leaders and identify your goals and next steps. Organizations have found that including comments and notes while answering questions helps to identify opportunities for further discussion in the organization. In addition to answering the questions outlined in the scoring tool, we encourage you to make notes in the column provided.

Integration is not easy; a number of barriers can make integration of primary care and behavioral health challenging. These include information sharing regulations, challenges financing the work, and cultural differences between primary care and behavioral health providers. Despite these challenges, behavioral health organizations are finding ways to increase overall integration. Many of the questions in the assessment relate to overcoming common barriers to integration.

COMPLETING THE BHICA

Staff working in the behavioral health setting will be asked to evaluate their population, their organization's processes, and their cultural norms. The Understanding Your Population section is open-ended responses intended to spark conversation and organizational reflection. The finance section is intended to be a self-reflection tool to guide conversations and planning within your organization. Most questions in this section have "yes/no" responses with blanks for open-ended responses. Please use the notes column to identify areas for further discussion. The culture section asks respondents to rate agreement with the statement from "strongly agree" to "strongly disagree." In some questions in the approaches and operational sections, there are "yes/no" responses, since they do not specifically address processes. For the other elements, respondents will be asked whether the organization has a certain process in place. If yes, they will be asked whether the existing process is reliable. Respondents will also be asked whether a reliable process is possible, given the organization's existing resources.



The process elements in the Tool will fall into an Assessment Category (green, yellow, orange, or red) based on the responses. The Assessment Categories are described in *Interpreting Your Results*. An *interactive evaluation grid* is provided so that you can easily identify the Assessment Category for each element based on your responses. Additional guidance about the results of the evaluation, including the Assessment Categories, is provided in *Interpreting Your Results.*

THE ASSESSMENT

1. UNDERSTANDING YOUR POPULATION

The following questions will help you consider how client needs may affect potential approaches to integration. Depending on your current infrastructure for data collection and interpretation (including data on demographics, mental and physical health conditions, and client desire for specific service types and methods), you may not be able to answer all questions. As much information as possible, however, will help in thinking about the appropriate integration approach. For example, if 75% of the population already has primary care providers, building integration in-house may not be necessary, as the primary care needs of many individuals are already being met. In that case, building formal or informal relationships with local primary care providers may be the best option. Conversely, a population with significant physical health needs and low primary care access may benefit from a more intensive integration approach to best meet their needs. For some organizations, these questions will identify opportunities to collect additional information on the population. This section will not be "scored"; rather, leaders and staff may use their responses to reflect on the needs of the population and the current organizational capacity to measure those needs. Each of the five sections in "Assessing the Optimal Integration Approach for Your Practice" includes notes about how to use this information to identify a path forward.

Describe the population you serve:

Total number of individuals seen in past 12 months:
Total number of visits in past 12 months:
Average proximity of clients to the practice:
Most prevalent (top five) mental health diagnoses: 1. 2. 3. 4. 5.
Most prevalent (top five) substance abuse diagnoses (for the purpose of this data collection, please include tobacco and alcohol): 1. 2. 3. 4. 5.
Most prevalent physical health diagnoses for all individuals seen in your practice (such as cardiovascular disease, diabetes, or asthma): 1. 2.

3. 4. 5.
Percentage of your population with multiple chronic conditions (e.g., diabetes or coronary heart disease):
Percentage of your population with long-term (>6 months) treatment with antidepressants, mood stabilizers, or antipsychotic drugs:
Percentage of your population receiving long-term (>6 months) sedative- hypnotic drugs such as benzodiazepam or sleeping pills such as zolopidem (Ambien):
Percentage of your population receiving long-term (>6 months) opioid management for chronic pain:
Percentage of your population receiving long-term substance abuse treatment medications:
Percentage of your population with stable, affordable, permanent housing:[8]
Percentage of your population currently working (separately report full-time and part-time percentages):

[8] HUD definition of affordable housing: In general, housing for which the occupant(s) is/are paying no more than 30 percent of his or her income for gross housing costs, including utilities. Please note that some jurisdictions may define affordable housing based on other, locally determined criteria, and that this definition is intended solely as an approximate guideline or general rule of thumb. This glossary may be of help: http://www.homebaseforhousing.org/Education/Definitions.cshtml

