

# **INTEGRATED BEHAVIORAL HEALTH PROJECT APPLICATION AND CRITERIA FOR DEMONSTRATION SITE SELECTION**

**I. Introduction and Background:** Launched in March, 2006 by The Tides Center and funded by The California Endowment, the Integrated Behavior Health Project (IBHP) seeks to increase and improve the integration of behavioral health services in community clinics statewide. During the past twelve months, IBHP has engaged in an extensive program development process, searching out integrated behavioral health program elements, strategies and treatment approaches within community clinics, counties and consortia; and conducting meetings with key stakeholders within the primary care and mental health fields to lay the groundwork for a multi-year initiative. The Project is now ready to award a select number of demonstration site grants and engage in partnerships with community clinics and consortia to accelerate and elevate promising integrated behavioral health care practices in primary care settings throughout California.

**II. IBHP Goals and Principles:** The goals of the IBHP are to improve access to behavioral health treatment services; to reduce the stigma associated with seeking such services; and to improve treatment outcomes for underserved populations. IBHP embraces key components of integration: communication, collaboration, comprehensiveness, continuity of care, commitment and cultural competency as essential to the success of any integrated program. Targeted outcomes of the initiative include:

- A. Collection of information about integration that can be developed into training materials and tools for other sites;
- B. Gathering of data via standardized instruments to measure client satisfaction, provider satisfaction, client functioning and general program effectiveness;
- C. Improved data collection and enhanced capacity at the provider level to utilize data for program management and clinical performance reviews;
- D. Improved standardization of data collection at a “macro” level for study and dissemination of promising practices that emerge;
- E. Establishment of a learning community of providers and stakeholders, including the building and maintenance of a web-based clearinghouse of information on integration and relevant issues within the field;

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- F. Training, mentoring, and consultation concerning integration strategies and promising practices to new sites selected for subsequent grant funding; and
- G. Advocacy for policy and system changes needed to reduce the barriers inhibiting integration efforts.

## III. Selection Criteria:

### *Primary Care Clinics:*

Selection of participating primary care clinics in California is based on their meeting the following criteria:

- A. Has a demonstrated history of experience in the provision of integrated behavioral health care in a primary care setting. “Integrated behavioral care” for these purposes is a team-based model in which medical and behavioral health providers partner to facilitate the detection, treatment and follow-up of behavioral disorders within the primary care setting;
- B. Currently operates an integrated program that has the following minimum components:
  - 1. co-located primary care and behavioral health services and close proximity of behavioral and primary care operations within clinic site(s);
  - 2. demonstrated close working relationship and a high level of collaboration between the primary care providers (PCP’s) and the behavioral staff, as evidenced by a high referral rate by PCP’s to the behavioral program; a follow-up system with written and oral feedback provided by behavioral staff to the PCP’s; frequent scheduled meetings and unscheduled dialogue between the PCP’s and behavioral staff about client care issues, including diagnosis, treatment recommendations, treatment objectives and disposition; and a general endorsement by PCP’s of the behavioral services program and the need for collaborative efforts;
  - 3. thorough medical record documentation of the clients’ behavioral care and treatment recommendations.

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4. protocols, policies and procedures for the delivery of integrated behavioral health services to primary care clients, including formal referral and feedback procedures between primary care providers and behavioral services personnel;
5. behavioral health services provided by qualified personnel having behavioral health-related experience and appropriate professional disciplines, which shall include any of the following: psychiatrists, psychologists, LCSW's, psychiatric nurses and/or MFT's. Behavioral health personnel shall perform clinical assessments, provide necessary therapeutic intervention, build on primary care interventions, educate clients in self-management skills, monitor the clients' progress, and engage in ongoing communication with the primary care provider about the clients' needs and response to treatment;
6. a screening instrument and/or diagnostic assessment tool currently in use to evaluate the presence of psychiatric disorders in primary care clients referred to the behavioral services. The clinic must also have the capability of re-administering this instrument periodically throughout the course of treatment to track the progress of those with identified mental health needs;
7. a clinical care coordinator to support the program who is responsible for monitoring adherence and response to treatment, providing client education and linkage to required resources, and coordinating the client's care with the primary care provider;
8. psychiatric supervision and consultation whereby the clinic has access to one or more psychiatrists who, when needed, will make recommendations for the identification and treatment, including appropriate medication, of behavioral disorders. Access to the psychiatrists can be in person or via telecommunication. Psychiatrists may either provide direct services to clinic clients or consultation to the primary care providers, behavioral services personnel and case managers, or both;
9. a data collection system potentially capable of tracking client contacts and clinical outcomes; and

