

## BEHAVIORAL HEALTH INTEGRATION

### FOCUS POPULATION: PATIENTS WITH UNIDENTIFIED BEHAVIORAL HEALTH NEEDS

*Developed under guidance from the Practice Transformation Task Force as part of the Connecticut State Innovation Model Initiative*

#### Program Description and Objective:

Description: The behavioral health integration standards will incorporate standardized, best-practice processes to identify unidentified behavioral health needs in the primary care setting. This program seeks to bolster the ability of providers to perform these functions as well as optimize existing resources.

Objective: To improve the ability of healthcare providers to identify and treat behavioral health needs and to improve the overall state of behavioral health in Connecticut.

#### High-Level Process:

1. Identify individuals with behavioral health needs
2. Address behavioral health needs
3. Behavioral health communication with primary care source of referral
4. Track behavioral health outcomes/improvement for identified individuals

#### 1. Identify individuals with behavioral health needs<sup>1</sup>

- The network develops a screening tool for behavioral health needs that is comprehensive and designed to identify a broad range of behavioral health needs at a minimum including:
  - Depression
  - Anxiety
  - Substance abuse
  - Trauma
- The network develops a screening tool that can be self-administered or administered by an individual who does not have a mental health degree<sup>2</sup> that includes:
  - The PHQ-9 to screen for depression
  - Standardized and validated screening tools for behavioral health needs outside of depression
- The network ensures there are support services to administer the tool for individuals with barriers to filling out the screening tool on their own<sup>3</sup>

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<sup>1</sup> The screening is not intended to identify individuals with severe and persistent mental illness

<sup>2</sup> The tool does not have to screen for a diagnosis but screen for areas of concern for follow-up by a licensed behavioral health specialist, and the individual who administers the tool should be trained to flag when follow-up screening of additional needs is required by a licensed clinician. Patients aged 12 and older, when possible, should complete the screening tool without the support of their parents.

<sup>3</sup> The networks should encourage patients aged 12 or older, when possible, to complete the screening tool without the support of their parents.

- The network utilizes a trained behavioral health specialist on site or through referral (at least with masters level training) who is expected to do a more targeted follow-up assessment<sup>4</sup> with the individual when necessary
- The network conducts the behavioral health screening no less often than every two years
- The network develops a process for identifying a re-screening at each routine visit<sup>5</sup>
- The screening tool results are captured in the EMR and made accessible to all relevant care team members

## 2. Address behavioral health need

- The network conducts an assessment of needed behavioral health resources among the advanced network/FQHC network population and establishes the necessary relationships to meet those needs
- The network develops a standardized set of criteria to determine whether or not the behavioral health need can be addressed in the primary care setting by a primary care provider that considers<sup>6</sup>:
  - The diagnosis/behavioral health need
  - Severity of the need
  - Comfort level of the primary care team to manage the individual's needs
  - Complexity of the required medication management
  - Age of the individual
  - Individual preference
  - If the provider doing medication management for the individual has psychiatric medication management training
- The practice establishes a mechanism for identifying available behavioral health resources and educates the individual on what these resources are regardless of whether or not a referral is needed.<sup>7</sup>
- Primary care providers providing behavioral health care will have behavioral health training that covers:
  - Behavioral health promotion, detection, diagnosis, and referral for treatment<sup>8</sup>.

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<sup>4</sup> The assessment should reflect the needs identified by the screening tool.

<sup>5</sup> This re-screening could include questions asked about changes by doctor or nurse as part of routine visit.

<sup>6</sup> If the individual can be treated in the primary care setting, it is expected that the individual be engaged to determine where they would prefer to receive care including primary care provider in the primary care setting, a behavioral health specialist in a behavioral health setting, or behavioral health specialist in a primary care setting if possible. If the individual's needs cannot be addressed in the primary care setting, it is expected the individual be engaged to inform and educate them on the diagnosis/behavioral health need and why a referral/care from a behavioral health specialist is recommended. The individual who engages the individual should be the behavioral health trained care provider with whom the individual is most comfortable.

<sup>7</sup> These resources may include but are not limited to: community resources (e.g., support groups, wellness centers, etc.); alternative therapies (e.g., acupuncture); and health promotion services (e.g., women's consortium).

<sup>8</sup> The technical assistance vendor will assist the networks to find appropriate trainings that focus on health promotion, detection, diagnosis and referral for treatment. Trainings identified by the vendor should be made available to all networks via the internet.

- If behavioral health services are not in network, the network executes an MOU with at least one behavioral health clinic and/or practice and develops processes and protocols for all other practices that include<sup>9</sup>
  - Guidelines on how information will be exchanged and within what timeframe
  - Designating an individual to be responsible for tracking and confirming referrals<sup>10</sup>
  - Developing technology, if possible, to alert the primary care practice when a referral is completed
  - Defining a timeframe within which a referral should be completed<sup>11</sup>
  - Appropriate coding and billing<sup>12</sup>

### **3. Behavioral health communication with primary care source of referral**

- The network develops process, protocol, and technology solutions identified for behavioral health provider to make the assessment and care plan available to the primary care team with appropriate consent
  - The behavioral health care plan outlines treatment goals, including when follow up is required and who is responsible for follow up
  - The behavioral health provider is available for consultation as needed by the primary care physician (process for this should be outlined by MOU) if individual is transferred back to the primary care setting

### **4. Track behavioral health outcomes/improvement for identified individuals**

- The network utilizes individual tracking tool to assess and document individual progress at one year and other intervals as determined by the provider
- The network develops processes and protocols for updating this tracking tool that includes<sup>13</sup>:
  - Who is responsible for updating
  - Defining intervals at which assessments are made
  - Adjusting treatment when not effective

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<sup>9</sup> This is recommended to ensure that an individual who chooses to seek care from a provider outside of the network or with whom there is no MOU is still assisted and supported in the referral process and does not feel pressured to receive care from a limited set of providers. Additionally, behavioral health needs vary and it may not be realistic to have providers in the network or MOUs with the extent of providers that cover the breadth of behavioral health needs that may arise (e.g., addiction treatment, depression, anxiety, etc.). Processes and protocols should identify how information will be exchanged with provider for whom there is not an MOU (e.g., release of information)

<sup>10</sup> Consider a designated behavioral health referral coordinator

<sup>11</sup> Completed means the consultation occurred and information on the consultation was shared with the primary care practice

<sup>12</sup> Pending policy developments around same day billing for behavioral health services may alleviate the need for this to be required of the MOU

<sup>13</sup> Consider technological solutions for tracking outcomes such as a disease registry