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

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

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

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

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


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

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

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

- **What is your biggest hurdle to sustainability?**
  - **Yes**
    - **Excellent!**
      - Then you know that this is a great way to keep the change process front and center in everyone’s mind.
    - **We’ll get to it.**
      - The sample Communication Plan can help.
  - **I have no idea. I can only choose one?**
    - Walk through the Sustainability Checklist to get a clearer picture.
  - **Thinking outside of the Medicaid and Medicare box.**
    - Look into how to get involved in managed care contracting.
  - **Not Quite**
    - Establish a core team to begin meeting and identify priority areas: leadership engagement, making the business case, key clinical champions, etc.
      - Note: the CIHS workforce web pages have sample job descriptions and policies and procedures, too.
      - Be diligent and establish regular ongoing meetings – and keep your eye on the goal!

- **Getting reimbursed for services.**
  - Check to see if there are approved codes for the services you provide - the state billing worksheets outline the latest codes (as of July 2014) for integrated services state-by-state.

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

- **Do you have a formal communication process that regularly (weekly is best, monthly at minimum) covers ongoing integration efforts, highlights positive outcomes, and looks to the future?**
  - **Yes**
  - **Not Quite**
    - Establish a core team to begin meeting and identify priority areas: leadership engagement, making the business case, key clinical champions, etc.
    - Note: the CIHS workforce web pages have sample job descriptions and policies and procedures, too.
    - Be diligent and establish regular ongoing meetings – and keep your eye on the goal!
Integrated care involves a patient-centered care team providing evidence-based treatments for a defined population using a measurement-based treat-to-target approach. In integrated settings, a behavioral health general practitioner works as part of the medical team to meet a wide range of needs. Behavioral Health generalists – such as psychologists, social workers, psychiatric nurses and peer support specialists – are trained to use evidenced-based strategies to promote behavior change across a broad range of populations, and behavioral and physical health conditions. It's about finding the right person, setting the right expectations and providing the right support.

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

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

**How might you be able to access a psychiatric consultant?**

**Good question**
Look into consultation models to learn the different ways primary care providers work with consulting psychiatrists.

**We're in a rural area with limited access to psychiatrists.**
Telehealth may be an option, read more.

**We can probably identify some people to work with.**
Great! Be sure to check out Sample Protocols and resources on Medication Management to get the relationship started.

**Learning more about how behavioral health staff will fit on our team.**
Look through the Behavioral Health Consultant Roles & Responsibilities in a Primary Care Setting and the Types of Primary Care Behavioral Services outlined by the Integrated Behavioral Health Project (IBHP).

**Getting the position approved and beginning recruitment.**
Refer to sample job descriptions and recruitment and retention resources on the CIHS website.

**Preparing behavioral health staff to work with us.**
Training Behavioral Health Professionals: How to Join a Medical Team outlines a plan for shadowing to get team members oriented.

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

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

**NO**

**YES**

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

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

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

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

- Clinical pathways
- Population-based care

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

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

What's stopping you?

- I’m not sure our EMR system would support it.
  - See how others have navigated this issue in A Resource Guide for Health Information Technology
- I’m not sure what to measure.
  - There are plenty of resources to help. NQF outlines suggested clinical measures, as does AHRQ in their Atlas of Care Coordination Measures.
- I’d like to find out what our patients think about our service.
  - AHRQ’s Consumer Assessment of Healthcare Providers and Systems (CAHPS) clinician and group surveys ask patients to report on and evaluate their experiences with health care.

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

**What’s stopping you?**

- I’m not sure our EMR system would support it.
- I’m not sure what to measure.
- I’d like to find out what our patients think about our service.

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

**YES**

- Wonderful, start with a process mapping exercise.
- Of course! Resources include a sample workflow and a Clinical Pathway Example from Zero Suicide.
- A cross-training option for teams is behavioral activation. The AIMS Center has behavioral activation training materials and modules for building integrated care.

### What do you suggest?

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

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

**I’ll give it a try.**

**Can I have an example?**

**It’d be great to get my team trained, too.**

### Ready to move ahead?

- I’ll give it a try.
- Of course! Resources include a sample workflow and a Clinical Pathway Example from Zero Suicide.
- A cross-training option for teams is behavioral activation. The AIMS Center has behavioral activation training materials and modules for building integrated care.

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

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

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

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

Do you have the capacity and functional systems in place to provide population-based care for patients with one or more physical or behavioral health chronic condition?

A whole-person approach includes the means to track all patients, not just those who present with an acute concern. Proactive care can maximize opportunities to help patients lead healthier lives. Resources include clinical registries, population dashboards, shared care plans, after-visit summaries, provider report cards, and support to build integrated electronic medical record (EMR) functionality.

Is behavioral health embedded in your continuous quality improvement (CQI) plan and is behavioral health included for all disciplines?

You’re A Plan/Do/Study/Act Pro. You see the benefit of conducting small tests of change to identify strategies for addressing psychosocial factors that overlap and interact with physical health.

Set up some small tests that broaden the focus beyond a patient’s physical condition.

To Know Thy Self Is Divine. Maintaining accountability to the full population of patients within a clinic, a system or even a community enhances all aspects of the triple aim - improvement in health outcomes, patient experience, and value of care.
Is behavioral health reflected in your care coordination processes?

NO

Take inventory of the needed information for the members of the care team. What is redundant?

We need to be better about keeping the whole team informed.

We could learn more from what we've already achieved.

Improved communication.

In what ways can you simplify, organize and prioritize?

YES

Ready to run a small CQI test?

Ok – what data should I pull?

Could I get some samples first?

Frustration Down, Efficiency Up.

Learn more about ways to make sure the EHR is aligned with your integrated services, including coordination with specialty behavioral health providers and that care team assignments are recorded in the EHR and provided to the patient.

Get the team together for Case Conferences.

Look into setting up regular team huddles.

Look up populations like frequent utilizers and people with diabetes or obesity. Then inquire about health habits, use of substances and status of social relationships as a way of expanding areas of care.

Yes – the National Association of Community Health Centers (NACHC) has some sample CQI materials.


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

The medical record is the centerpiece for communicating findings and treatment recommendations. The behavioral health provider’s assessment, plan and documentation of progress need to be easily accessible by the PCP, who is co-treating the patient and, in certain cases, may be the provider implementing and supporting behavioral health recommendations.
Have you identified a patient-centered process for shared care planning across disciplines?

Does your EHR have shared records in one chart?

Integration can be complex, and what better way to keep track but with a coordinated plan that includes all aspects of treatment, clinical and functional goals, resources, and next steps?

Have you identified a patient-centered process for shared care planning across disciplines?

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

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

A plan of care is invaluable for getting everyone on the same page (literally!).

You’re Dashboard Ready. Maintain a regular review of how staff uses the EHR and prioritize enhancements. These may include identifying workarounds that cause inefficiency, updating problem lists or embedding screening tools.

Your Patients Will Thank You. After all, the end goal is to support the patient in taking “ownership” of his/her change plan.

Ok, what else will help me create this coordinated plan?

Do you have a written plan that puts the patient’s goals and priorities in a central location where everyone can see them? Does the plan spell out the action each team member, including the patient, is responsible for carrying out? Finally, at the end of each visit, does the patient receive a copy of the plan with his or her goals and planned actions highlighted?