Percentage of your population that does **not** have a primary care provider: *This information can be obtained through self-report or inferred from claims data (e.g., individuals with high utilization of the emergency department).*
Percentage of your population that reports that they do **not** have a connection with a primary care provider: *This information can be obtained by asking individuals whether they feel that they have a meaningful connection to a primary care provider. A meaningful connection is based on the subjective experience that an individual has with his or her provider and can be measured quantitatively by looking at the number of return visits to the same provider and by asking individuals to rank the quality of their relationship with their provider.*
Total number of individuals seen in your practice who visited the emergency department within the last year: Total number of emergency room visits: Number of patients admitted to the hospital from the emergency department: *This information may be found in the electronic medical record or obtained from individuals' primary care providers.*

2. Assessing Your Infrastructure

Providers and organizations that want to move towards integration need to address five core operational capabilities:

1) Capacity to Collect Data, Exchange Information, and Monitor Population Health;
2) Progress and Outcome Tracking Capability;
3) Process for Engaging and Communicating with Individuals and Family Members;
4) Capacity to Provide Clients with Community Wellness Resources; and
5) Culture to Support Integration.

2.1. Capacity to Collect Data, Exchange Information, and Monitor Population Health

Capability: Organizations use an electronic health record (EHR) or other methods to collect individual and practice-level data that allows them to identify, track, and segment the population.

Ideally, organizations have a reliable system for collecting data that supports aggregation of data, information sharing, and identification of high-risk populations.

2.1.1	**Does your organization routinely collect individual-level data?** For example, data on individuals' visits, diagnoses, and clinical outcomes
2.1.2	**Does your organization routinely aggregate individual-level data?** For example, compiling individual-level data to assess how well the organization is doing as a whole in terms of meeting treatment and recovery goals for all individuals seen in the organization
2.1.3	**Do you record the names of individuals' primary care providers?**
2.1.4	**Do you record the date of individuals' last primary care visit?**
2.1.5	**Do you record progress notes or information on the nature of the last primary care visit?**
2.1.6	**Do you record the names of individuals' home and community-based supports?**
2.1.7	**Do you record the number of individuals' past-year hospitalizations for both psychiatric and medical reasons?**
2.1.8	**Do you record the number of individuals' past-year ER visits for both psychiatric and medical reasons?**
2.1.9	**Does your organization securely exchange individuals' information with other practices?** For example, through secure messaging or facsimiles

2.1.10	**Does your practice use an electronic health record (EHR)?** *If you do not use an electronic health record, skip to section 2.2*
2.1.11	**Does your EHR meet Stage 1 meaningful use criteria?**
2.1.12	**Are you able to track chronic conditions in the EHR?**
2.1.13	**Is your EHR able to interface with other systems outside of the organization?**
2.1.14	**Are you generating clinical care and recovery-oriented service reports for each individual?** That is, reports that contain clinical information (such as symptoms, diagnoses, and treatment), not service utilization data, which each individual can take home for their personal records
2.1.15	**Are you participating in a Health Information Exchange in your state?**
2.1.16	**Are you participating in a secure, shared electronic messaging service?**

2.2. Progress and Outcome Tracking Capability

Capability: The organization is able to measure the effectiveness of the treatment provided.

Ideally, organizations are able to track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.

2.2.1	**Does your organization track medication use of individuals treated by the organization?**
2.2.2	**Does your organization track medication adjustments or changes?**
2.2.3	**Does your organization track medication fills?**
2.2.4	**Does your organization track lab work?** This includes tracking the results of lab work

2.2.5	**Does your organization track communication of results to individuals and follow-up?**
2.2.6	**Does your organization track individual changes in health outcomes?** For example, changes in blood pressure, cholesterol, body mass index, or blood sugar
2.2.7	**Does your organization track individual changes in health behaviors?** For example, tobacco use
2.2.8	**Does your organization track measures of self-reported health outcomes for individuals seen within your practice?** For example, "How's Your Health" questions
2.2.9	**Does your organization track individual changes in substance abuse behaviors?** For example, the results of urine drug screening
2.2.10	**Does your organization track individual changes in behavioral health outcomes?** For example, a self-reported change in depressive symptoms
2.2.11	**Does your organization use the data it collects to assess how it is doing with care delivery?**
2.2.12	**Does your organization use the individual-level data it collects to determine what kinds of improvements or adjustments to make in clinical care or organizational processes?**
2.2.13	**Does your organization track individuals' measures related to satisfaction with services received?** This could be individuals' perception of and experience with the services they receive
2.2.14	**Does your organization track provider satisfaction measures?**

2.3. Process for Engaging and Communicating with Individuals, Family Members, and Natural Supports

Capability: Behavioral health and primary care providers have supportive, consistent, and clear communication with individuals and their families or natural supports.[9]

For the following set of questions, the term "provider" refers to behavioral health providers, as well as primary care providers if the organization already has a relationship with a primary care provider(s).. In these questions, we assume that permission for communication has been given by the individual.

