Integrated Behavioral Healthcare: What It Is, How It Can Be Implemented, and Why This Matters

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UTSA Department of Counseling
Thank you!

Texas A&M University Corpus Christi
Tex-CHIP
HRSA BHWET
Community partners
Danielle Hoard (PEP GA and tech support)
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Project Evaluator

3/1/20XX
PEP Project Director
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Agenda

I. Introductions
II. What is integrated behavioral healthcare?
III. How is it implemented?
IV. Why this matters?
V. Action plan
VI. Closing and Q&A
## Learning Outcomes

<table>
<thead>
<tr>
<th>Define</th>
<th>Understand</th>
<th>Explore</th>
<th>Examine</th>
<th>Develop</th>
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</thead>
<tbody>
<tr>
<td>Participants will define integrated behavioral healthcare, including levels of integrated practice</td>
<td>Participants will understand the major components of the Primary Care Behavioral Health (PCBH) model</td>
<td>Participants will explore integrated behavioral healthcare implementation through the PITCH Expanded Providers Program</td>
<td>Participants will examine why integrated behavioral health matters relative to the Quintuple Health Aim and Social Determinants of Health</td>
<td>Participants will develop a brief Integrated Behavioral Healthcare Action Plan</td>
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</table>
Workshop Flow

Active Engagement

Actionable Steps

Mutual Learning
Workshop Handouts
1. Introductions

Journey to Integrated Care - PITCH to PEP - Breakout Room #1
My journey to integrated care
Program for the Integrated Training of Counselors in Behavioral Health (PITCH)

- Apply for HRSA BHWET (2017)
- BWHET Awarded
- PITCH is born!
- 48 CMHC trainees
  - Develop site partnerships
  - Institutionalize initiative
Major PITCH Accomplishments (2017-2021)

- 12-hour graduate certificate in Integrated Behavioral Healthcare
- 12 (and growing) new clinical training sites
- Supervisor learning community
- Yearly workshops
- 46 CMHC alumni
- 15,000 (and growing) hours of pro-bono services
PITCH Expanded Providers (PEP)

2021-2025

+ Includes 96 CMHC, SC, SW, and PSY trainees
+ Integrated school, community, and primary care placements
+ Specialized track curriculums
+ Interprofessional Education
Why I love Integrated Care?
Breakout Room #1
Introductions

- Name (Bonus: Joyful Jessica)
- Experience in integrated care
- Your why
- One thing hope to gain from workshop
- Add name/role in Zoom box if not already present
Connections from Introductions
II. What is integrated behavioral healthcare?

Definitions - CHI Framework - Scavenger Hunt Worksheet
What words come to mind when considering integrated care?
Issues with Defining Integrated Care

Problems?

Broad or Narrow?  Operationalizing  Connection to Value
What is integrated care?
Major IBH Resources

Agency for Healthcare Research & Quality
• The Academy Integrating Behavioral Health & Primary Care

Center of Excellence for Integrated Health Solutions
• SAMSHA Operated by National Council for Wellbeing

Collaborative Family Healthcare Association

HRSA
In any physical health (PH) or behavioral health (BH) setting, “integrated services” means the provision and coordination by the treatment team of appropriately matched interventions for both PH and BH conditions, along with attention to SDOH, in the setting in which the person is most naturally engaged.”

(CHI, 2022, p. 2)
Barriers to Integrated Behavioral Health Implementation

- Lack of flexibility
- Lack of measures of “integratedness”
- Lack of metrics connected to value
- Lack of financing
Comprehensive Healthcare Integration (CHI) Framework

+ Released by the National Council for Wellbeing in April 2022
+ Help providers, payers and population managers to (1) measure progress in organizing delivery of integrated services - referred to in this report as “integratedness” (2) demonstrate the value produced by progress in integrated service delivery and (3) provide initial and sustainable financing for integration
8 domains of integration

- Screening, Referral, to Care and Follow-up
- Prevention and Treatment of Common Conditions
- Ongoing Care Management
- Multi-Disciplinary Teamwork
- Self-Management Support
- Systematic Measurement and QI
- Linkage with Community/SDH
- Financial Sustainability
Three Integration Constructs

The Three Integration Constructs are:

