

ORGANIZATIONAL ASSESSMENT TOOLKIT FOR PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION



SAMHSA-HRSA
Center for Integrated Health Solutions

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SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

CIHS is funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), and run by the National Council for Behavioral Health. CIHS provides training and technical assistance to community behavioral health organizations that received Primary and Behavioral Health Care Integration (PBHCI) grants as well as to community health centers and other primary care and behavioral health organizations. The PBHCI Grant program is part of an unprecedented push by Congress and the Health and Human Services Administration to help prevent and reduce chronic disease and promote wellness by treating behavioral health needs on an equal footing with other health conditions.

CIHS’ array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the whole health and wellness of individuals living with behavioral health disorders.

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INTRODUCTION

Designed by a team of integration experts, the Organizational Assessment Toolkit for primary and behavioral health care Integration (OATI) provides a compendium of tools that lay out a path for organizations to assess their readiness for integration, as well as benchmarking opportunities for those organizations well down the line in integration efforts.

Bidirectional integration¹ is the systematic coordination of mental health and substance use care (i.e., behavioral health care) with physical health care services (i.e., primary care). Since physical and behavioral health problems often occur simultaneously, integrating services to treat the whole health of individuals achieves the best results. People who receive integrated care prefer this approach, finding it the most acceptable, convenient, and effective approach to obtaining care.²

Organization-wide bidirectional primary and behavioral health care 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, 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 a federally qualified health center (FQHC). It is more than an FQHC hiring mental health and substance use 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 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.



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.

THE FOUR MAJOR SELF-ASSESSMENT TOOLS

This toolkit provides four organizational integration readiness and capability self-assessment tools. The four tools can be used in order, or can stand alone as an integration aid (or benchmarking tool).

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

1. The Partnership Checklist
2. The Executive Walkthrough
3. The Administrative Readiness Tool (ART) for Primary Health Behavioral Health Integration
4. The COMPASS-Primary Health and Behavioral Health™

Originally conceptualized as a single tool to be used in in totality, in testing in the field, the individual tools were each found to be effective at self-assessment of key integration infrastructure areas. Key questions answered through the assessments include:

- ▶ Do we need a partner to do integration and, if so, how do I select a partner? (Partnership Checklist)
- ▶ Is the organization welcoming to customers and what's it like to secure access to our services? (The Executive Walkthrough and COMPASS - Primary and Behavioral Healthcare)
- ▶ Does the organization's administrative infrastructure support key elements of integration success such as health information technology (HIT), billing and coding, costing, policies and procedures, and human resource functions? (The Administrative Readiness Tool and COMPASS - Primary and Behavioral Healthcare)
- ▶ Are clinical services infused with integration language and processes including medication management, person centered planning, documentation, and professional competencies and training? (COMPASS - Primary and Behavioral Healthcare)
- ▶ Does the organization's quality improvement process include rapid-cycle change models and action plans that support implementation and improvement? (The Administrative Readiness Tool and COMPASS - Primary and Behavioral Healthcare)

The answers to these and many more core questions regarding successful integration are identified and supported through the use of the tools in OATI. The goal is 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.

It is common that different parts of the organization or the organizational partnership will be in different stages of readiness to proceed. It is recommended, but not required, to use the tools in the sequence listed. Organizations and programs can review the description, desired outcomes, and best way to use each of the tools below, and then may choose which tool (or tools) is most useful as a starting place.



Centers working toward Patient-Centered Medical Home (PCMH) certification can easily locate PCMH certification criteria within the toolkit.

Each item that specifically relates to PCMH certification is flagged as "PCMH"

TOOL 1: Partnership Checklist

The Partnership Checklist can assist organizations in determining the need for a partner, assessing a partner's potential contributions to the partnership, and identifying next steps for how to develop more effective partnerships.