2.3.1	**Do providers engage with individuals and/or families about setting treatment goals?**
2.3.2	**Do providers communicate with individuals and/or families about progress towards treatment and recovery support goals?**
2.3.3	**Do providers communicate with individuals and/or families about medication compliance, activities of daily living, and functional changes?**
2.3.4	**Do providers communicate with individuals and/or families about diagnoses, level of disability, and level of functioning?**
2.3.5	**Do providers include the individual and family in developing the treatment and recovery support plan?**
2.3.6	**Do providers communicate with individuals and/or families about key changes to their diagnoses and/or treatment and recovery support plans?**
2.3.7	**Do providers communicate with individuals and/or families about missed appointments?**
2.3.8	**Is there a process to train providers in skills to facilitate engagement such as motivational interviewing?** Please see Appendix A for additional resources on motivational interviewing.
2.3.9	**Is there a system to encourage involvement of the individual and families in ongoing treatment and recovery support activities?**

[9] For the purposes of this tool, families refer to immediate family and natural supports identified by the individual.

	For example, a staff member who calls to remind individuals and families about a group support session
2.3.10	**Is information about individuals' illness provided to them in multiple formats in a way that individuals can understand?** For example, multiple formats might include verbal and written. Ensuring that individuals can understand might include using different languages and appropriate reading levels
2.3.11	**Are HIPAA provisions and consents for sharing protected information in place?** This may include HIPAA protections or other state regulations
2.3.12	**Are individuals informed of their rights regarding the sharing of information?**

2.4. Capacity to Provide Clients with Community Wellness Resources

Capability: The organization provides individuals with resources that promote wellness.

2.4.1	**Does the organization provide individuals with materials to encourage them to ask providers about physical health problems?** For example, posting signs on exam room walls or making brochures available in waiting rooms and/or exam rooms
2.4.2	**Do providers engage individuals in identifying life goals?** Providers do not distinguish between physical, behavioral, spiritual, personal or professional goals
2.4.3	**Does the organization support clients in self-management of chronic illnesses?** Please see Appendix A for additional resources on self-management support. For example, providing consumers options for therapeutic interventions at the appropriate literacy level and in the appropriate language
2.4.4	**Does the organization offer wellness programs?**

	For example, smoking cessation or exercise programs
2.4.5	**Does the organization maintain a list of local wellness activities that would be appropriate for individuals with mental illness?** For example, yoga classes tailored to individuals with mental illness or other activities such as exercise classes

2.5. Culture to Support Integration

Please note that section 2.5 uses a different scoring methodology in the evaluation grid. Each statement is evaluated on a scale from "strongly agree" to "strongly disagree." As you answer the extent to which you agree, it may be helpful to think of a specific instance or interaction with leadership or staff that illustrates the item.

2.5.1 Leadership Culture

Capability: There is administrative support and leadership buy-in to pursue integration, encourage change, and remove barriers.

Mental health and substance abuse service providers looking to integrate care require a fundamental change in strategic planning and operations. Leaders need vision and understanding of where the organization is trying to go in order to effectively manage organizational change. This vision must be articulated for all staff in the organization so they can understand what they are working on and what they are trying to achieve for their population as well as how integration will affect their day-to-day work.

2.5.1.1	**Leaders actively support the concepts of integration.** Think about your organization's integration champions
2.5.1.2	**Moving towards integrated care is a key component of the organization's strategic plan.**
2.5.1.3	**Leaders believe their involvement in primary care is required to optimally care for individuals with complex needs.** By complex needs, we mean individuals with a high level of medical and social need, who often have multiple chronic conditions and limited access to resources to assist in managing their care
2.5.1.4	**The organization has a means for providers to systematically learn from each other.**