1. Screening and Enhanced Referral
2. Care Management with Consultation
3. Comprehensive Treatment and Population Management
## CHI Framework Domains

### Sub-Domains 1-4

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<tr>
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<tbody>
<tr>
<td>• 1.1. Screening and follow-up</td>
<td>• 2.1. Use of screening and prevention guidelines and protocols</td>
<td>• 3.1. Longitudinal clinical monitoring and engagement</td>
<td>• 4.1 Use of tools to promote patient activation and recovery</td>
</tr>
<tr>
<td>• 1.2 Facilitation of referrals</td>
<td>• 2.2. Use of treatment guidelines or protocols</td>
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<td></td>
<td>• 2.3. Use of medication</td>
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### CHI Framework Domains

#### Sub-Domains 5-8

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</thead>
<tbody>
<tr>
<td>• 5.1 Care team</td>
<td>• 6.1 Use of quality metrics</td>
<td>• 7.1 Linkages to housing, entitlement and other social support system</td>
<td>• 8.1 Process for billing and outcome reporting</td>
</tr>
<tr>
<td>• 5.2. Sharing of treatment information, case review, feedback</td>
<td></td>
<td></td>
<td>• 8.2 Process for expanding regulatory and/or licensure opportunities</td>
</tr>
<tr>
<td>• 5.3 Integrated care team training</td>
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### CHI Framework – Domain 1

**Key Elements and Integration Progress**

<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>SUBDOMAINS</th>
<th>HISTORICAL PRACTICE</th>
<th>SCREENING AND ENHANCED REFERRAL</th>
<th>CARE MANAGEMENT AND CONSULTATION</th>
<th>COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Integrated Screening referral to care and follow-up (f/u).</td>
<td>Response to patient self-report of co-occurring behavioral health (MH, SUD, nicotine), PH conditions and preventive risk factors.</td>
<td>Systematic screening for high prevalence BH and/or PH conditions and risk factors and proactive health/BH.</td>
<td>Identify PCP and BH providers (if any) for all. Formal agreement between PH practice and BH providers to routinely facilitate referrals and share information about progress. Measurement of referrals to assess show rate and information exchange with the referral source.</td>
<td>Systematic screening and education for BH and/or PH conditions and risk factors PLUS systematic data collection and tracking of positive results to ensure engagement in appropriate services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.</td>
<td>Systematic screening and education for BH and/or PH conditions and risk factors PLUS systematic data collection and tracking of positive results to ensure engagement in appropriate services.</td>
<td>Capacity for integrated teamwork, such as a nurse or care coordinator for a BH team, or a BHC for a primary care team, to ensure follow-up and coordination re positive screens, with access to well-coordinated referrals to internal or external PH and/or BH service providers.</td>
<td>Systematic screening and tracking for BH and/or PH conditions PLUS routine capacity for registries and analysis of patient population stratified by severity of PH/BH complexity and/or utilization and measuring the level of intensity of integrated care coordination.</td>
</tr>
</tbody>
</table>

In addition to integrated teamwork, there is a systemic collaborative and consulting partnership with PH and BH services in one or more locations that can help meet population needs internally through both integrated service delivery and enhanced referral facilitation to both internal and external partners, with automated data sharing and accountability for engagement.
### CHI Framework – Domain 2