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- 10. an accepted, systematic and time-limited approach to behavioral therapy and intervention that meets professional standards of care.
- C. Implements a model of integration that can be clearly described and quantified;
- D. Contains programmatic components relevant and replicable to other primary clinics interested in establishing or enhancing integrated models of behavioral care;
- E. Has the demonstrated organizational capacity and infrastructure needed to participate in required data collection/evaluation tasks, program-related activities, project convenings, and other demonstration grant requirements;
- F. Has a demonstrated commitment to the principles of integration by the agency's leadership, and a willingness on the part of leadership to advance the integrated care beyond the internal practices of their own organization;
- G. Has a CEO and medical director with demonstrated experience leading transformational projects that enhance service effectiveness and improve client outcomes;
- H. Provides culturally competent services to underserved communities and contributes to the diversity of populations served by California's primary care system;
- I. Demonstrates a willingness to work with IBHP staff and evaluators in assessing operational processes and outcomes, and a willingness to allow access to facilities, personnel and written materials that inform the evaluation effort; and
- J. Is in good standing and compliant with all applicable licensing, certification and other county, state and federal governmental requirements.

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## ***Regional Consortia Sites:***

The consortia will be selected based on the evidence of the following criteria within their projects:

- A. Demonstrated history of partnership with county health systems to deliver effective primary care services to the uninsured/underserved;
- B. Current partnership with county mental health departments to lead and execute a new system of integrated primary care and mental health services that includes consortia-led a) uniform standard of care; b) data collection; c) quality improvement process; and d) training, or established history of leadership in integrative behavioral health among consortium members;
- C. Ability to lead case study processes documenting the development, challenges, successes and outcomes of new integrated systems that will demonstrate potential replicability to other regions of the state;
- D. Demonstrated organizational capacity and infrastructure needed to participate in required data collection/evaluation tasks, program-related activities, participation in the project convenings and other demonstration grant requirements;
- E. Demonstrated commitment to the principles of integration by the organizational leadership, as exemplified by a willingness to advance the field beyond the internal practices of their own regional consortia;
- F. Demonstrated experience in leading and implementing change/transformational processes on a system/countywide basis;
- G. Representation of and advocacy for diversity of populations and cultural competency within participating primary care sites; and
- H. Willingness to work with IBHP staff and evaluators in assessing operational processes and outcomes, and a willingness to allow access to the facilities,

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personnel and written materials that inform the evaluation effort.

## ***Both Primary Care and Consortia Sites:***

The following additional criteria will be applied in making primary care clinic and consortia grantee selections:

- A. Representation of geographic diversity, including size of the community (urban, rural or suburban) and location within the State (northern, central and southern regions);
- B. Representation by clinic participants and non-participants in local and regional consortia;
- C. Representation of variations in the range and level of integration achieved;
- D. Representation of clinics with unique and replicable operational components or models of care that may benefit other similarly-situated clinics and programs;
- E. Representation of clinics with models that are generalizable to the larger clinic population;
- F. Representation of structural diversity, to include single and or multiple site operations; and
- G. Representation of diversity in client volume, diagnosis and severity of behavioral problems treated.

## **IV. Participant Requirements and Deliverables**

### ***Primary Care Sites:***

- A. Participate as a member of a small group of community clinics, health centers, and consortia that advise the IBHP team on a range and scope of policies, procedures, protocols, problems and outcomes related to establishing and

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maintaining integrated behavioral care programs within primary care operations;