Organizations using the partnership checklist will be able to:

- ▶▶ Identify if they need a partner to pursue integration
- ▶▶ Examine core elements in selecting a potential partner
- ▶▶ Identify their strengths and weaknesses in a partnership
- ▶▶ Identify potential partners for integration

Best Way to Use the Partnership Checklist: The Partnership Checklist is designed as a discussion guide for team based projects to use in determining if the partnership model is the best choice for organizational integration efforts. Through discussion, senior leadership teams, special integration discussion teams or multi-organizational planning teams review each element and identify strengths, weaknesses and needs for successful integration efforts. Each task can be discussed and/or assignments can be made for individuals to complete and bring the information back to the group for discussion. The key element is: this is not a task that should be assigned to one person – it's a group task within and/or across organizations.

TOOL 2: Executive Walkthrough

This tool can help leadership see the organization(s) through a customer's eyes. It is helpful to do this for both your and your partner's organization. To help your senior management team, and that of your organization's partners, evaluate the current level of customer service, it is important to move beyond anecdotal information and to experience firsthand the level of customer service actually provided. This tool can assess the customer service levels your organization has achieved through the use of objective data and lay out a path for improving the "customer experience" of individuals who have health and behavioral health needs.

What's the difference between client, consumer, and customer focused philosophies?³

Client Focus	Consumer Focus	Customer Focus
They are not empowered	They are somewhat empowered	They are fully empowered
They usually don't know what they need	They tend to know what they need	They know what they want
They have little or no choice	They have choices	They have choices
They usually don't know what they need	They tend to know what they need	They know what they want
They are here to receive treatment	They are here to utilize service opportunities	They are here to participate in their recovery
They Need Us!	They Choose Us!	We Choose Each Other!

Outcomes:

- ▶▶ Customer-centered service orientation within delivery processes
- ▶▶ Customers are viewed as essential partners in the change process.
- ▶▶ Welcoming, efficient, and effective customer experiences

³ Lloyd, D. (2002). *How to Deliver Accountable Care*. Washington, DC: The National Council for Community Behavioral Healthcare.

Best Way to Use the Executive Walkthrough: A helpful starting place is to engage clinical and support staff in a conversation about their “customer service philosophy.” Ask them how they view the organization’s customer service philosophy. There are typically three customer service philosophies in use: client focus, consumer focus, and customer focus. When your staff begins discussing and defining each term, it invites exploration of current attitudes and helps your organization move from a client focus to a customer focus.

TOOL 3: The Administrative Readiness Tool (ART) for Primary Health Behavioral Health Integration

The Administrative Readiness Tool (ART) for Primary Health Behavioral Health Integration assesses the core administrative processes and practices needed most to support successful delivery of integrated care.

Organization of the ART Sections: (Sections A-G, K, M: PCMH*)

- A. Clinic has a time and cost effective **access to treatment** process
- B. Clinic has Centralized Electronic **schedule management** system
- C. Clinic has implemented **caseload management** to support appropriate utilization levels
- D. Clinic has **re-engagement/transition procedures** for current cases not actively in treatment.
- E. Clinic has **real time documentation support** processes
- F. Clinic has **cost based key performance indicators (KPIs)** for all staff and a measurement capacity to support coaching/mentoring activities by supervisors/managers
- G. Clinic has integrated KPIs into the job descriptions of all staff and into the **performance evaluation** model used
- H. Clinic has implemented **internal utilization management functions** including credentialing support for clinical staff; pre-certs, authorizations and re-authorizations; and referrals to clinicians credentialed on the appropriate third party/ACO/Medical Home/Health Home panels
- I. Clinic has a **diversified payer mix**
- J. Clinic has **appropriate revenue cycle management** including co-pay collections and claim submission
- K. Clinic has **outcome assessment capacity** and measurement tools to integrate achieved outcomes into support service delivery process change
- L. **Community Awareness, Branding and Market Share**
- M. Clinic has **decision making** and change management capacity including the use of Rapid Cycle Change models

Outcomes:

- ▶ Assessment of the data available within your organization to continually make data based decisions around effective administrative procedures
- ▶ Assessment of ability to participate in bundled/shared risk payment models.
- ▶ Assessment of ability to focus on episodic care needs and treat to target models
- ▶ Assessment of electronic health record capacity
- ▶ Assessment of ability to provide high quality services at the lowest possible cost
- ▶ Assessment of ability to produce measureable outcomes

Note that this tool will not just ask you if you believe you can collect the data. It will actually ask you to find the data. That may seem challenging, but it is best to start building your foundation early so it is ready when you need it.

