IBH: The Next Chapter

Where are we now?

According to the California Primary Care Association's (CPCA) latest Community Health Center survey, 100% of Community Health Centers (CHC) in California have some level of integrated behavioral health services. Twenty years after The California Endowment (TCE) launched the Integrated Behavioral Health Project to study the seven 'vanguard' organizations (early adopters of IBH), Integration is now the norm.

Shout Out! Organizations like CPCA, Health Resources & Services Administration (HRSA) TCE; Consortia such as Integrated Health Partners, Community Health Center Network, Central Valley Health Network, and countless CHC CEOs, Medical and BH Leaders have led, studied, supported, facilitated and funded IBH expansion across California.

What's next?

Our team has worked with over 60 CHCs in California over the last ten years, conducting assessments of IBH departments and providing coaching and technical assistance to enhance, expand, and deepen integrated care. Although CHCs are all unique in some respects, we have found overwhelming similarities in the strengths and challenges of IBH implementation and delivery. Here are **the 10 most common IBH recommendations we make to CHCs**
(and the 4 IBH myths we wish would fade!)

The Big Stuff

1 **Increase the ratio of BH providers to 1 BH provider per 2 Primary Care Providers.** The overwhelming majority of CHCs are deeply understaffed to meet the behavioral health needs of the community served. Research consistently shows that 70% of primary care visits are psychosocial-related, and over 40% of primary care patients want and need behavioral health services. In our work with CHCs, we run reports to find out the penetration rate of BH services; it is rarely over 10%. Without proper ratios, improving the health of a population remains out of reach. More importantly, many people continue to suffer without aid. **Due to the severe scarcity, It is impossible to meet the need by relying on recruiting licensed or unlicensed clinicians.** To grow IBH services to the level needed, we recommend three main strategies:

✔ Grow Your Own Mental Health Counselors:

Train CHWs, Case Managers, SUD Counselors, and Care Coordinators to do mental health counseling. Provide clinical supervision, support, and continued learning from within the IBH department. **Lay Counselors** (mental health counselors without traditional licenses or degrees) have been shown to have outcomes comparable to licensed clinicians. They are widely used in lower-income countries as a solution to clinician scarcity.

In addition to addressing access, this strategy addresses the need for more linguistic and cultural concordance between the BH workforce with the community served.

The **Lay Counselor Academy** is an example of a mental health counseling training course. **Asian Health Services**, **Hill Country Health and Wellness**, and **San Ysidro Health** are just a few of the CHCs who have invested heavily in this strategy.

Recruitment Strategies for Traditional Providers:

Eliminate all criteria that are barriers to employment for clinicians, such as mandating full-time work, employee status, and in-person work. Recruit for any number of hours from anywhere in the State.

Salud Para La Gente and **Alexander Valley Health Centers** utilize this strategy successfully, contracting with part-time, fully remote clinicians.

Focus on ASW recruitment. If supervision needs exceed capacity, contract for outside supervision.

Community Medical Centers, which have one of the highest ratios of BH clinicians to PCPs, utilize this strategy, with over 75% of BH services provided by ASWs.

2 **Elevate BH Leadership to Chief Behavioral Health Officers.** *Currently, Only 8 CHCs in California have CBHOs.* CBHOs working alongside other Chief Clinical Officers is the foundational DNA of all whole-health philosophies and practices. CBHO's realm of leadership is not circumscribed to the IBH department; instead, it includes the BH needs of employees, all patients, and the community.

CommuniCare+OLE and **Marin Community Clinics** have had CBHOs for many years.

Most IBH departments are still overseen by the CMO. It can be useful as a thought exercise to consider if a psychologist or LCSW would oversee the medical department.

Simple But Not Easy:

3 **Cease cumbersome internal referral processes and move to 'direct book' workflows.** Complex referral protocols that demand multiple staff touches are time-consuming and unnecessary, causing delays and cracks for patients to fall through.

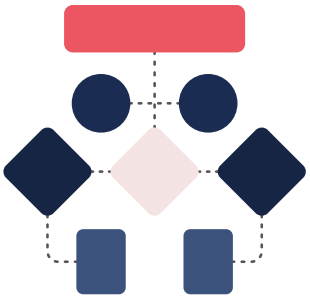
Santa Cruz Community Health Centers and **Umma Community Health Centers** use 'direct book' strategies.

4 **Encourage all staff to schedule patients for BH services;** Gatekeeping BH referrals by only allowing PCPs to refer causes disparities in care, is inefficient, and ignores the trusted relationship many staff have with patients. Relatedly, allow patients to self-refer to BH.

QueensCare Health Centers and **Open Door Community Health Centers** have 'no wrong door' pathways for IBH.

5 **Implement an Integrated Consent to Treat and Release of Information (ROI).** The Consent to Treat and ROI should include all medical, dental, and behavioral health services, substance use disorder treatments, case management, social services, health education, perinatal services, and all other services. Separate BH consents and releases are unnecessary and burdensome for staff and patients.