- B. Furnish a detailed description and provide related written policies and procedures regarding the clinic's behavioral care operations, including, but not limited to, cultural competency practices, substance abuse services or interface, in-service training, client management, successes and problems;
- C. Make behavioral health outcome data collected prior to the demonstration period available to IBHP evaluators for compilation and analysis. Included are results from standardized instruments measuring clients' symptoms, functioning and satisfaction. Of specific interest is provision of retrospective PHQ-9 data. Provide specified client demographic data that can be linked to client outcomes;
- D. Cooperate with periodic IBHP surveys of primary care providers and behavioral staff regarding a) attitudes and behaviors related to the integrated behavioral program; b) select aspects of integrated care operations; and c) client outcomes;
- E. Furnish the total and per client costs involved in providing behavioral health services and, if available, cost offsets and/or savings realized;
- F. At specified intervals during the demonstration period, institute mutually agreed upon standardized outcome measures (PHQ-9 and others) to track treatment effectiveness for behavioral health care clients, and submit the data to IBHP for compilation, analysis and feedback. If the clinic is already tabulating the data, submission of the data in raw form with identifiers removed is acceptable. Results will be reported back to the clinic and any reports released publicly will not include the clinic's name. Confidentiality provisions are included Section V;
- G. At specified intervals in the course of behavioral care, administer a client satisfaction survey furnished by IBHP and approved by clinic administration. IBHP will tabulate and analyze the data and will report results to the clinic. If

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the clinic is already using its own client satisfaction survey and does not want to change instruments, it must agree to add a few items created by the IBHP. Results by clinic will not be made public nor used as a basis for deciding future grant funding. It is hoped, however, that each clinic will take steps to address concerns or problem areas prevalently identified in the client satisfaction survey;

- H. Include mutually agreed upon screener questions in new clients' intake forms to identify persons with substantial mental health problems. IBHP is willing to work with the clinics to customize and modify this requirement to meet the clinic's needs and operations;
- I. Work with IBHP to develop an Integrated Behavioral Care Learning Community and participate in the learning process by identifying, documenting and disseminating successful program elements and lessons learned relating to integrated behavioral care;
- J. Participate as a co-planner of Phase II of IBHP Initiative rollout, with specific activities that will be mutually developed during demonstration grant period;
- K. Participate with IBHP in the design of a plan to enhance client engagement and retention rates by assessing reasons for client "drop-outs" and "no-shows" and taking action to address barriers to service. Prepare for implementation of the plan and initiate it (to be determined, pending demonstration period timeline). As part of the learning community, report on development of plan and implementation results achieved during the demonstration period;
- L. Participate as a "thought partner" with IBHP in the design of one or more of the following components to be implemented in Phase II:
  - 1. a program to increase consumer involvement and participation in the delivery and design of the integrated behavioral program;
  - 2. a program to augment client empowerment and participation in his or her own treatment and recovery;

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3. a method to increase care coordination of behavioral clients and linkage to community resources. (Note: This component could be combined with bullet points (a) and/or (b) above);
4. a system to improve access to screening, identification, and treatment pathways for primary care clients who may be experiencing behavioral health problems; and
5. a program to augment psychiatric consultation via telepsychiatry or other communication vehicles.

Though not required, clinics are encouraged to implement one or more of the above projects during the initial Demonstration Phase and report on results achieved during this period.

- M. Participate with IBHP in the development of a cultural competence measurement, based on *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile* to assess cultural competency of the clinic overall and the integrated behavioral health program in specific;
- N. Cooperate with IBHP team members or consultants by providing access to staff, project activities and data collection processes relating to integrated behavioral care; and
- O. Take action to ensure that IBHP staff is given necessary clearances to access data as described above. (See Confidentiality Section V).

### ***Regional Consortia Sites:***

- A. Participate as a member of a small group of community clinics and health centers and consortia that advises the IBHP team on range and scope of policies, procedures, protocols, problems and outcomes related to establishing and maintaining a countywide integrated behavioral health (IBH) system of care during demonstration and implementation phase;

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- B. Furnish a detailed description of the system's adopted behavioral care operations, including policies, procedures, prescribing and cultural competency practices, training, substance abuse services or interface, successes and problems;
- C. Provide summaries of any data collected and/or research undertakings related to integrated behavioral health., including but not limited to, clinical outcomes, numbers served, total program and per client costs, revenues collected and savings realized;
- D. Facilitate IBHP introduction to public partners and system care representatives, if requested;
- E. Participate with IBHP in the development of a cultural competence measurement, based on *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, to assess organizational cultural competency;
- F. Participate in the Learning Community under development to identify, document and disseminate successful program elements and lessons learned that warrant replication of the IBH system of care to regional consortia throughout the state;
- G. Participate as planner for Phase II of initiative rollout, with specific activities to be mutually developed during demonstration grant period;
- H. Cooperate with IBHP staff by providing access to staff, project activities and data collection processes related to integrated behavioral care;
- I. As requested by IBHP, notify member clinics of convenings and other learning opportunities the IBHP may sponsor or endorse. Assist IBHP in the coordination and logistics involved in arranging convenings, seminars, conferences and other learning or discussion opportunities involving member clinics; and

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- J. Conduct periodic polls, as requested by IBHP, of membership about various aspects of integrated behavioral care.

