Zufall Health Center Integrated Behavioral Health and Primary Care Change Package
(For FQHCs or Community Health Centers working with Mental Health Agencies)

**Leadership Commitment**: Develop organizational relationships that promote behavioral health integration into primary care and optimal health outcomes.

A. Foster a culture of quality with a shared vision of integrated behavioral health and primary care services to improve health outcomes.
   a. Assess organizational capacity for providing quality behavioral health and primary care services respectively by conducting needs assessments and aligning with vision and mission of the organizations.
   b. Set clear organizational goals on quality services based on needs assessment and mission of respective organizations.
   c. Provide staff with tools needed to accomplish organizational goals for quality services such as Care Model and PDSAs.
   d. Review organizational chart to provide each clinical group with equal access to executive leadership and decision-making capability.
   e. Develop a learning network with other organizations to share models and programs, share successes and failures. Include organizational culture into trainings.
   f. Assess the characteristics of behavioral health and primary care organizations to determine shared and common values, mission and outlook, and align with staff and patients.
   g. Assess the qualities of new team members to align with mission and services including bilingual staff and clinicians, ensuring that they have background and training on underserved populations, understand the challenges faced by the underserved, are willing to work with underserved individuals, and are flexible and willing to work with a variety of people and in different systems.

B. Form partnerships to achieve a shared compelling vision by aligning and leveraging resources.
   a. Establish partnerships and collaboration with nearby behavioral health provider agencies.
   b. Establish partnerships with schools and training programs to train and identify clinicians.
   c. Form an advisory group of community members to recommend program services and improvements from a patient perspective.
   d. Develop a clinical network to share effective strategies, lessons learned and resources.
   e. Engage patients, families and community in outreach efforts to provide education about the partnering agency and the services it offers.
C. Build the foundation for sustainability of integrated behavioral health and primary care services.
   a. Conduct needs assessment of patients in need of primary care and preventive services.
   b. Collect data on number of potential mutual patients (to be served by both behavioral health and primary care), costs, billable visits, number of clinicians and space. (The larger the behavioral health population, the more likely the integration will be successful).
   c. Collect baseline data on health outcomes including preventive screenings, ED visits and hospitalizations and use cost savings data.
   d. Determine whether the model of care will include co location or integration in the clinical floor, and analyze cost for space, facilities, remodeling, EMR and other costs.
   e. Maximize the 340B program by educating providers and clinical staff on drug-pricing, on cost effective therapeutic plan and on handling medications from referring physicians.
   f. Review financial plans, billing processes and revenue cycles and adapt process changes if required. Clearly define income and revenue streams for services provided.
   g. Develop and write policies and procedures that reflect the work of the program and delineate processes. Share with partner organization if applicable.
   h. Identify opportunities to fund and sustain patient navigation services and other gaps in care that are usually not covered by insurance or charity care.

D. Build local and state support for integrated services.
   a. Review licensure requirements and standards for providing primary care in behavioral health settings and vice versa with the State licensing commission.
   b. Review billing and reimbursement practices in the state’s MCOs, private insurers and charity care program to determine feasibility and sustainability through income.

Clinical Information Systems and Measurable Improvement: Achieve change through the use of evidence-based, data-driven approaches and organize data to facilitate efficient and effective care.

A. Collect, analyze and disseminate data that is necessary to guide the improvement process.
   a. Develop a plan for capturing data on process improvements using shared data tools, EMR after defining measures that are relevant and applicable to the patients served.
   b. Perform random chart reviews or peer reviews to document clinical performance and present at QA/PI committee meetings.
   c. Identify areas of improvement and apply the Care Model and PDSA process.
   d. Analyze data to benchmark with similar organizations and establish baselines to trend over time.

B. Manage delivery system for improvements in health outcomes in integrated population.
   a. Research and identify key indicators (process, outcome measures) that are aligned with the vision and scope of the project and grantors/funding agencies (HRSA, SAMHSA, etc).
   b. Incorporate process and outcome measures into organization’s QA plan and work plan including defining measures based on standards (CMS, HEDIS, UDS).
   c. Review and gain consensus from QA/PI members and project leaders to adopt measures and implement steps of change (PDSA cycles) with clear aims and measurable outcomes.
d. Assign team members to PDSA implementation steps with the purpose of collecting data and achieving improvements.
e. Display findings and data in software for analysis and ease of visualization by the team and leadership. Use trend analysis to measure progress.
f. Manage data and outcomes to share with stakeholders, outside partners and patients.

**Integrated Care Delivery**: Build an integrated health care system across organizations, clinicians and settings that produces optimal health outcomes and assures the delivery of efficient, effective clinical care and self-management support.

A. Develop an integrated multi-disciplinary care team that includes behavioral health and primary care.
   a. Establish trust and good communication among the participating agencies through team meetings, trainings, developing protocols and other means.
   b. Practice effective communication styles around referrals, case finding, screenings and other shared practices.
   c. Promote internal collaboration to build teamwork by reviewing PCMH model of care standards and developing care teams.
   d. Define and describe position descriptions in the care team that may be new to the organization, including the Behavioral or Integrated Health Consultant or Specialist, and the patient navigator/case manager.
   e. Conduct annual and periodic reviews of team members to ensure competence and effectiveness. Include outcomes data, peer reviews and patient satisfaction scores if applicable in reviews.