#### Key Elements and Integration Progress

<table>
<thead>
<tr>
<th>Domains</th>
<th>Subdomains</th>
<th>Historical Practice</th>
<th>Screening and Enhanced Referral</th>
<th>Care Management and Consultation</th>
<th>Comprehensive Treatment and Population Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 EB guidelines or protocols for preventive interventions such as health risk screenings, suicide risk screening, opiod risk screening, developmental screening.</td>
<td>Not used or minimal guidelines or protocols used for universal PH or BH prevention screenings. No minimal training for providers on recommended preventive screening frequency and response to results.</td>
<td>Routine use of EB or consensus guidelines for performing or referring for risk factor screenings with basic training for providers on screening frequency and result interpretation. Coordination with outside providers for any preventive activities.</td>
<td>Routine use of EB or consensus guidelines for universal and targeted screening with use of standard workflows for f/u on positive results. Provider team monitored on screening frequency and follow up on results.</td>
<td>Prescribers more regularly initiate and manage a range of medications for common co-occurring PH or BH conditions, including medication treatment for SUD, with routine consultation and collaboration with “co-occurring” consultant.</td>
<td></td>
</tr>
<tr>
<td>2.2 EB guidelines or treatment protocols for common PH or BH conditions (as well as for addressing relevant health behaviors that affect the conditions being addressed).</td>
<td>Not used or with minimal guidelines or EB workflows for improving access to care for PH and/or BH conditions.</td>
<td>Intermittent or limited use of EB/consensus guidelines and/or workflows for treatment of common PH and/or BH conditions with limited monitoring. Team receives basic training on PH and/or BH interventions.</td>
<td>Demonstrated use of common preventive screening guidelines to screen for at least one BH or PH condition.</td>
<td>See Integration Construct 2 plus evidence of treating more than one condition (in collaboration with a consulting psychiatric or physical health provider).</td>
<td></td>
</tr>
<tr>
<td>2.3 Use of medications by prescribers for common PH and/or BH conditions, including tobacco cessation.</td>
<td>None or limited use by prescribers for common PH or BH conditions. Medications for co-occurring PH or BH conditions are primarily referred to other type of prescriber to treat.</td>
<td>Prescribers routinely provide NRT or other medications for tobacco cessation and will continue to prescribe stable medications for co-occurring PH or BH conditions for a limited number of individuals.</td>
<td>Provider team, including embedded BH or PH consultant if any, routinely adheres to PH and/or BH guidelines or workflows for patients with PH and/or BH conditions.</td>
<td>In addition to Integration Construct 2: Adoption of trauma-informed care strategies, treatment and protocols by treatment team at all levels. Routine use of validated trauma assessment tools.</td>
<td></td>
</tr>
<tr>
<td>2.4 EB or consensus approaches to addressing trauma and providing trauma-informed care.</td>
<td>Staff have no or minimal awareness of effects of trauma on PH and BH care and do not have systematic application of person-centered trauma-informed practice.</td>
<td>Staff have no or minimal awareness of effects of trauma on PH and BH care and do not have systematic application of person-centered trauma-informed practice.</td>
<td>Prescribers will occasionally initiate medications for selected co-occurring conditions, including medication treatment for SUD, and will consult with “co-occurring” prescriber for assistance with ongoing management.</td>
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</tbody>
</table>

- Evidence-based (EB) care for prevention intervention for common PH and/or BH conditions.
Domains of Integration Scavenger Hunt – Break Out Room #2

Use Domains of Integration Scavenger Hunt Worksheet

- Note which domains stood out
- Note how present/absent at sites
- Note what want to learn more about
Summary/Wrap Up

+ Introductions
+ Definitions
+ CHI Framework (Domains, Integration Constructs)
+ Scavenger Hunt
BREAK
Welcome Back

+ How integrated care can be implemented
+ Why this matters?
+ Action plan development
III. How it can be implemented

PCBH - PEP Training Curriculum - Case Examples and Videos
Primary Care Behavioral Health

+ PCBH is a prominent approach to the integration of behavioral health services in primary care settings (Reiter et al., 2018, 109)
+ “When we say PCBH, we mean PCBH”
Operationalizing the role of Behavioral Health Consultants (BHCs) in PCBH

G.A.T.H.E.R.  

Dobmeyer, 2017
How this looks in our training curriculum

- TWO DIDACTIC COURSES
- SPECIALIZED INTERNSHIP SECTIONS
- SUPERVISOR LEARNING COMMUNITY
- SITE COACHING
Core Components of a BHC Visit
Visit Example
## PCBH Mock Visit Tapescript Evaluation