### **V. IBHP Confidentiality Practices for Demonstration Grantees:**

- A. Client data will be maintained by IBHP in a secured environment with access to data sets restricted to no more than four contract evaluators. Electronic files will be coded so as not to reveal the identity of clinics. Within each data set, a unique identifier will be created for each client; no names will be used;
- B. If the agency requests it, raw data provided to the IBHP evaluation team will be returned. No copies of information will be made;
- C. IBHP evaluation consultants will compile and analyze data and prepare a confidential report of results for each demonstration site. To the extent possible, only aggregated data across demonstration sites, without individual clinic identification, will be included in any reports made public by the IBHP. However, in instances where differing results are associated with diverse intervention models, a disaggregation of data by agency-model may be reported;
- D. Results from outcome, cost and satisfaction data will have no bearing on demonstration grant funding; and
- E. Where required, IBHP staff and consultants will sign agency confidentiality agreements, and will follow HIPAA policies and procedures.

**VI. Technical Support:** An evaluation firm has been engaged to assist demonstration sites with the compilation of descriptive, service and survey data. A customized evaluation plan will be developed for each site based on Section IV's discussion of Participant Requirements and Deliverables. Telephone and on-site consultation will be provided throughout the demonstration period.

Demonstration sites will facilitate the compilation of retrospective and prospective data and utilization of survey instruments, benefiting from the technical support provided by

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the evaluation consultants. It is expected that sites will support data compilation and management activities.

Agencies are responsible for providing data in raw, un-tabulated form. The evaluation consultants will enter this information into statistical and other software programs, and will provide periodic reports to demonstration sites of findings as well as to this Initiative.

**VII. Application Process:** Applicant Information Form and supporting documents must be submitted to IBHP via email at **ibhp@tides.org** no later than **Friday, March 9, 2007 at 5:00 p.m.** Failure to submit by the required deadline could result in your elimination as a potential recipient.

Upon successful completion and submission of the Applicant Information, IBHP will enter into contract negotiations with applicants. All negotiations will take place the week of March 19, 2007. IBHP will contact each applicant and schedule the negotiation meeting upon receipt of the Applicant Information. Demonstration grant award amounts will be \$50,000 for clinic participant sites and \$25,000 for consortia participant sites. All demonstration grant periods will begin April 15, 2007 and terminate March 31, 2008. Funding will be disbursed in two installments: half at initiation and half upon completion.

**VIII. Grant Reporting Requirements:** Each applicant will be required to submit a mid-term and final narrative progress report detailing successes and challenges of grant implementation. Guidelines will be forthcoming.

## **IX Grant-making Timeline:**

February 26, 2007	Release of Application and Demonstration Site Criteria to Prospective Demonstration Sites
March 9, 2007 by 5:00 PM	<b>Deadline for Submission of Applicant Information. They must be submitted electronically to <a href="mailto:ibhp@tides.org">ibhp@tides.org</a></b>

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Week of March 19, 2007	Individual Demonstration Site Agency Negotiations with IBHP Team
March 29 – 30, 2007	Mandatory Training and Demonstration Site Pre-Contract Meeting (Sacramento Holiday Inn)
April 15, 2007	Implementation of Demonstration Site Grants
October 31, 2007	Interim Grant Progress Report Deadline
March 31, 2008	End of Demonstration Grant Period
April 30, 2008	Final Grant Progress Report Deadline

**X. Overall Project Evaluation:** The California Endowment will commission a global, Initiative-wide evaluation. It is anticipated that the evaluation will be participatory and that the outcomes will be shared with all grantees and with external audiences. Each grantee will be required to participate in the evaluation process.

## **XI. Contact Information**

Programmatic questions: Mary Rainwater ([rainwatermary@msn.com](mailto:rainwatermary@msn.com)) and Barb Demming Lurie ([blurie@mhmp.org](mailto:blurie@mhmp.org)). Both can be reached at (323) 436-7478.

Grant administration questions: Olivia Nava ([ibhp@tides.org](mailto:ibhp@tides.org)); (415) 561-6387