	For example, the organization has periodic team meetings to share successes and failures in a larger setting
2.5.1.5	**The organization identifies staff training needs for individuals and teams.**
2.5.1.6	**The organization meets identified training needs.**
2.5.1.7	**The organization offers ongoing primary care education for behavioral health providers to enhance mutual understanding and knowledge.**
2.5.1.8	**The organization's policies allow for flexibility in job roles.** For example, some organizations that have unionized staff or very rigid job descriptions may struggle in beginning integrated care as employees must be cross-functional across job categories
2.5.1.9	**The organization hires staff members who are qualified with the requisite skill set to work in an integrated environment.** For example, flexible and collaborative thinkers, staff who focus on whole health, or staff who are cross-trained in behavioral health and primary care environments
2.5.1.10	**Leaders recognize the need to train the current workforce to meet the needs of the individuals and organization.**
2.5.1.11	**Leaders encourage active discussions about incorporating changes into the practice.**
2.5.1.12	**Leaders use standardized, data-driven processes to decide whether to change course or keep going with an existing program.**
2.5.1.13	**The organization has a culture of shared leadership, with everyone taking responsibility for change and improvement.**
2.5.1.14	**Leaders promote the use of evidence-based tools, instruments, and processes to support clinical improvements of individuals.**
2.5.1.15	**Financial leaders are involved in creating the business plan for increased integration.**
2.5.1.16	**Leaders consistently show commitment to practice transformation.**

2.5.1.17	**Leaders work to engage all staff in integration.**

2.5.2 Provider and Staff Engagement

Capability: Staff is committed to making changes to accommodate integration efforts. Behavioral health and primary care providers are comfortable working with each other.

Practices will be integrating a different culture into a pre-established culture. It is important to have processes in place that help each team identify roles and responsibilities for each team member as well as the new skills that each may need to develop in the integrated approach.

2.5.2.1	**Staff members have a basic understanding of the principles of integration.**
2.5.2.2	**Staff members would feel comfortable working with a member of the primary care team in designing a joint treatment and recovery support plan.**
2.5.2.3	**Staff members are willing to make changes to their work habits to accommodate offering integrated services.**
2.5.2.4	**Staff members embrace a whole person approach to care.**

3. Identifying the Population and Matching Care

It is important to have a process in place for identifying the population you want to serve or reach, as well as a process for matching individuals' needs to the appropriate care. Once you decide how you wish to define the target population (e.g., individuals with more than one chronic health condition, all individuals with diabetes, or smokers), then you must develop a strategy for reliably identifying and tracking those individuals. One of the best ways to consistently identify individuals at risk for different health issues is to have a comprehensive, universal screening tool given to individuals at some predetermined time, such as during intake, annual visits, or every six months. As appropriate, given the target population, the screening tool should identify multiple conditions to help providers[10] better tailor the suite of services to offer or arrange for individuals. Once individuals within the target population have been identified, their care needs can be matched to the appropriate services.

[10] For the purposes of this tool, "providers" refers to behavioral health providers (e.g., therapists, psychiatrists), unless specifically noted to refer to primary care providers.

3.1. Screening

Capability: The organization provides comprehensive, universal screening of the population that allows for identification of the individuals to receive focused tracking and intervention.

3.1.1	**Do you screen for a full range of mental health and substance abuse issues and concerns?** For example, alcohol and opiates
3.1.2	**If you do not directly provide substance abuse services, do you use the SBIRT (Screening, Brief Intervention, and Referral to Treatment) approach to ensure effective and timely referral to treatment for individuals experiencing substance abuse issues?**
3.1.3	**Do you screen for physical health conditions?** For example, diabetes and hypertension
3.1.4	**Do you collect information on general health measures?** For example, body mass index and blood pressure
3.1.5	**Do you collect information on social determinants of health?** For example, homelessness, employment status, and social relationships
3.1.6	**Does your organization follow screening guidelines for behavioral and/or physical health issues?**
3.1.7	**Do your staff discuss the results of these various screening and data collection efforts with individuals in your practice and, if appropriate, family members?**
3.1.8	**Is care utilization information recorded in a central place where all providers can access the information?** Care utilization might include emergency department visits or hospitalizations
3.1.9	**Are screening data updated regularly?**

3.2. Staffing for Screening

Capability: The appropriate staff member is designated to reliably carry out each function related to screening. Alternatively, your organization may also choose to designate a group of staff members to take on this task in addition to their clinical responsibilities.

It is important to assign staff members to carry out different functions related to screening. Depending on the components of the screening, these functions can be performed by different staff, such as a primary care- specific nurse; primary care physician; behavioral health provider; behavioral health-specific nurse; social worker; physician assistant; or a medical assistant.

3.2.1	**Is a staff member assigned to administer a comprehensive intake assessment?** A comprehensive intake may include information about physical health, mental health, substance use, and social needs
3.2.2	**Is a staff member assigned to administer physical health screenings?** For example, taking blood pressure, listening to the heart and lungs, finger sticks to check blood sugar, and Body Mass Index evaluations
3.2.5	**Is a staff member assigned to interpret data from completed screenings?**
3.2.6	**Is a staff member assigned to notify all relevant providers that reports are available?**
3.2.7	**Are screening data readily available to inform an individual's care and support services?**
3.2.8	**Do individuals receive the results of the screening tests?**

3.3. Identification of High-Risk and High-Need Individuals and Care Matching

Capability: Organizations use screening results and other data to segment the client population into groups requiring different levels or types of care.