Bay Area Community Health Centers and **Innercare** have integrated consents and ROIs.



Clinical Practice Changes:

6 **Establish standardized clinical pathways (standing orders) to BH for specific screening measures, health conditions, or other sub-populations.** BH Counseling is a first-line treatment for depression and other mood disorders, anxiety, chronic pain, insomnia, trauma, and toxic stress. substance use disorders, eating disorders, chronic disease management, and more. For evidenced-based, equitable care, the decision about who gets referred to BH and who should be built into the system.

Note: This is not possible without a high ratio of BH counselors to PCPs. Just one standardized clinical pathway (referring all patients with >10 PHQ9 score to BH, would fill all existing BH schedules if there are insufficient FTE.)

7 **No More 'Intakes'**
Formal intake protocols and lengthy standard assessment procedures are without clinical merit, prioritizes the system over the patient, displaces the primary task in the first sessions of developing trust and a therapeutic alliance, leads more patients to drop-off after the first session, and causes bottlenecks in access. *We are always assessing*, we don't lose that by foregoing formal intakes. We are instead clearing away the paperwork and typing, to connect deeply with patients, listening to them about what is troubling them.

Santa Cruz Community Health Centers dropped all formal assessment procedures.

8 **Whittle Down Documentation To 10 Minutes Per Patient visit**. This is feasible with simple, standardized templates and efficient documentation practices. Documentation that takes longer lowers job satisfaction, burdens clinicians, and decreases appointment slots, with little benefit for patients. Worse, intense documentation practices drive the habit of typing during sessions.

Camino Health Centers IBH steadily brought their BH documentation time down significantly.

The Big Complex Stuff:

9 **Enhance Empathic Practices:** Patients' experience of empathy from providers and staff is crucial for improved population health (this is true for emotional, behavioral, physical, and social care). When patients feel genuine empathy from care providers, it improves adherence to recommendations, lowers missed appointment rates, speeds physical and emotional healing, lowers physical and emotional pain, lowers HbA1cs, blood pressure, depression, anxiety, and more. In addition to being evidenced-based, empathy-based care is more rewarding for care providers, resulting in higher job satisfaction. For many people in the helping professions, it is also aligned with spiritual beliefs and values.

Examples of empathy-based practices in IBH are: A warm welcome when patients enter the clinic, including eye contact, smiles and greeting by staff; **empathic waiting room environments**, ensuring BH treatment rooms have couches, rugs, art and non-fluorescent lighting; listening deeply during sessions (no typing), making certain all BH staff are confident in foundational empathic communication, and managing judgments and biases.

All the CHCs in this document are examples of some amazing empathic practices!

For a list of all empathy research cited (and more!), see **EM consulting's empathy bibliography.**

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Employee support:
We want to deliver care that is relationship-based, respectful, and empathic, care that focuses on strengths and acknowledges and supports patient autonomy, and care that truly 'sees' patients as unique people through a lens of unconditional positive regard. The foundation for delivering this type of care is workplace cultures that treat employees this way. Examples of relationship-based, empathic, respectful workplace practices are: leadership that communicates empathically, meaningful anti-racist and anti-discrimination efforts, high autonomy/low surveillance for employees, time dedicated to strengthening team relationships, conflict-resolution support, and easy access to mental health support for employees.

Communicare + OLE and **Community Medical Centers** provide access to supplemental mental health services for employees, beyond insurance-based services and the EAP.

Dispense with the Myths:

Myth: IBH addresses only 'mild to moderate' BH conditions. CHCs never saw just people with 'mild to moderate' conditions; people with more severely impacting mental health conditions comprise between 25-75% of all IBH services. Particularly in rural counties and areas of severe BH clinician shortages, such as the Central Valley, Northern and Sierra counties, and the Inland Empire, CHCs are the primary source of behavioral health services across the spectrum of severity.

Myth: IBH should focus on helping patients manage their (physical) chronic diseases. By most conservative estimates, 40% of CHC patients have a BH (mental health or SUD) condition. For a medium-sized CHC with 25,000 patients, 10,000 have diagnosable conditions. IBH departments do not have the capacity to provide self-management coaching to patients with no other behavioral health concerns. Medical assistants, primary care providers, health educators, and CHWs are better sources of care for chronic disease management support.

Myth: IBH is not self-supporting; it loses money or is grant-dependent. In all our work with CHCs, we have seen very few unprofitable IBH department. This myth typically persists because CHCs do not have accurate data on the costs and revenue of the department, are costing out psychiatry in behavioral health departments (prescribers should be a shared cost with the medical department), or are using overhead allocations modeled on medical care (BH overhead is much lower).

Myth: Warm hand-offs are a mandatory part of IBH. Warm hand-offs were always just one strategy to improve access and engagement (similarly, IBH isn't a goal but a strategy for access and quality care). If warm handoffs aren't feasible due to lack of reimbursement, telehealth-based providers, or clinician shortages, other ways exist to address barriers to access and engagement and support team-based care.