B. Develop a delivery system that incorporates primary health care home with linkages to providers and services within and outside the organization.
   a. Develop integrated consent forms to facilitate exchange of medical information between primary care and mental health providers.
   b. Establish a primary care home and a behavioral health home incorporating PCMH elements (NCQA, TJC) including:
      i. Coordinated and tracked services
      ii. Integrated healthcare information
      iii. Plan of care developed in coordination with the patient and the multidisciplinary team
      iv. Availability of care after hours
      v. Care team and case management designated to individuals
   c. Hold regular team meetings to discuss shared patients, review policies and procedures and allow for process improvement.
   d. Establish clear methods of communication across and among providers such as by sharing EMRs, data-sharing, entering into Business Agreements, hospital portals and P2P communications.
   e. Establish clear protocols and methods to ensure seamless care transitions between agencies and organizations.
   f. Reconcile medication lists at every visit and at care transitions. Train staff on the use of the EMR and other data to ensure accurate medication reconciliation occurs.
   g. Identify and manage 340B medication discounts between organizations to ensure seamless access to medications.

C. Develop a delivery system that reduces barriers to care, physical, temporal and cultural
a. Review and design a system of care that allows behavioral health patients to access clinicians at convenient locations and times with the use of the patient navigator as a facilitator/scheduler.

b. Design a system of care that utilizes fully licensed medical and dental vans to bring services to day treatment centers where behavioral health patients are located.

c. Ensure that delivery of services is consistent and dependable, with a dedicated staff that is known to and trusted by the patient including the provider, the Medical or Dental Assistant and the Patient Representative on the van or at the sites.

d. Arrange for ancillary services to be provided on the same day and at low cost to patients including laboratory work, EKGs and other testing.

e. Identify areas of needed services and assign specific provider staff to be available to provide those services (e.g. gyn, podiatry, nutrition, pharmacy).

Clinical Decision Support: Design a delivery system that directly aids in clinical decision making, using patient specific interventions, assessments, recommendations, guidelines and standards of care.

A. Provide clinical staff with state of the art practice guidelines and standards of care.
   a. Organize clinical meetings, Grand Rounds and other educational sessions to review and discuss practice guidelines and standards in primary care and behavioral health topics such as psychotropic medications and side effects.
   b. Identify subject area experts that are available to staff on management of patients in an ambulatory setting, for example, a clinical psychiatrist that is available for consultation regarding management of medications or complex conditions.
   c. Insert knowledge-based resources in EMR for easy reference and access during clinical visits, such as “Up to Date”.
   d. Support integrated CME coursework with time and resources for all clinical staff.
   e. Organize case reviews to focus on interesting and/or challenging cases that are representative of conditions that patients often face.
   f. Include nonclinical staff in meetings to obtain different approach to care and identify available non-clinical resources (e.g. patient navigators, case workers, outreach, front desk staff).

B. Develop independent yet collaborative pathways for whole person care for the entire team.
   a. Meet with care team on a daily basis focusing on the work to be done (“huddles”) or on high risk problem prone individuals
   b. Establish standing orders for medical support staff to conduct screenings and education on patients with selected conditions.
   c. Meet regularly with clinical support staff to ensure that activities assigned are understood within the context of the whole person care.
   d. Review referral processes with clinical support staff to ensure seamless transitions.
   e. Conduct annual competencies.
   f. Conduct chart reviews to identify areas where standing orders are not addressed.
   g. Enter into collaborative agreements with pharmacists to ensure that their contributions to care are synergistic (e.g., ability to make substitutions, dose adjustments, order labs, make referrals)
C. Ensure clear and constant communications between team members
   a. Streamline referral processes between disciplines to ensure timely access to interventions.
   b. Meet regularly with team and establish norms and guidelines for communications.
   c. Explore ways to enhance information sharing among team members.
   d. Review and streamline information sharing between disciplines according to organizational guidelines and state regulations. Strive for a shared, integrated medical record.

Patient/Family Engagement – Build a patient-centered integrated service delivery model.
A. Obtain PCMH recognition or accreditation for the organization.
   a. Access NCQA, The Joint Commission or the Accreditation Association for Ambulatory Health Care for use and adoption of PCMH tools, resources and processes.
   b. Include behavioral and mental health services in process mapping to ensure comprehensive, patient-centered care.
B. Use communication techniques that are appropriate for the cultural backgrounds and literacy skills of patients and families.
   a. Use universal precautions in health education including simple language, translated materials, and teach back techniques.
   b. Train staff on motivational interviewing techniques to engage patients and engender behavior change.
   c. Use visual educational material, links to websites and other patient-centered resources (chosen by patient focus groups) to illustrate conditions or behaviors and their effects on patients and family.
   d. Encourage patients to use the patient portal and other enhancements to the EMR so that they are engaged and informed.
C. Develop alternative visit types to encourage patient and family engagement and engender self-management
   a. Refer to clinical pharmacists and other clinical support staff where patients and families discuss barriers to managing their conditions.
   b. Develop counseling curriculum that addresses social, financial, cultural and other needs of patients in the clinical support visit
   c. Develop group visit models for selected conditions and encourage or identify patients and/or family members to attend.
   d. Explore remote visits with special services to improve access to patients with transportation issues.
   e. Include self-management goal setting for patients with chronic conditions.