Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration

Section 1: Introduction to the Toolkit

The Organizational Assessment Toolkit for Primary and Behavioral Health Integration (OATI) was designed by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) to help organizations adopt integrated care successfully to improve care, lower healthcare costs, and save lives. CIHS also wishes to acknowledge the contribution of ZiaPartners, Inc, and MTM Associates, Inc. to the development of the OATI as a whole, and to the creation of specific tools within the OATI.

This toolkit can support your entire organization as you assume the challenges of developing an integrated primary and behavioral health organization. It is specifically helpful for:

- Primary care providers of any type, including hospital-based health systems, federally qualified health centers (FQHCs), rural health centers (RHCs), community health centers, and private practice settings.
- Behavioral health organizations of any type or in any setting, including specialty addiction, mental health, developmental disabilities, and traumatic brain injuries providers; geriatric, adult, or youth services; homeless settings, criminal justice, outpatient, and inpatient/residential settings.
- Organizations working on integration independently, primary and behavioral health organizations working as partners, and/or teams of provider organizations working in an organized network collaboration.
- Organizations fully committed to becoming a person-centered medical home, specialty care health home, or person-centered health neighborhood and/or participating in an accountable care organization or regional health collaborative.
- Organizations that want to achieve better outcomes for individuals and families with complex health and/or behavioral health needs.
- Organizations just beginning the integration process as well as those well along in their integration projects and change processes.
- Organizations working within any resource base, funding model, or delivery system, regardless of whether or not they have co-located services, specialty onsite staff, financial incentives, or grant funding to support integration.

Key Concepts

This section summarizes the key concepts that contributed to the design of this toolkit:

- Organization-wide Assessment and Improvement
- Bidirectional Integration of Primary and Behavioral Healthcare services
- Customer-Oriented Continuous Quality Improvement

Organization-wide Assessment and Improvement

The OATI is designed to help entire organizations, or organizational partnerships, make progress in improving the delivery of integrated primary and behavioral health care to populations with complex needs. IT IS NOT DESIGNED TO FOCUS ONLY ON SPECIALTY PRIMARY AND BEHAVIORAL HEALTH INTEGRATION PROGRAMS. The premise of the OATI is that individuals with co-occurring primary health, behavioral health, and human service needs are an expectation in ALL programs in any primary health or behavioral health organization or organizational partnership. Therefore, ALL programs need to be assessing and improving their capability to deliver integrated services, within whatever resource base or staffing complement they currently have.

Frequently, the OATI will be initially utilized by a specialized "integrated program", such as a grant funded integrated primary and behavioral healthcare home (as might be funded by SAMHSA-HRSA PHBHI grants, as well as other grant programs). The OATI can certainly be helpful for the specialized program to use the tools (in Section 2 of the OATI) perform a baseline self-assessment of its integration capability, and then to develop an improvement plan for that program.

However, the more important purpose of the OATI is to help to leverage change in all the programs in the larger organization (or partnership) of which the specialized integrated program may be just a small part. The specialized program may be an "early adopter" that helps to bring the message to scale in order to support sustainability of primary and behavioral healthcare integration over time. The OATI helps the larger organization to answer the following questions:

- How will the larger organization(s) use the learning and experience from the pilot "specialty integration program" to support sustainable organizational improvement in the delivery of integrated services in all programs, within base resources?
- For example, how do "routine" case management services for adults or children with serious disabilities, or "routine" residential substance abuse services, or "routine" primary health clinics or urgent care centers improve their ability to deliver integrated primary and behavioral health care?

Further, the OATI is designed as well to support progress in any type of organization or any type of program whether or not that organization has obtained grant funding for a specialty integrated health home, whether or not that program can afford to hire additional specialty health or behavioral health staff, and whether or not the program in the near term has the ability to provide co-located health and behavioral health programming.

The OATI is designed so that any program in any primary health or behavioral health organization (and hopefully, every program in every primary health or behavioral health organization) can perform a range of self-assessments, establish a baseline, and proceed with successful, sustainable, and measurable improvements that result in improved integration of care and improved outcomes for individuals and families with co-occurring health and behavioral health needs.