Best Way to Use the ART: A self-assessment tool, the ART requires your management team to schedule time to meet and work through the sections. Typically, the assessment takes 6-8 hours to complete.

As your management team prepares to use ART, consider the following:

1. It is important for your team to move away from anecdotal responses to the questions such as “I think the rate is...” and to understand the actual rate or data point.
2. If there are significant variances in response levels or service process data among the management team members, it is important to identify if an ART needs to be completed for specific programs or locations (e.g., children/adolescent/pediatric vs. adult/geriatric) to identify process variances with the clinic. If it is determined that multiple ART forms are needed to assess the organization’s components, add and average the question and section scores to generate an overall score for the organization as a whole.
3. If the question and section scores have more than a one point difference, the key issue to identify is if your organization is operating coherently as a “group practice” or “program team” rather than as a “loosely held federation of individual practices.”

If variance is found within program practice, integrating primary care services will be more difficult. Therefore, the ART should be used to identify internal practice and administrative support variance to reduce the time and cost of service delivery processes prior to starting integrated care efforts.

4. The self-assessment scoring model for each question and section of the ART is based on a five point scale:

5	4	3	2	1
Not a Challenge	Small Concern	Moderate Concern	Quite a bit of Concern	Serious Challenge

At the end of each section of the ART, there is a “total cumulative score” indicator that will allow your team to total all individual question scores in a section. Also, at the end of the ART, there is a scoring sheet that provides for transferring the sections’ cumulative scores to an overall score summary with recommendations for next steps.

TOOL 4: COMPASS-Primary Health and Behavioral Health™

The COMPASS-Primary Health and Behavioral Health™ (COMPASS-PH/PC) is a continuous quality improvement tool for clinics and treatment programs, whether working in their own integration process or in partnership with others, to organize themselves to develop core integrated capability to meet the needs of service populations with physical health and behavioral health issues.

Outcomes:

- ▶ Empowers organizations and staff to accomplish step-by-step goals to create integrated care for people and families with complex needs.
- ▶ Communicates a common language and understanding of integrated primary health and behavioral health capable services.
- ▶ Establishes an organizational baseline of integrated primary health and behavioral health capability so there is a rational foundation for a change process.
- ▶ Creates a shared process using a common tool that can be used in any system for an array of diverse programs working in partnership on integrated primary health and behavioral health capability development.
- ▶ Produces a universal continuous quality improvement framework for all types of programs in any system of care that serves individuals and families with complex lives.

Companion Tools

COMPASS-PH/PC™ also has companion tools that are tailored to meet the needs of a variety of partner programs working on various aspects of integrated co-occurring capability. Examples are:

- ▶ **COMPASS-Prevention™** for prevention and early intervention programs.
- ▶ **COMPASS-EZ™** for mental health and substance abuse treatment programs working on integrated mental health/ substance abuse co-occurring capability development.
- ▶ **COMPASS-ID™** for providers serving people with intellectual disabilities working on integrated ID/BH co-occurring capability development.

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 organizations of any size can – and should – use to make progress within base resources. Further, development of broad capability for using 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 using customer-oriented continuous quality improvement strategies and techniques to improve integrated care delivery. Each of the four tools in the OATI provides an opportunity for an “improvement team” to perform a baseline self-assessment to “study the process” of how care is 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 are:

- ▶ **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 prepare and inform organizations about their readiness and needed steps to integrate primary and behavioral health. From there, organizations seeking to boost their overall capability for using customer-oriented continuous quality improvement to manage significant change can delve deeper into these core elements with other existing tools (such as the QI-IQ) or review a basic approach to plan-do-check-act cycles and/or rapid cycle change.

Based on what is learned during the self-assessment process using the four major self-assessment tools, organizations can then develop a successful, achievable, and measurable improvement plan.

For more information and assessments related to successful implementation of integrated primary and behavioral health care, visit www.integration.SAMHSA.gov/operations-administration/assessment-tools

For further information on the toolkit, or to explore the availability of technical assistance in using the tools, please contact:

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