CQC Behavioral Health Integration Curriculum
Facilitator's Guide

About: this document is meant to be a companion guide for coaches or improvement collaborative conveners supporting provider organizations implementing the CQC Behavioral Health Integration Improvement Collaborative Curriculum. Key areas are detailed below with recommendations on where to provide additional support.

Improvement Collaborative Program Needs

- ☐ Regular touch points with individual teams (improvement advising, described as coaching in the curriculum), ideally biweekly but no more than three weeks apart
- ☐ Monthly (at least) virtual meetings with cohort
- ☐ Dedicated webpage for program resources and, ideally, team collaboration
- ☐ Coordination between facilitator(s) and improvement advisor coaches
- ☐ Data submission process and analysis

Phase or Phase #. Activity #	Facilitator Notes
Where to Start if You Have Not Started	• If an organization has not yet hired a behavioral health lead, it's essential they to have BH team-members before starting a BHI project. • Organizations should do some early planning work to determine the level of staffing (e.g., director, manager, therapist). • Active recruiting and hiring can take some time so make sure to build out that step into any project plan.
Phase 1	**Launch the journey (Month 1)**
Activity 1.3	• Consider adding coaching or webinar exercises related to: o Establishing a shared vision around improved outcomes (Quadruple Aim – patients and providers/staff) o Internal and team member commitment to the changes needed to advance integration
Phase 2:	**Get started (Months 2-3)**
Activity 2.1	• In coaching calls, emphasize that organizations should take a population health focus to understand community needs which should be applied to understanding the real/potential impact on the clinic/practice. o Even if organizations don't currently collect data on depression or anxiety, they should be able to harvest anecdotal data to better understand the needs of the patients and the impact of BH issues on their practice. o There needs to be a sense of patient/practice outcomes they want changed by delivering better care since it will be hard to show a direct impact on the population health of the community, at least in the shorter term.

Phase or Phase #. Activity #	Facilitator Notes
Activities 2.1, 2.2, 2.3	• Essential to do a thorough job in data analysis phase. Coaches should help organizations really look at the data available: what does the community, organization, clinic needs? • This information will really inform how to implement a program: make sure teams understand patient demographics and clinical needs at each potential pilot site.
Activity 2.4	• Patient feedback should be collected early in the process to define the problem, goals, model design, and outcomes that need to be tracked. With the commitment to health equity, patient/family voice needs to be prioritized. • This step also serves as a project bellwether regarding the organizational culture in terms of openness for and commitment to change.
Activity 2.7	• Financial planning and modeling can be difficult within provider groups (especially those with commercial health plans) if they are at risk for certain medical utilizations, but there is a carve out through the health plan that pays for the psych admissions. However, it's often the medical admissions (e.g. ER visits for SOB or anxiety) that provider organizations end up paying for since patients aren't being adequately managed by the MH carve outs. ○ For this situation, point out that the business case is in investing in mild to moderate care and appropriate referral for higher acuity to drive down hospital costs related to medical admissions (or be proactive to manage BH needs before they become higher acuity). • Help organizations make the connection between reducing hospital utilizations and costs and recommend examining financial arrangements related to carved outs. • Later in the curriculum (Activity 6.3), organizations are encourage to dialogue with health plans to problem-solve for carve outs.
Activity 2.8	• One of the challenges is that many organizations have different sites with different levels of integration at each site. It may be that they need to assess each site separately and decide for each site what the next stage of development should be. ○ Users may choose to only assess one site or assess many/all before making a plan. • When teams complete the assessment they have to agree on the terms and framework –depending on who did the assessment you may come out with very different ideas on how integrated a site is. • Support organizations to reflect on where they want to/need to go on the BHI continuum. A reminder: full integration is not always optimal given local conditions and resources.

Phase or Phase #. Activity #	Facilitator Notes
Activity 2.9	• Barriers related to internal culture and buy-in are important to understand and develop an action plan for addressing. It's important to connect the dots between ranking and thinking about strategies to address any and all barriers. It's also important to make sure this is considered for all staff in the organization, not just clinical.
Phase 3	**Prepare for the pilot (Months 5 –9)**
Activity 3.11	• For FQHCs the main revenue will be from billing encounters using PPS for reimbursement, the "bread and butter" which will support integration. Planners need to focus on the model and productivity expectations and then figure out what that revenue can support in terms of support staff.
Phase 4	**Implement care model (Months 10- 15)**
Activity 4.4	• Reviewing external care pathways is not inconsequential – especially if the team doesn't have a relationship with County Behavioral Health. • Ensure teams map to potential referral entities in the community to better understand options and develop workflows for referrals and care coordination. This step should also be completed for the health plans and the managed behavioral health organizations that cover their patients. • Note this is different from community asset mapping (Activity 4.16)
Activity 4.9	• Training is a huge area – and can be a hurdle for implementation. All of these listed topics are important to cover with staff, and should be reviewed to create plan that takes sites through priorities. • Trainings on clinical practices and workflows need to happen first to put some context around/anchor these other topics that need to be integrated into practice.
Phase 5	**Evaluate & spread (Months 16 – 17)**
Activity 5.5	• The whole issue of recruitment and hiring needs to be appropriately resourced. Teams will also need to work with others at the organization to update an org chart and expectations about administrative and clinical supervision, clinical consultation resources and continuing education. • Integration efforts are not sustainable without leadership buy in and commitment –even to the extent of requiring a BH position on the leadership team to signal the commitment to and importance of integration. • A note about culture: some primary care practices treat BH clinicians as if they are primary care providers and they don't understand how different the practice and support needs are as well as the general culture of the profession.
Phase 6	**Refresh your sustainability plan (Months 18 – 19)**
Activity 6.2	• A possible way to sustain and expand workforce is to look at academic partnerships (e.g., School of Social Work or Marriage & Family Therapist programs).