Bidirectional Primary and Behavioral Healthcare Integration

Bidirectional integration[1] is the systematic coordination of mental health and substance abuse care (i.e., behavioral healthcare) with physical healthcare services (e.g., primary care). Since physical and behavioral health problems often occur simultaneously, integrating services to treat both types of problems achieves the best results, and people who receive integrated care prefer it, finding it the most acceptable, convenient, and effective approach to obtaining care.[2]

The hallmark of integrated service delivery is for primary and behavioral healthcare staff to work as integrated teams, in which each "team member" assumes responsibility for participating in integrated service delivery for the benefit of the person receiving care. Ideally, teams are organized so that primary health and behavioral health clinicians can work in the same setting. However, given the variability and complexity of organizational delivery systems, the "product" of integrated care can be organized and delivered in many different ways, with many different structures.

Organization-wide Bi-directional Primary and Behavioral Healthcare Integration involves two simultaneous processes:

1. The ongoing development of an organizational culture centered around high quality customer service that ensures every staff member's focus remains on the experiences and outcomes of customers with both physical and behavioral health needs.

2. A comprehensive, system-level transformation of different aspects of the organizational process, structure, programming, practice, and financing that ensures the provision of seamless integrated care.

Successful integration requires a complete review and redesign of an organization's service delivery. Assuming that most of the people you serve have both physical and behavioral health needs, you will need to review every program, policy, procedure, and practice, and staff member to implement integrated services that achieve the best outcomes at the lowest cost.

Hallmarks of Integration:

- Integration is a process that occurs over time in the *entire* organization.
- Integration activities create a system of care in which your organization operates.
- Integration is more than having a good referral partner, care capacity, or a co-located site. It is more than a behavioral health center becoming or acquiring an FQHC. It is more than an FQHC

[1] Throughout this toolkit, the word "integration" pertains to the bidirectional model of integration

[2] Lopez, M., et. al. (2008). Connecting Mind and Body: A Resource Guide to Integrated Healthcare in Texas and the United States. Hogg Foundation. Austin, Texas.

hiring mental health and substance abuse specialists or becoming certified as a community mental health center or substance abuse clinic. It is more than achieving certification as a person-centered medical home/health home (see below).

- Integration is more than a particular tool (e.g., PHQ 9), diagnostic combination (e.g., depression and diabetes), process (e.g., SBIRT), or evidence-based program (e.g., IMPACT).
- Integration involves multiple organizational components changing simultaneously in different timeframes. While some change process is linear, it also involves working through a series of rapid-cycle changes as you make progress.
- Integration is a fully articulated "customer-oriented continuous quality improvement process," not a time-limited project. The integration journey never ends because there are always new challenges, new populations, new improvement opportunities, and new partners.

Customer-Oriented Continuous Quality Improvement

Organization-wide change may seem daunting in complex organizations facing multiple clinical, organizational, and financial challenges. Fortunately, there is a well-established organizational process, termed customer-oriented continuous quality improvement, which can – and should - be utilized by organizations of any size to make progress within base resources. Further, as will be seen in the next section of this introduction, development of broad capability for utilizing continuous quality improvement strategies to improve care is a core feature of acquiring Person-Centered Medical Home Certification, as well as a core feature of the national movement to achieve the Triple Aim of Improved Customer Experience, Improved Cost, and Improved Health, as defined by the Institute for Healthcare Improvement.

The OATI is designed to help any organization or organizational partnership (and any program within that organization or partnership) to make progress by utilizing customer oriented continuous quality improvement strategies and techniques to improve integrated care delivery. Each tool in Section 2 of the OATI provides an opportunity for an "improvement team" to perform a baseline self-assessment to "study the process" of how care is currently delivered for individuals with both primary health and behavioral health needs. Once that baseline is established, the improvement team can then select improvements to target, engage in plan-do-study-act Rapid Change Cycles, and identify measurable indicators of progress to demonstrate success. The core elements of customer-oriented continuous quality improvement help to keep the process grounded and achievable:

- **Customer First**: Always focus on improving the customer experience for individuals who present with co-occurring health and behavioral health needs. This approach helps to stay on track when there are many competing priorities.
- **Progress Not Perfection**: The initial goal is not to improve everything at once. Continuous quality improvement is not a compliance audit. The initial goal is to select achievable improvements that can be accomplished within available resources in a reasonable time frame. Further, in a complex organization or system, each program can be working on its own improvements. This results in significant progress across the whole organization even though each program may only be making small steps.

- **Continuous Cycles of Change**: Finally, progress is achieved by continuous improvement over time. Once each rapid change cycle is completed, the organization (and its programs) then can choose the next improvement targets based on their self-assessments, develop new rapid change cycles with new indicators of progress, and keep going.

The tools in the OATI are designed to be used repeatedly – for example, at annual intervals - to help the organization monitor overall progress, as well as to use repeated self-assessments to select new improvement targets.

