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A Technical Assistance Framework to Facilitate the Delivery of Integrated Behavioral Health Services in Federally Qualified Health Centers (FQHCs)☆

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ABSTRACT

An implementation approach, featuring direct, onsite technical assistance is described, and findings from a pilot study assessing the capability of Federally Qualified Health Centers to provide integrated behavioral health services are presented. Investigators used the Behavioral Health Integration in Medical Care (BHIMC) index to measure integration at baseline and follow-up at four FQHCs in New Jersey. Results indicate that the average baseline capability score of 1.95 increased to 2.44 at follow-up, almost one-half point on the five-point BHIMC index. This pilot project demonstrates that co-occurring capability can be assessed, and system-wide technical assistance can be delivered to assist FQHCs in integrating behavioral health services. Future research should test technical assistance as an implementation strategy to promote the integration of medical care and behavioral health treatment on a wider scale.

1. Introduction

Integrated care – defined by the Center for Integrated Health Solutions as "the systematic coordination of general and behavioral healthcare" – is believed to be the most effective approach to caring for people with multiple healthcare needs. In the advent of healthcare reform, we have a great opportunity to address the largely unmet behavioral health needs of Americans via the integration of behavioral health services within medical settings. The Affordable Care Act (ACA), building on the Mental Health Parity and Addiction Equity Act expands behavioral health benefits by: including mental health and substance use disorders benefits as Essential Health Benefit categories, applying federal parity protections to mental health and substance use disorder benefits, and providing 27 million previously uninsured Americans with coverage for mental health and substance use disorder services (Beronio, Po, Skopec, & Glied, 2013). Given that about 22% of all patients in health care settings have a substance use condition (Treatment Research Institutes, 2010) and that many individuals with substance use and mental health disorders do not come into contact with the specialty care systems, medical settings are ideal places to identify individuals with behavioral health disorders, engage them in understanding the need for treatment, and begin providing services (Babor et al., 2007; Cantor et al., 2014; Cherpitel & Ye, 2008). Thus, medical settings will likely become the gateway to the behavioral health system under the ACA.

The movement toward integration of behavioral health and medical services has evolved in many models of and approaches to service delivery (Butler et al., 2008; Collins, Hewson, Munger, & Wade, 2010; Lopez, Coleman-Beattie, Jahnke, & Sanchez, 2008; Mauer, 2006, 2009; Mauer & Jarvis, 2010; Miller, Kessler, & Peek, 2011; Robinson & Reiter, 2007; Russell, 2010). A growing body of evidence supports the use of treatments that integrate substance use disorder (SUD) services within medical care settings. Care management programs for alcohol use disorders delivered in primary care have been associated with higher rates of patient engagement in treatment and a significantly lower number of drinking days than specialty SUD care provided separately (Lee, Kresina, Campopiano, Lubran, & Clark, 2015; Oslin et al., 2013). Research has also shown that the integration of SUD services and primary care can lead to improved physical and mental health (Friedmann, Hendrickson, Gerstein, Zhang, & Stein, 2006; Gourevitch, Chatterji, Deb, Schoenbaum, & Turner, 2007; Laine et al., 2001; Madras et al., 2009) and to reduced levels of drug use (Gryczynski et al., 2011; Madras et al., 2009), and can result in cost savings for overall health care systems (Babor et al., 2007; Parthasarathy, Mertens, Moore, & Weisner, 2003).

Despite this evolving need, the fact remains that little is known about how best to promote behavioral health and primary care

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integration, what populations are being served and in what practice settings, what policy and financing barriers exist for providers, and what system structures would best support behavioral health and primary care integration. In addition, very few studies have assessed behavioral health integration in primary care settings, primarily due to the lack of standardized tools that can be employed as objective measures of integration (Technical Assistance Collaborative/Human Services Research Institutes, 2012). Those that have assessed behavioral health integration generally indicate that despite progress, significant gaps remain (Lardiere, Jones, & Perez, 2011).

During the past 10 years, two benchmark measures – the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) indices – have been used in over two-thirds of U.S. states and in tribal systems to measure and facilitate integration efforts between the mental health and addiction treatment systems (McGovern, Lambert-Harris, McHugo, Giard, & Mangrum, 2010). A companion measure to the DDCAT/DDCMHT was recently developed – the Behavioral Health Integration in Medical Care (BHIMC) index, formerly known as the Dual Diagnosis Capability in Health Care Settings (DDCHCS) index – to assess integrated behavioral health (i.e. mental health and substance use) services within a single medical setting (McGovern, Urada, Lambert-Harris, Sullivan, & Mazade, 2012). These measures have been instrumental toward documenting system capacity to integrate services and influential in guiding policy, practice and a wide range of workforce improvements across multiple disciplines.

