

SBIRT and Integrated Care Readiness Assessment

One of the initial steps toward the integration of primary and behavioral health care in any organization is to identify the important components of integrated care and then determine which areas need the most attention. The two brief questionnaires in this document cover the more important dimensions on this process as they may exist in federally qualified health centers (FQHCs), rural health centers (RHCs) and community health centers (CHCs). The process involves three steps.

Step 1: Complete the appropriate questionnaire

The CEO or administrator of the center should complete one of the instruments and the clinicians providing primary and behavioral health care should complete the other. The assessment follows a straightforward format. Respondents are presented with a series of statements, divided into categories, which describe an important aspect of a clinic where primary and behavioral health care are well integrated. The respondents then indicate how well the statement describes their own clinic by enter a number next to the statement:

- 1 = “This does not really describe us.”
- 2 = “We are making some progress, but we are not this far along”
- 3 = “For the most part, this describes us.”

The readiness assessment to be completed by the CEO or other key administrative personnel is divided into two sections:

1. Structural Integration of Primary and Behavioral Health Care within the Clinic: The nine statements describe physical proximity of primary care providers (PCPs) and behavioral health providers (BHPs), ease with which scheduling and patient notes are shared between providers, and resource allocation for behavioral health providers in the primary care setting.
2. Financial Integration of Primary and Behavioral Health Care within the Clinic: the six statements describe routine referral processes between PCPs and BHPs, clinic-wide goals for behavioral health screening using validated tools, and ongoing process evaluation.

The readiness assessment to be completed by the Medical Director or other key clinician is divided into two sections:

1. Communication Pathways: the nine statements how patients are screened for behavioral health issues, how the PCPs interact with BHPs and how PCPs and BHPs collaborate regarding patient treatment plan
2. Patient Population Impact: the six statements describe frequency, type and use of screening data collection, as well as types of patient referral processes and coordination of care coordinator follow-up.

Step 2: Discuss the results with your SBIRT/Integrated Care mentor

Until September 2016, SBIRT training and outreach services are funded at the Indiana Prevention Resource Center through a grant received by FSSA/DMHA from SAMHSA. For more information on this program, visit www.IndianaSBIRT.org.

Step 3: Meet with your team and begin implementation

For now, the best source of information on implementing SBIRT and integrated care processes can be found at the following SAMHSA/HRSA Center for Integrated Health Solutions websites:

For general information on billing: <http://www.integration.samhsa.gov>

For information specific to SBIRT: <http://www.integration.samhsa.gov/clinical-practice/sbirt>
<http://www.cdc.gov/ncbddd/fasd/documents/alcoholbsiimplementationguide.pdf>

The following assessment tools are modified from the “Integrated Behavioral Health Survey” developed for assessing readiness in Virginia FQHCs by Bill McFeature, Ph.D., Kirk Strosahl, Ph.D., and Joseph Hyde, LMHC, CAS, of Radford University. The Indiana SBIRT Policy Steering Committee wishes to acknowledge their generous assistance and permission to use their work.

SBIRT and Integrated Care Readiness Assessment

Questions on this page should be completed by CEO or other clinic administrator. After each statement, enter the number indicating how well the statement describes your clinic:

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Structural Integration of Primary and Behavioral Health Care within the Clinic

- 1 The behavioral health (BH) provider is located in the exam room area of the clinic and renders a diversity of billable and non-billable services.
- 2 The clinic has one shared system for making both medical and BH appointments.
- 3 The clinic uses scheduling strategies that allows patients to be seen by the BH provider during or after a medical visit.
- 4 The clinic has a system to schedule BH visits on the same day as PCP visits per request of the PCP.
- 5 BH provider feedback to PCP clinical notations is placed in the same EHR with PCP clinical notes.
- 6 PCPs and BH providers' can quickly access each other's schedule information.
- 7 PCPs can schedule appointments directly into the BH provider's schedule.
- 8 Administrative staff believe that scheduling, reception, and medical assistant support staffing level is adequate for clinic needs for the BH provider.
- 9 The BH provider has access to the space needed to conduct onsite BH services, i.e., individual psychological consultation and group intervention appointments.