Further, an important section (Section 3) of the OATI is a Customer Oriented Continuous Quality Improvement Reference Guide. This section is not a "tool" per se, but instead is a set of materials that focus on the provision of basic guidance on how to do rapid cycle change, and some examples of common starting places for improvement, along with recommended indicators that any program or organization might use to guide development of its rapid cycle change activities. This section also identifies some common traps or barriers that organizations encounter, and provides guidance for how to avoid those traps. Finally, this section includes an optional tool (QI-IQ) for assessment and improvement of the organization's overall capability for utilizing customer-oriented continuous quality improvement to manage significant change.

Integration and Person-Centered Medical Home Certification

Many organizations working on integrating care seek certification as a person-centered medical home (PCMH). These organizations use the National Committee for Quality Assurance (NCQA) PCMH Accreditation Standards (*see more detailed definitions and references in the Appendix*). The current NCQA PCMH standards, as of November 2011, require attention to primary and behavioral healthcare integration for PCMH certification. However, achieving certification does NOT mean that a program has become "completely" integrated. Further, achieving certification in one program does not imply that there has been progress in an entire organization or organizational partnership. Finally, progress in integration can occur without seeking NCQA PCMH certification.

The NCQA PCMH Accreditation Standards are very helpful. They have six core focus areas with associated service delivery requirements. The following table outlines these, and provides a focus on how the standards related to provision of integrated services. Sections in bold italics can be adapted to address primary and behavioral health service provision. Regardless of whether an organization seeks PCMH status, these standards provide a valuable framework for integration.

NCQA Standards Focus Area	Key Service Delivery Requirements
Enhance Access and Continuity	a. Provides same day appointments, ***including access to primary and behavioral healthcare collaborative care*** b. Defines roles for clinical and nonclinical care team members ***in relation to provision of integrated care***

Identify and Manage Patient Populations	a. Maintains an up-to-date problem list for patients with current and active diagnoses, ***including physical and behavioral health conditions*** and allergies (i.e., medication allergies and adverse reactions more than 80% of the time) b. Measures blood pressure, height, weight, body mass index (BMI), and tobacco use in more than 50% of patients c. Uses standardized tools to conducts comprehensive integrated care assessments, including screening for behaviors that affect health, patient/family behavioral health history, developmental issues, and depression
Plan and Manage Care ***Each requirement specifically attends to co-occurring physical and behavioral health issues***	a. Systematically identifies and treats the three most important conditions b. Establishes criteria and systematic processes to identify high-risk or complex patients and determines percentage of high-risk patients in its population c. Collaborates with patient/family to develop and provide an individual care plan, including treatment goals that are reviewed and updated at each relevant visit
Provide Self-care Support and Community Resources	a. Develops and documents patients' self-management abilities ***for physical and behavioral health issues*** and develops plans that include providing self-management tools at least 50% of the time b. Counsels patients/families to adopt healthy behaviors at least 50% of the time c. Tracks referrals provided to patients/families, ***including for collaborative primary and behavioral healthcare care*** d. Offers opportunities for health/***behavioral health*** education and peer support
Track and Coordinate Care ***Each requirement specifically attends to co-occurring physical and behavioral health issues***	a. Coordinates specialists' reasons for referrals, establishing and documenting agreements with specialists for case co-management b. Demonstrates the capacity for electronic exchange of key clinical information between clinicians c. Demonstrates electronic exchange of key clinical information with another care facility
Measure and Improve Performance ***Each requirement specifically attends to co-occurring physical and behavioral health issues***	a. Receives data on at least three preventive care measures, three chronic or acute care measures, and two utilization measures affecting healthcare costs b. Stratifies performance data for vulnerable populations c. Conducts surveys to evaluate patient/family experiences on at least three of the following: access, communication, coordination, and whole person care d. Sets goals to improve at least three outcome measures e. Involves patients/families in quality improvement teams or on the practice's advisory council f. Tracks results over time and assesses the effect of its actions

The Major Components of This Toolkit and How They Fit Together

The Five Sections of the OATI

- **Section 1: Introduction (The Current Section)**
- **Section 2: The Four Major Self-Assessment Tools**
- **Section 3: Customer Oriented Continuous Quality Improvement Reference Guide**
- **Section 4: Addendum: Optional Tools and Materials for Change Management**
- **Section 5: Appendix: References and Materials on Primary and Behavioral Health Integration**

The Four Major Self-Assessment Tools

Section 2 of this toolkit provides organizational integration readiness and capability self- assessment tools.