After identifying individuals within the target population, the next step is matching the care needs with the appropriate services. Successful organizations must be able to take the results of the screening and identify different sub-populations as well as conditions that need to be addressed at the individual and aggregate levels. Treatment and recovery support goals are set for each individual, based on their existing conditions and their assessed risk for other issues. Depending on the organization, the population may be narrower (e.g., individuals with diabetes) or broader (e.g., individuals with multiple conditions).

3.3.1	**Does the organization identify which individuals appear to have the most complex care needs?** For example, individuals with high emergency department use or multiple chronic conditions
3.3.2	**Is the organization able to segment the population into different levels of need?** For example, by severity of illness or access to primary care
3.3.3	**Does the organization tailor services to a population or condition-specific segments of a population?**
3.3.4	**Does your organization assess progress for individuals with complex needs?** For example, the organization is able to measure improvements in the overall population for certain disorders or health outcomes, such as diabetes

4. ASSESSING THE OPTIMAL INTEGRATION APPROACH FOR YOUR PRACTICE

There is no one right way to integrate. Selecting the appropriate approach or combination of approaches will depend on your organization's aim, resources, capacity, and financial arrangements. The processes to achieve integration may differ from practice to practice. In this section, you will answer questions that assess your organization's current capability to implement one of three integration approaches: 1) Coordinate care; 2) Co-located primary care services; or 3) In-house primary care capability. You may decide to answer any or all of the sections depending on your organization's goals and interests. The following questions are divided into these three approaches. There is some repetition across sections to ensure that organizations completing only one portion of the assessment complete all appropriate items. Organizations may take a hybrid approach that does not fall cleanly into one of the three approaches, but will draw on key processes noted in each section. For organizations that have already been doing some work in integration and are looking for ways to improve, the questions can identify some additional areas of work and ways to improve the reliability of processes you already have in place.

4.1. Coordinate Care

Behavioral health organizations collaborate and consult with community organizations and other providers to address the health needs of their population through better coordinating their care. To accomplish this, organizations may build relationships with community organizations that address the health, wellness, or social needs of individuals in their practice (e.g., YMCA, peer support centers, low-income housing advocates). Organizations may also build formal relationships through contracts with primary care providers or build informal networks of primary care and specialty providers. Organizations share as much data and information between providers as possible while still abiding by any federal or state information-sharing laws. As you go through the tool, it may be helpful to include in the note section the individual or provider type that is responsible for this task. If this task is not something you currently do, consider noting the individual that might be responsible for this work in the note section of the scoring tool.

As you reflect on the Understanding Your Population section, this approach may be most appropriate if you serve a relatively small population with few primary care needs. In addition, this approach works well if a high percentage of the population already has a primary care provider and feels connected to that provider.

4.1.1. Referral and Communication with Community Organizations and Peer Support Agencies

4.1.1.1	**Does the organization partner with other community organizations to connect people with population-specific wellness activities?** For example, nutritionists or gyms
4.1.1.2	**Does your organization follow up on referrals to community organizations?**
4.1.1.3	**Do community organizations give feedback to providers about individuals?**
4.1.1.4	**Does your organization refer individuals to peer support agencies, groups, or organizations?** A peer support agency provides services by and for individuals with mental illness that are designed to help individuals with their recovery. Peer support for substance abuse includes spiritually based groups such as Twelve Step recovery and cognitive behavioral-oriented groups, such as the Self-Management and Recovery Training (SMART) recovery program. The referral may be to internal or external resources. *If no, please skip to question 4.1.2*

4.1.1.5	**If yes, does your organization follow up on referrals to peer support agencies?**
4.1.1.6	**Are peer support services, groups, and organizations a part of the individual's care?** For example, peer support agencies may share information with providers that might include medication adherence or how well individuals perceive their treatment to be working.

