Behavioral Health Integration

Executive Summary BH Integration Survey

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In December 2014, the Department of Health and Welfare received a four-year state Center for Medicare and Medicaid Innovation model grant. The grant totals $39,683,813 and funds transformation of Idaho's healthcare delivery system. The system will change from a fee-for-service, volume-based system to a value-based system of care focused on improving health outcomes and reducing costs.

The grant design implements the Idaho State Healthcare Innovation Plan (SHIP). Strategic planning encompassed the 2015 grant-year focus. During 2016, the first cohort of patient centered medical home (PCMH) clinics will pursue transformation. Additional clinics will join the project in 2017 and 2018. During the grant period, Idaho will test models for transformation of the state's entire healthcare system.

Idaho recognizes the critical importance of integrating behavioral health into the PCMH model to increase quality of life and life expectancy for individuals with behavioral health conditions. Integrated Primary Care combines medical and behavioral health services to address the full spectrum of health concerns patients present.

It is important to note that integration is not a replacement for specialty mental health care. Close collaboration between specialty mental health and primary care is critical to ensure that individuals with severe and persistent mental illness receive clinically appropriate services. Integration and collaboration are means to increased community-based services.

Most often behavioral health services are integrated into primary care clinics. Reverse integration refers integration of physical health services into a specialty behavioral health center. With either approach, behavioral health integration will increase through effective care coordination between

- Primary care providers practicing patient-centered care and
- Broader medical neighborhoods of
    - Specialists,
    - Hospitals,
    - Behavioral health professionals,
    - Long-term care providers, and
    - Other ancillary care services.

Defining Levels of Integration

The Integrated Practice Assessment Tool© (IPAT©) is based on the Substance Abuse and Mental Health Service Administration (SAMHSA) Framework for Levels of Integrated Healthcare. Developed by Jeanette Waxmonsky, PhD, Andrea Auxier, PhD, Pam Wise Romero, PhD, and Bern Heath, PhD, it is a descriptive, qualitative instrument intended to categorize practices along the integration continuum.

The IPAT© focuses on qualitative change. The elements that comprise a high degree of integration are difficult to tease apart and do not occur separately in the real world setting. Rather they are intertwined. Designed to be user friendly, quick to administer, and equally applicable for both medical and behavioral health settings, the IPAT© serves a "conversation starter" for integration.

The IPAT© assigns clinics a score along a continuum of integration. The six levels of care are grouped according to pre-coordinated, co-located and integrated criteria.

Pre-coordinated care

- Level 1: Minimal collaboration - Patients are referred to a provider at another practice site, and providers have minimal communication.
- Level 2: Basic collaboration - Providers at separate sites periodically communicate about shared patients.

Co-located care (on-site)

- Level 3: Basic collaboration on-site - Providers share the same facility but maintain separate cultures and develop separate treatment plans for patients.
- Level 4: Close collaboration on-site - Providers share records and some system integration.

Integrated care

- Level 5: Close collaboration approaching an integrated practice - Providers develop and implement collaborative treatment planning for shared patients but not for other patients.
- Level 6: Full collaboration in a merged integrated practice for all patients - Providers develop and implement collaborative treatment planning for all patients

Additional Idaho Insights
In addition level of integration assessment, a series of questions gathered center practices for the following areas:

- Clinic Specific Integration Practices, Procedures and Policies
- Referral Practices and Tracking
- Communication Practices
- Internal/External Agreements with Providers of Specialty Services
- Screening Tools and Frequency
- Information Sharing Internal/External

- Treatment Planning Processes
- Follow-up Practices
- Behavioral Health Training

Survey Protocol

Idaho Department of Health and Welfare (DHW) Division of Behavioral Health (DBH) staff conducted onsite surveys between October 14 and December 14, 2015 with existing patient centered medical homes (PCMH) enrolled in the Idaho Medicaid Health Home Program.

The Idaho Medicaid Health Home Program was implemented in January of 2013. Currently 50 primary care clinics participate in the network, serving 9,000 patients with chronic conditions.

Onsite interviews with key center staff (care coordinators, behavioral health specialists, primary care providers and clinic/center administrators) drove data collection. The process yielded a collection of rich qualitative survey data.

Profile of Survey Clinic s

Forty-seven clinics enrolled in the Idaho Medicaid Health Homes Pilot participated, representing all seven DHW regions. Eighty-seven percent of the clinics were National Committee for Quality Assurance (NCQA) certified; about two-thirds were certified at level 3. Nearly 60% were Federally Qualified Health Centers (FQHC), with one Rural Health Center (RHC); most were family practice clinics or multiple specialty clinics.