While the 4 tools in this Section are designed to be used in order, each tool can stand alone as an integration aid.

For those working toward PCMH certification, this toolkit incorporates PCMH certification criteria throughout. To easily locate these items in the tools, note that:

1. Each item that specifically relates to PCMH certification is flagged as "**PCMH***"
2. The appendix contains a crosswalk that lists each of the PCMH criteria relevant to integration, and where it is addressed in the toolkit.

The four major building blocks for assessing organizational capability and readiness are:

1. **Partnership Checklist**: Assessing an organization's need for a partner, its potential contributions to the partnership, and identifying next steps for how to develop more effective partnerships
2. **Executive Walkthrough:** Defining a customer oriented change process by assessing and improving the "customer experience" of individuals who have health and behavioral health needs.
3. **Administative Readiness Tool (ART):** Assessing and improving key administrative practices and processes that are necessary for successful delivery of integrated care
4. **COMPASS Primary Health-Behavioral Health (COMPASS PH-BH):** Assessing and improving clinical policies, procedures, practices, and processes that contribute to successful delivery of integrated care – in any program - within base resources.

Section 2 includes the four tools, in order, with instructions for their use. It is recommended (but not required) that you use the tools in the sequence listed. Organizations (and programs) may choose which tool (or tools) is most useful as a starting place, and proceed from there.

Note that for an organization wide change process, it is usually helpful, before using any of the tools, for the organization leadership to articulate an overall vision of integration, engage the different parts of the organization as change partners, identify a "change team" to manage the process and to identify the best next step strategies for success, including how to best use the OATI Tools in Section 2. In addition, the organization can use the Partnership Checklist (either on its own or with a potential partner) to determine whether the change process (and use of the various tools) will proceed unilaterally, or will be done in the partnership.

It is common that different parts of the organization or the organizational partnership will be in different stages of readiness to proceed. Remember: Progress not perfection. Organizational change often proceeds most successfully by simply finding the best next step that the organization, its partners, and each of its programs can and will take. A key element of continuous quality improvement is to acknowledge and measure these small steps of success.

Customer Oriented Continuous Quality Improvement Reference Guide

As described earlier in the introduction, this section provides a brief overview of the basic approach to Plan-Do-Check-Act cycles and Rapid Cycle Change, and then illustrates the application of continuous quality improvement strategies to common improvement areas that are likely to emerge from the organizational self-assessment tools in Section 2.

These common starting places are listed below:

- **Creating a Relationship (PCMH 1)**
  - Customer service (welcoming, hope, and engagement)
  - Facilitating integrated access
  - Improving "rate of return" (continuity)
- **Seeing the Issues (PCMH 2)**
  - Screening and identification
  - Integrated assessment documentation
- **Providing Helpful Care (PCMH 3)**
  - Integrated Care Planning and Stage-Matched Interventions
  - Implementation of Collaborative Care and Disease Management Protocols
- **Providing Cost-effective Care**
  - Maximizing Revenue Flow for Integrated Care Delivery
  - Improving Outcomes for High Utilizers
- **Supporting Self-care (PCMH 4)**
  - Implementing self-management skills training
  - Providing access to peer health coaching and recovery support
- **Working as a Team (PCMH 5)**
  - Information Sharing
  - Cross Consultation, Collaboration, and Teamwork
- **Building a Capable Workforce (All PCMH)**
  - Workforce Development

It is suggested that each change team reviews this section after using the tools in Section 2 to help develop a successful, achievable and measurable improvement plan based on what it learned during the self-assessment process.

This section also includes an optional tool (**QI-IQ)** that an organization may use to assess and improve its overall capability to use customer oriented continuous quality improvement to manage complex change, with a specific focus on improving integrated care.

Addendum: Optional Tools and Materials for Change Management

This section includes additional materials developed by CIHS that OATI users can utilize, or not, at their discretion. The materials include a guide for strategic planning related to integration, as well as various project management templates and matrices. It is suggested that each organization review these materials quickly, to determine whether they address any gap the organization might have in strategic planning and implementation of complex organization-wide or system-wide change.

Appendix: Reference Materials on Primary and Behavioral Health Integration

These materials are provided in this section for the convenience of the user, and incorporate a range of useful clinical tools, program references, integration materials, and helpful links that have been collected by the Center for Integrated Health Solutions. Note that these materials are current as of the date of the release of the OATI, and are continuouly improving and expanding. Please feel free to contact CIHS for any information about updated materials.

Contact Information

For further information on the toolkit, or to explore the availability of technical assistance in using the tools, the following contact information may be helpful:

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