4.1.2. Referrals to and Relationships with Physical Health Resources and Primary and Tertiary Care Providers

4.1.2.1	**Does your organization refer individuals to primary care providers?**
4.1.2.2	**If yes, does your organization follow up on referrals to primary care providers?**
4.1.2.3	**Do providers talk with individuals about the release of their information when making a referral?**
4.1.2.4	**Do providers contact local primary care providers for advice about treating an individual?** This question refers to general information sharing rather than specific information about an individual
4.1.2.5	**Do providers share an individual's history with the primary care providers?** For example, diagnoses, medications, and current treatment plans
4.1.2.6	**Do providers ask individuals about preventative health screenings?** For example, whether they have received flu shots or mammograms
4.1.2.7	**Does the organization have a trigger for providers to ask about specific services?** For example, an office visit protocol or medical record prompt to remind providers to ask individuals whether they have received preventative or other important health services
4.1.2.8	**Does the organization track which individuals successfully make it to their referred appointment?**

4.1.2.9	**Does the organization consistently track progress related to an individual's medical needs?** For example, staff members receive and review updates on an individual's physical health conditions during a visit
4.1.2.10	**Does the organization help individuals schedule appointments with community care providers, such as primary care providers or specialists?**

4.1.3. Build Relationships and Exchange Information with Primary Care Providers

4.1.3.1	**Does the organization have a formal agreement to share information with a primary care provider(s) or organization?**
4.1.3.2	**Does the organization provide individual information to the primary care provider when the primary care provider is involved in the individual's care?** For example, patient history, care plan, labs, and medications
4.1.3.3	**Does the organization have an informed consent process through which individuals agree that their health information can be shared?**
4.1.3.4	**Does the organization have a financial relationship for service provision with a primary care provider(s)?**
4.1.3.5	**Does the organization have a written memorandum of understanding (MOU) with a primary care provider(s)?** The MOU defines clear roles and responsibilities for the partnership
4.1.3.6	**Does the organization share relevant labs and exam findings with primary care providers?**
4.1.3.7	**Does the organization share medication lists or formularies across providers?**
4.1.3.8	**Do multiple providers contribute to a shared care, treatment, and recovery support plan for each individual?**
4.1.3.9	**Does the organization track the progress of individuals after a referral?**

4.1.3.10	**Does the organization circle back with the individual to relay information and recommendations from the referral and help the individual act on it?**

4.1.4. Assist Individuals without Primary Care Providers

4.1.4.1.	**Does the organization provide information about local primary care providers who are taking new patients?**
4.1.4.2.	**Does the organization provide information about which providers accept Medicare, Medicaid, or uninsured individuals?**
4.1.4.3.	**Does the organization include information about organizations that serve a high number of individuals with mental illness?**
4.1.4.4	**Does the organization track referrals made for individuals without a current primary care provider?**
4.1.4.5	**Does the organization track time between referral to primary or specialty care and initiation of treatment?**

4.2. Co-Locate Primary Care Services

Behavioral health organizations may also integrate care by being on the same site or campus with a primary care provider or federally qualified health center. In this approach, the two co-located organizations provide team-based care with referrals between behavioral and primary care providers and, when possible, warm hand-offs (i.e., providers directly introducing the individual to the other provider at the time of the individual's visit). The co-located organizations share as much data and information as possible.

As you reflect on the Understanding Your Population section, this approach may be appropriate if you serve a population in a relatively small geographic area and the individuals seen in your practice have moderate health needs. In addition, this approach may be appropriate if a moderate number of individuals have identified a primary care provider, but a small percentage of individuals report a meaningful connection to this provider.

4.2.1. Access to Primary Care Services

4.2.1.1	**Is there central coordination of scheduling between behavioral health and primary care?**
4.2.1.2	**Does the organization provide a warm hand-off to primary care?** A warm hand-off is when the behavioral health provider directly introduces the client to the primary care provider at the time of the individual's visit. This can be done in person or over the phone.
4.2.1.3	**Do behavioral health and primary care providers contribute to a shared care and treatment plan for each individual?**
4.2.1.4	**Is your organization in close physical proximity to a primary care provider?** For example, the same building or a nearby building

4.2.2. Provide Navigation and/or Care Coordination Services

4.2.2.1	**Is there someone who assists individuals in accessing an array of services within and outside the organization?** Every organization defines this role differently. This may be called a care manager, case manager, care coordinator, outreach worker, health navigator, peer support specialist, or practice coach, and the person is either paid directly by your organization or by a third party, such as a health plan or other health care provider entity. *If your organization does not have an individual in this role, please skip to section 4.3.*
4.2.2.2	**Is there someone who assists individuals in managing medical conditions and related psychosocial problems?** For example, a staff person may help an individual improve nutritional habits in order to manage their diabetes.
4.3.2.3	**Does this person engage with individuals around medical issues?**
4.2.2.4	**Does this person communicate information between physical and behavioral health providers?**
4.2.2.5	**Is there someone who connects people with the health care and social service resources they need, with the aim of increasing their appropriate use of services and**

	integrating services? This person would bridge physical *and* behavioral health care through techniques such as outreach, care coordination, personalized health coaching, or supported self-management. This person may be called a navigator and be paid directly by the organization or by a third party, such as a health plan or other health care provider entity.
4.2.2.6	**If yes, is this person on-site?**

4.3. Build Primary Care Capability In-House

Behavioral health organizations bring primary care providers on staff—permanently or on a contract basis—to address the physical health needs of individuals seen in their organization. General screening and wellness is offered on-site. Walk-in and advance appointments are accepted, and the behavioral and physical health providers work together to address the comprehensive needs of the individuals at the behavioral health center.