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Duration</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Greet patient and say intro script</td>
<td>1 minute</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>- Who they are and role in clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- How long visit will be</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- What will happen during visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Types of follow-up might occur</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Notes will go in EMR</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- PCP will get feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Provide brief BH screener to patient</td>
<td>1 minute</td>
<td>/0.5</td>
</tr>
<tr>
<td>3</td>
<td>Identify/clarify presenting program</td>
<td>1 minute</td>
<td>/1</td>
</tr>
<tr>
<td>4</td>
<td>Review BH screening results with patient</td>
<td>1 minute</td>
<td>/1</td>
</tr>
<tr>
<td>5</td>
<td>Contextual Interview (LWP)</td>
<td>5-7 minutes</td>
<td>/2</td>
</tr>
<tr>
<td></td>
<td>- Relationship status</td>
<td></td>
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<tr>
<td></td>
<td>- Living situation</td>
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<td></td>
<td>- Family</td>
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<tr>
<td></td>
<td>- Social</td>
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<tr>
<td></td>
<td>- Work/Income</td>
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<tr>
<td></td>
<td>- Spiritual Life/Religion/hobbies</td>
<td></td>
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<tr>
<td></td>
<td>- Substance use/cigs/caffeine</td>
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<tr>
<td></td>
<td>- Diet (regular meals)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- Exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Sleep</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Contextual Interview (3Ts)</td>
<td>3.5 minutes</td>
<td>/2</td>
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<tr>
<td></td>
<td>- When did problem start</td>
<td></td>
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<tr>
<td></td>
<td>- Something recent make it worse</td>
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<tr>
<td></td>
<td>- Triggers/situations for problem</td>
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<td></td>
<td>- What makes it better/worse (previous tx?)</td>
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<td></td>
<td>- Problem impact on life/LWP</td>
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</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td>Time</td>
<td>Score</td>
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<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>7</td>
<td>Conceptualization: Provides brief summary of CI and biopsychosocial impressions/formulation or problem</td>
<td>1-3 min</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Conceptualization: Clarify with patient that conceptualization is correct</td>
<td>1 min</td>
<td>0.5</td>
</tr>
</tbody>
</table>
| 9    | - Offer patient opportunity to think of best option for addressing problem (try first)  
- Offer patient 2-3 specific, personalized tx options with rationale  
- Options address improved sx picture/improved functioning/improved QoL/health | 1-3 min | 2     |
| 10   | - Patient chooses tx option(s) to target during remainder of appt.           | 1 min  | 1     |
PCBH Competencies

Practitioner-based Competencies

- Identification and Assessment of BH Needs
- Treatment of BH Needs
- Primary Care Culture
- Patient Engagement
- Whole Person Care and Cultural Competencies
- Team-based Care and Collaboration
- Communication
- Professional Values and Attitudes
PCBH Competencies

Team-based Competencies

- Workflow and operations
- Practice Culture
- Administration and Leadership
- Organizations and Support
- Team Structure and Roles
Case Example

Cecelia is a 43-year-old woman who presents with insomnia. As you talk to her, it becomes clear she is suffering from anxiety due to work stress and parenting challenges (she has two teenage children).

Within a traditional medical setting, you provide supportive counseling and discuss medication options. She elects to talk to a therapist, and you give her the number to make an appointment. Three weeks later she calls back to say she hasn't slept in days and her appointment with the therapist is still weeks away. She requests a sleep aid.
Case Example
Breakout Room Discussions #3

How would you intervene with Cecelia in an integrated setting?

How might this look at different levels of integration?

What benefits and challenges exist to working with Cecelia in an integrated setting?
IV. Why this matters

Quintuple Aim - Social Determinants of Health
Quintuple Aim of Healthcare Improvement

1. Improvement of population health
2. Enhancement of the care experience
3. Reduction of costs
4. Improvement of provider wellbeing
5. Enhancement of health equity
Social Determinants of Health
Social Determinants of Health: The Unaddressed Variable Accounting for 80% of Health Outcomes

(Deng & Shih, 2020)
V. Integrated Behavioral Health Action Plan

Quintuple Aim - Social Determinants of Health
V. Action Plan Development

+ Use Integrated Behavioral Health Action Plan Handout
+ Includes major takeaways, goals, supports needed, and questions remaining
+ Will be given ~10 minutes to work individually, then invited to share with larger group
Action Plan
Share Outs
Summary

- How integrated care can be implemented?
  - PCBH Model
  - PEP Training
- Why this matters?
  - Quintuple Aim
  - Social Determinants of Health
- Integrated Care Action Plan
- Q&A
VI.
Closings and Q&A
Thank you

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References

Clinical Scholars. (2021, March 11). Social Determinants of Health: What are they and how do they impact the health of populations? [Video]. Youtube. https://www.youtube.com/watch?v=oC_MPCXs0Sw