This manuscript describes a pilot project to assess the utility of a technical assistance approach to promote integrated behavioral health (i.e. mental health and addiction) services within Federally Qualified Health Centers (FQHCs). Technical assistance provided to FQHCs was informed mainly by the Facilitating Adoption of Best Practices (FAB) model (Damush, Bravata, Plue, Woodward-Hagg, & Williams, 2008), which focuses on the implementation of evidence-based practices at the organizational level (Tabak, Khoong, Chambers, & Brownson, 2012). In designing the TA approach employed for this study, the following eclectic array of implementation principles was employed: (1) **obtain "top down support"** to help ensure that leadership makes available the resources necessary to support implementation (Dezdar & Ainin, 2011; Forsner, Hansson, Brommels, Wistedt, & Forsell, 2010; Yung, Chen, & Wang, 2014); (2) **obtain staff input** as people are more likely to invest in and commit to organizational policies that they have helped to shape (Cotton, 1995; Sagie, 1995; Sagie, Elizur, & Koslowsky, 1990; 1995; Wanberg & Banas, 2000); (3) **facilitate a change process** that identifies "purveyors" or "change agents" to guide implementation (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Havelock & Havelock, 1973; NIATx, 2013); (4) **promote peer-to-peer learning** that in turn facilitates inter-organizational collaboration and enables participants to learn from their collective implementation experiences (Ovretveit et al., 2002); (5) **use measurement and feedback** to evaluate implementation success (Deming, 1950; Proctor et al., 2011); and (6) **build staff competencies** by providing the necessary training and technical assistance support to facilitate effective implementation of a new innovation (Davis, Thomson, Oxman, & Haynes, 1995; McHugh & Barlow, 2010; Miller, Yahne, Moyers, Martinez, & Pirratano, 2004).

This manuscript describes a project that employed the BHIMC to measure the level of integration of mental health and/or substance use services in four FQHCs and to guide the provision of technical assistance that was designed to enhance integration. The use of standardized measurement tools as a framework for the provision of technical assistance offers a promising model for promoting the integration of behavioral health services in routine medical settings. Based on prior work with the DDCAT/DDCMHT (Chaple & Sacks, 2014; Gotham, Claus, Selig, & Homer, 2010; McGovern et al., 2010), it was hypothesized that the technical assistance provided to FQHCs would result in successful implementation of 5–7 goals and objectives outlined in the implementation plan, which would then increase integrated care capacity as measured by the BHIMC index a minimum of 0.35 points on the five-point scale.

2. Materials and methods

2.1. Pilot project overview

Recognizing the importance of integrating behavioral and physical health, The Nicholson Foundation funded NDRI (National Development and Research Institutes, Inc.) to conduct "*A Pilot Project to Facilitate the Delivery of Integrated Behavioral Health* [*Substance Use and Mental Health*] *in Federally Qualified Health Centers* (FQHCs)". This was part of their larger agenda to advance integrated behavioral health care within New Jersey's primary care network that provides services in medically underserved urban and rural communities. The purpose of this project was to demonstrate the readiness of select New Jersey FQHCs to integrate behavioral (substance use and mental health) health services in primary care settings, and to obtain data documenting improvements in service integration subsequent to the delivery of technical assistance and implementation support.

2.2. Participating Federally Qualified Health Centers (FQHCs)

Participation in the proposed pilot study was limited to Federally Qualified Health Centers (FQHCs), a federal designation given by the Bureau of Primary Health Care and the Center for Medicare and Medicaid Services that is assigned to private non-profit or public health care organizations. FQHCs serve the uninsured or federally designated Medically Underserved Areas/Populations (MUAs or MUPs). Therefore, FQHCs provide services to all persons regardless of ability to pay, and charge a Board-approved, sliding-fee scale based on patients' family income and size.

At the time of the pilot study, the universe of New Jersey FQHCs consisted of approximately 28 organizations and 105 individual sites. Two FQHCs in New Jersey, comprised of four medical facilities, were identified jointly by the New Jersey Primary Care Association and The Nicholson Foundation as ideal participants for the pilot study. These FQHCs had leadership in place who had expressed great interest in furthering the integration of behavioral health services. The investigative team met with medical and behavioral health directors from both organizations to outline the goals and objectives of the pilot study and communicate what would be required of participating FQHCs. It was made clear that the decision to participate was voluntary, and both FQHCs volunteered to take part in the pilot.

Participating FQHCs provided comprehensive preventive and primary care medical, dental and behavioral health services for both adults and children. Preventive care included screening and assessment for a variety of debilitating and chronic illnesses such as cardiovascular health, cancers, and behavioral health, including substance abuse. Assistance with smoking cessation, strategies to manage chronic diseases (e.g., asthma, diabetes, etc.), health education, and other nutrition services are provided to promote the health of the community. Primary health care services included but were not limited to: adult medicine, gynecology, pediatrics, HIV treatment, dental, ophthalmology, and podiatry. Participating FQHCs also offered the convenience of an onsite pharmacy.

2.3. Measures

2.3.1. Behavioral Health Integration in Medical Care (BHIMC) Index

The BHIMC Index is composed of 36 benchmark items and organized by 7 dimensions (see Table 1 below). Each item is scored on a 5-point Likert-type scale, which is based upon the American Society of Addiction Medicine's taxonomy of dual diagnosis capability (Mee-Lee, Schulman, Fishman, Gastfriend, & Griffith, 2001): "1" Health Care Only Services (HCOS)—does not offer mental health or substance use services in a consistent manner; to "3" Dual Diagnosis Capable (DDC)—offers behavioral health services but inconsistently or favors either mental health or substance use; to "5" Dual Diagnosis Enhanced (DDE)—addresses mental health and substance use issues using a systematic and protocol-driven