As you reflect on the Understanding Your Population section, this approach may make sense if you have a high overall volume of patients with high physical and behavioral health needs. In addition, this approach may make sense if a small percentage of individuals in your practice have identified primary care providers, and if those with primary care providers report that they do not feel connected to that provider.

4.3.1. Provide Navigation and/or Care Coordination Services

	Is there someone who assists individuals in facilitating an array of services within and outside the organization?
4.3.1.1	Every organization defines this role differently. This may be called a care manager, case manager, care coordinator, outreach worker, health navigator, peer support specialist, or a practice coach, and the person is either paid directly by your organization or by a third party, such as a health plan or other health care provider entity. *If your organization does not have an individual in this role, please skip to section 4.3.2.*
4.3.1.2	**Is there someone who assists individuals in managing medical conditions and related psychosocial problems?** For example, a staff person may help an individual improve nutritional habits in order to manage their diabetes.

4.3.1.3	**Does this person engage with individuals around medical issues?**
4.3.1.4	**Does this person communicate information between physical and behavioral health providers?**
4.3.1.5	**Is there someone who connects people with the health care and social service resources they need, with the aim of increasing their appropriate use of services and integrating services?** This person would bridge physical *and* behavioral health care through techniques such as outreach, care coordination, personalized health coaching, and supported self-management. This person may be called a navigator and be paid directly by the organization or by a third party, such as a health plan or other health care provider entity.
4.3.1.6	**If yes, is this person on-site?** This service is provided by someone at the organization, not an outside entity
4.3.1.7	**Is there physical proximity between behavioral health staff and the medical staff?**

4.3.2. Screening Functions

4.3.2.1	**Does your organization take an individual's blood pressure during each encounter?**
4.3.2.2	**Does your organization measure height and weight?**
4.3.2.3	**Does your organization screen for substance abuse/illicit drug use?** Screening could include substance abuse questionnaires or blood/urine screens
4.3.2.4	**Does your organization offer on-site lab services?**
4.3.2.5	**Does your organization have the capacity to draw blood?**
4.3.2.6	**Is your organization able to use a finger stick to draw blood (such as Cholestech to test cholesterol)?**

4.3.2.7	**Is your organization able to send out blood for labs?**

4.3.3. Provide Primary Care Services

4.3.3.1	**Does your organization offer preventative screening?** For example, body mass index, cholesterol, or blood pressure
4.3.3.2	**Does your organization offer preventative vaccinations?** For example, flu shots
4.3.3.3	**Do behavioral health and primary care providers contribute to a shared care and treatment plan for each individual?**
4.3.3.4	**Do behavioral health and medical care providers meet regularly to discuss individual cases?**
4.3.3.5	**Does your organization offer on-site pharmacy services?** On-site pharmacy services would be licensed and could be directly operated by the behavioral health organization or operated independently

4.3.4. Space, Supplies, and Materials

4.3.4.1	**Does your organization have needed materials to provide primary care services?** For example, disposable needle containers, gloves, gowns, blood pressure cuff and monitors, stethoscopes, thermometers, alcohol pads, face masks, q-tips, cotton balls, otoscopes, ophthalmoscope, gauze, medical tape, hand sanitizer, refrigerator, sink in offices/exam rooms, exam room tables, examination light, wiring for Internet access, computers, printer, telephone
4.3.4.2	**Does your organization meet state and county licensing requirements for providing primary care?** Many states and counties have specific requirements around providing primary care, which include parameters for the physical space itself (e.g., number of doors, locations of bathrooms). It is important for behavioral health organizations to know these

	requirements and whether they meet them.
4.3.4.3	**Does your organization have space that can accommodate the activities and equipment necessary to provide primary care?** For example, exam tables and sinks
4.3.4.4	**Is your space American with Disabilities Act compliant?**

4.3.5. Access to Primary Care Services

4.3.5.1	**Does your practice offer expanded hours for primary care services?**
4.3.5.2	**Do you have secure messaging capability between individuals and providers?**
4.3.5.3	**Do individuals know there are different services on-site?** For example, individuals are aware that they can see a primary care provider when they present for a behavioral health visit

4.3.6 Enhanced Communication among Providers

Capability: Behavioral health and primary care providers seamlessly communicate with one another.