A variety of behavioral health professionals, from psychologist to social workers and counselors are employed by Idaho's PMHC's. The following provides a break out of the professional credentials for behavioral health providers employed by the survey participants:

Findings: Strengths, Observations and Opportunities

The survey reveals strengths among many Idaho clinics, especially those with PMHC certification. These strengths provide opportunity to expand to new clinics and maintain/enhance in current clinics. A summary of these strengths include:

- Primary Care Physicians provide treatment for mental health issues on a routine basis but not as often for chemical dependency issues.
- PCMH certification rates were high among survey participants (94%), which lead to good referral processes, access to BH care, and missed appointment follow-up for BH clients.
- Community Health Centers (CHC) and Rural Health Centers (RHC) report higher integration due to enhanced funding.

- Screening tools are used but not consistently or routinely for all patients. The Patient Health Questionnaire (PHQ) versions 2 and 9 were the most common screening tool. Screening rates appeared higher among CHC/RHC.
- High use of Electronic Health Records (EHRs) increases ability to access information across disciplines.

The certification process provided structure to help clinics increase integration. Given those strengths, these observations were common across most respondents:

- Sharing records and referral information is often one way communication.
- All respondents cited uncertainty if patients understand they are part of a health home or belong to a team.
- Integration did not always correlate to collaboration with community providers.
- Despite frequent rate of recording whether or not clients are connected to BH providers, most noted low rates in receiving client treatment information/progress reports.

The survey uncovered areas of opportunity. Currently, respondents indicated a desire for assistance to address

- Low frequency of agreements or MOA's between BH referral partners
- Low frequency of specific BH registries or using information in a strategic way
- Low utilization of Tele-Health for BH
- Low frequency of training on BH issues for medical staff

Recommendations

The survey results provide guides for helping current and future cohorts integrate behavioral health into primary care. No single model is proposed as the survey demonstrated that a variety of locally driven approaches work best for all areas of Idaho. Rather, the following recommendations for actions and goals provide substantive assistance to Idaho clinics better serve Idahoans' health care needs, including those citizens with behavioral health conditions.

The recommended actions include:

- Provide Technical Assistance for
  - Mission Statements
  - Business Planning
  - MOU's and Agreements
  - Organization Readiness
  - Policies and Procedures
  - Culture Shift (Individual, Clinic, Community, Public)
  - Workforce Recruitment, Training, and Retention
  - Clinical Tools

    - Collaboration with Relevant Community Partners
    - Collaboration with BH Peers
- Promote Universal Screening
- Provide Training on BH Topics: SBIRT, Motivational Interviewing, Mental Health First Aid
- Promote BH Registries/Reviewing of Outcomes
- Expand of use of Tele-Health

These action items will require time and effort. Here is a proposed priority of these action items as goals going forward:

Year 1

- Assess First Year Cohort (clinics not assessed in this survey)
- Promote PHQ-2 and PHQ-9 screening
- Promote Universal Screening
- Encourage SBIRT Training
- Support Mental Health First Aid
- Increase access to BH Integration Topics
- Support a network of Behavioral Health Providers in Primary Care
- Provide Readiness Assessment TA

Year 2

- Encourage Memorandums of Understanding with Health Partners
- Promote Partnerships between PC and BH Providers
- Build a Technical Support Network (between existing providers)

Year 3

- Find alternative funding options for co-located and integrated models
- Promote reverse integration

A variety of tools and resources will help clinics achieve these goals. The following is a potential, but not an all-inclusive list of resources:

- PCMH Contractors
- Peer to Peer
- BH Integration Sub-Committee
- Other Funders-SAMHSA, HRSA, Foundations
- Division of Behavioral Health
- Internet Tool-Kits
- Regional Health Collaboratives

- Regional Behavioral Health Boards
- Idaho Federation of Families
- NAMI
- Recover Support Centers

Limitation of the Report

The findings of this survey are qualitative in nature. Limitations include possible variations in interpretation of respondent comments or their understanding of questions. While efforts were made to survey each clinic's key staff, some information may be missing due to lack of availability of all pertinent staff. The goal of this survey was to acquire general observations with as much specific detail as possible within the limitations. The results are intended to guide next steps for successful behavioral health integration at the local level throughout Idaho – in the variety of forms integration will take.