Financial Integration of Primary and Behavioral Health Care within the Clinic

- 10 The clinic targets specific patient populations for development of pathway programs that target chronic, comorbid, high-risk conditions (e.g., bipolar disorder, prescription drug abuse, diabetes). PCPs refer patients to BH provider for services within the clinic.
- 11 The clinic establishes target measures (e.g., universal depression and substance use screening will identify target goals for the number of patients screening positive for substance use problems). The clinic reviews HEDIS measure performance standards associated with depression screening (PHQ-2) and substance abuse/dependency screening (PHQ-2, CAGE-AID, AUDIT-C, AUDIT, or DAST10).
- 12 The clinic identifies target goals for the number of patients receiving brief treatment services.
- 13 The clinic reviews outcome data relevant to both medical health (e.g., diabetes, cardiovascular health, respiratory health, tobacco use) and behavioral health (e.g., depression, anxiety, substance use).
- 14 The clinic has established quality evaluation standards for the BH provider that include measuring things like the number of patients seen per day, number of new and established patients seen per month, etc.
- 15 The clinic administration uses a team approach involving medical director, behavioral health director, nursing director, chief financial officer/chief operations officer. This team reviews integrated care data relevant to billing/reimbursement and daily clinic flow practices.

SBIRT and Integrated Care Readiness Assessment

Questions on this page should be completed by Medical Director or other Care Provider (Primary and/or Behavioral Health). After each statement, enter the number indicating how well the statement describes your clinic:

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Communication Pathways

- | | | |
|---|---|--------------------------|
| 1 | Prior to or during exams, patients are routinely screened for behavioral health (BH) problems, such as depression, anxiety, and substance use issues. | <input type="checkbox"/> |
| 2 | All members of the primary care team understand the role of the BH provider and how to use this BH specialty. | <input type="checkbox"/> |
| 3 | PCPs ask the BH provider to co-consult during exam room visits. | <input type="checkbox"/> |
| 4 | A system is used for PCPs to contact the BH provider during working hours for "warm handoff" consults. | <input type="checkbox"/> |
| 5 | PCPs routinely discuss patient care issues with the BH provider before and after same-day warm handoff. | <input type="checkbox"/> |
| 6 | PCPs request advice/consultation/intervention from the BH provider for patients presenting with BH issues. | <input type="checkbox"/> |
| 7 | The BH provider is regarded as a core member of the primary care team (along with physicians, nurse practitioners, physician assistants, supportive nursing staff, etc.) and attends all primary care meetings. | <input type="checkbox"/> |
| 8 | The PC team is educated on specific behavioral health topics. | <input type="checkbox"/> |
| 9 | The clinic has defined a steering group (medical director, nursing director, and BH director) as champions for the PCBHI-SBIRT program. | <input type="checkbox"/> |

Patient Population Impact

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|----|---|---|
| 10 | Universal screenings are conducted prior to or during the exam room visit through 1) warm handoff from the nursing staff or PCP and/or 2) referral to BH provider for further depression and substance use screening. | <input type="checkbox"/> |
| 11 | Patients are screened by nursing staff/health educators to review healthy lifestyle self-management, such as developing an exercise plan, diet plan, smoking cessation and reducing other health risks. | <input type="checkbox"/> |
| 12 | Patients presenting specific medical indicators (e.g., diabetes, weight, pain scale, depression or substance use) are referred to the BH provider for consultation/SBIRT treatment intervention. | <input type="checkbox"/> |
| 13 | Patients with somatic complaints (e.g., headaches, insomnia, irritable bowel syndrome) associated with depression and anxiety are routinely referred to BH provider. | <input type="checkbox"/> |
| 14 | Care coordinator nurses assist in monitoring prescribed self-care plans for patients with comorbid, chronic PC and BH conditions and collaborate with clinical case managers regarding referrals to both medical and BH specialty services for more intensive treatment recommended by the primary care team. | <input type="checkbox"/> |
| 15 | Please indicate which of the following services are provided by your clinic: (Check all that apply) | |
| | <input type="checkbox"/> a. Consultation to primary care | <input type="checkbox"/> d. Behavioral health treatment services |
| | <input type="checkbox"/> b. Diagnostic evaluation | <input type="checkbox"/> e. Pharmacotherapy for mental disorders |
| | <input type="checkbox"/> c. Patient consultation/education | <input type="checkbox"/> f. Pharmacotherapy for substance use disorders |