Integrating care can add another layer of administrative burden to providers. Seamless communication between different types of providers is integral to providing high quality, integrated care. The following questions refer to behavioral health and primary care providers communicating with each other.

4.3.6.1	**Is there a systematic communication strategy established among team members to communicate about individuals?** For example, electronic health record capabilities, email capability, regular team meetings, water cooler "huddles"
4.3.6.2	**Are individuals' treatment plans for behavioral health and primary care integrated and available to all providers on the team?**

4.3.6.3	**Do providers communicate about progress towards treatment and recovery support goals with each other?**
4.3.6.4	**Do providers communicate about diagnoses with each other?**
4.3.6.5	**Do providers communicate about missed appointments or referrals?**
4.3.6.6	**Do providers communicate about changes in diagnoses or treatment plans?**
4.3.6.7	**Does your EHR contain all records, including behavioral health records, fully integrated with little or no separation among specialties?**

5. FINANCING INTEGRATION

The challenge with any new integration effort is that integration as a clinical model frequently does not have an integrated financial model to support it. Organizations often must create unique strategies to offset the cost of the new integrated services. To that end, it is helpful to first think of what business model makes the most sense for the organization. Each integration approach has its own set of financial issues that are likely to require creative, collaborative solutions. For additional information, consider reading Mauer & Jarvis's paper on the business case for bi-directional integrated care.[11]

Please note that this section is intended to be a self-reflection tool to guide conversations and planning within your organization. Most questions in this section have "yes/no" responses with blanks for open ended responses. Consider both the primary care and behavioral health functions when answering the questions. Please use the notes column to identify areas for further discussion.

[11] http://www.mhsoac.ca.gov/meetings/docs/Meetings/2012/Mar/OAC_032212_Morning_BusCase.pdf

5.1	**Has the practice identified billing procedures and related processes for each integration-related billing activity?**
5.2	**Does the practice currently participate in integration-related activities that are not billable?**
5.3	**If yes to question 5.2, how are these services financed?**
5.4	**Are the costs (direct/indirect) of the integrated care program known and tracked?**
5.5	**Are appropriate billing codes used by the practice staff as available?**
5.6	**Does the organization structure its staffing model so that individuals work "at the top of their license," that is, they perform the highest complexity work that they are credentialed to perform?** For example, psychiatrists spend the majority of their time on what only psychiatrists can do, and various support staff perform other critical functions that do not require a psychiatric credential.
5.7	**Does the organization structure its staffing model and billing procedures to maximize billing opportunities?** For example, billable staff spend the majority of their time on billable activities while various non-billable staff perform other critical functions that are non-billable.
5.8	**Does the practice track billing and monitor payment and denials?**
5.8	**Does your organization have a relationship with a hospital or health system that is participating in an Accountable Care Organization (ACO)?**
5.9	**Is your organization engaged with payers in related demonstrations?** For example, the CMS financial alignment initiative
5.10	**Is your organization aware of demonstrations and/or initiatives in your state or region that would be applicable to your efforts?** See Appendix A for additional resources.

5.11	**Is your organization aware of federal rules, regulations, and incentives to integrate care?**
5.12	**Is your organization aware of any relevant Medicaid waivers received by your state?**
5.13	**Does your organization collect information on current use of acute care services (e.g., readmissions or ER visits) to build a business case that increased primary care use can decrease overall health care costs?**

This self-assessment is a work in progress and your feedback allows us to continually improve. Please send comments to cmurphy@ihi.org.

Appendix A: Additional Resources

Here are additional resources that may be helpful to organizations interested in integrating behavioral health and primary care.

Monograph that outlines the business case for integrating behavioral health and primary care: http://www.integration.samhsa.gov/integrated-care-models/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf

A guide to resources, promising practices, and tools on integrating physical health services into behavioral health organizations: https://www.resourcesforintegratedcare.com/sites/default/files/Integration%20Guide_1.pdf

A website dedicated to resources on motivational interviewing: http://www.motivationalinterview.org/

A guide to approaches to supporting self-management for individuals with serious mental illness: https://www.resourcesforintegratedcare.com/node/32.

A site outlining existing CMS demonstrations and innovations: http://innovation.cms.gov/