VERSION 3.3

BHIMC Index

Behavioral Health Integration in Medical Care

The Behavioral Health Integration in Medical Care (BHIMC) is a quantitative measure of the capacity and degree to which primary care settings have integrated behavioral health (mental health and substance related) services, along policy, clinical practice, and workforce domains.

The BHIMC consists of 36 benchmark items across seven dimensions. The seven dimensions are: 1) Clinic Structure (i.e., organizational aspects such as mission, license or certifications, and financing); 2) Clinic Milieu (i.e., physical and social environment of an organization); 3) Identification & Triage (i.e., screening and assessment protocols); 4) Care Delivery (i.e., integrated care plan and procedures); 5) Monitoring & Coordination (i.e., treatment coordination, ongoing management and follow-ups); 6) Workforce (i.e., staff expertise and workflow for providing integrated behavioral health services); and 7) Training (i.e., basic and specialized training in behavioral health). Each item is rated on a scale from 1 (minimal integration) to 3 (partial integration) to 5 (full integration). Each item is also categorized according to behavioral health prioritization: mental health only; substance related only; both mental health and substance related; or none.

Data are collected during site visits to primary care or other medical settings. BHIMC ratings are based on interviews with key informants, rapid ethnographic observations, and document review. Scores are then calculated for each item and dimension. An overall BHMIC score (mean of dimension scores) and the percent of BHIMC items overall behavioral health prioritization are also derived.

DATE: _____/_____/_____

TIME SPENT (HOURS): _____

RATER(S): _____

AGENCY NAME: _____

PROGRAM NAME: _____

CONTACT PERSON: _____

TITLE: _____

TELEPHONE: _____

FAX: _____

EMAIL: _____

ADDRESS: _____

_____

STATE: _____

ZIP CODE: _____

REGION (RUCA CODE): _____

PROGRAM ID (10 DIGIT CODE): _____

TIME PERIOD (SELECT ONE): T1_____ **T2**_____**T3**_____**T4**_____

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Please enter Y, N, or NA for all categories below— except for categories 'Program Activity' and 'On-site Care Providers' in which you will put a numerical value.

1. **Payments Received**
   - _____ Self-Pay (e.g., patient payments)
   - _____ Private Health Insurance (e.g., HMO, PPO, MBHO)
   - _____ Medicaid
   - _____ Medicare
   - _____ State Financed Insurance (other than Medicaid; e.g., SCHIP, etc.)
   - _____ Military Insurance (e.g., VA, Champus, TRICARE, etc.)

   Other Funding Sources:
   - _____ Other Public Funds [(e.g., Federal, State, Local Grants (SAMHSR)]
   - _____ Other Funds (e.g., Donations, Fundraising, Charities)

2. **Agency Type**
   - _____ Private
   - _____ Public
   - _____ Non-Profit
   - _____ For-Profit
   - _____ Government Operated (e.g., Federal, State, Local, Tribal)

3. **Program Activity** (*numeric answers*)
   - _____ Total number of patients in practice panel
   - _____ Total number of new patient visits per month (on average)

4. **Care Setting**
   - _____Outpatient
   - _____ Inpatient Hospital
   - _____ Acute Care/Emergency
   - _____ Rehabilitation/Residential
   - _____ Other (please specify)
     _____

5. **Practice Type/Specialty**
   - _____ Federally Qualified Health Center
   - _____ General Internal Medicine- adult only
   - _____ Pediatrics
   - _____ Emergency Department
   - _____ Family Practice
   - _____ Specialty Practice (please specify)
     _____
     _____
     _____
     _____

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6. **On-site Care Providers**

Type	*#*	*FTE*	*# with Advanced Addiction Certification (e.g., ASAM, AAAP, Other) or Licensure (e.g., LADC)*	*# x-waivered*
MD/DO				
MD/DO- Psychiatry				
APRN				
APRN-Psychiatry				
RN/BSN				
PhD/PsyD				
LCSW/MSW				
MA/MS				
BA/BS				
Other (please specify)				
_____				
_____				
_____				

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7. **BHIMC Assessment—Sources Used**
   - _____ Chart Review
   - _____ Observe Treatment Session
   - _____ Team Meeting Observation
   - _____ Interview with Program Director
   - _____ Program Manual Review
   - _____ Agency Brochure Review
   - _____ Med Asst./Care Coordinator Interviews (#: ____)
   - _____ Supervision Observation
   - _____ Physical Site Tour
   - _____ Nurse Interviews (#: _____)
   - _____ Patient Interviews (#: _____)
   - _____ NP/PA Interviews (#: _____)
   - _____ MD/DO Interviews (#: ____)
   - _____ BHC Interviews (#: _____)

   Total Number of Sources Used: _____

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Behavioral Health Integration in Medical Care

1. CLINIC STRUCTURE						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
1A. Primary focus of agency as stated in mission statement. What is the agency's mission statement? In addition to physical health care, does it leave open the potential to address MH *and/or* SR problems? Does it explicitly state any behavioral health goals?	Physical health care only.	Primary focus is physical health care, MH *or* SR is treated; OR Generic focus on health and well-being.	Broad focus on physical health as primary, but with explicit mention of behavioral health (both MH *and* SR) along with other aspects of well-being.	More specific focus on physical and behavioral health (MH *and* SR) but not equivalent balance between MH *and* SR.	A specific and equivalent focus on both physical and behavioral health (MH *and* SR) with explicit mention of co-occurring disorders.	_____ MH _____ SR _____ Both _____ Neither
1B. Organizational certification & licensure. What does licensure or certification permit? Are there impediments to providing either MH *or* SR treatment services? Are these impediments real?	Permits only physical health care services.	Provides physical health care services, and has no actual barrier to treatment of MH *or* SR, but staff report regulatory barriers, OR has no barrier but provides treatment for either MH *or* SR problems without formal behavioral health license or certification.	Provides physical health care and treatment of both MH *and* SR but has no specific formal behavioral health license or certification.	Provides physical health care services, and has formal license or certification to provide MH *or* SR treatment, but not both.	Is certified and/or licensed to provide both physical health care and treatment of MH, SR *and* co-occurring disorders.	_____ MH _____ SR _____ Both _____ Neither
1C. Coordination and collaboration with specialty MH *and/or* SR treatment services. How and where is MH *or* SR treatment services provided? Through loose relationships or integrated on-site? Are these relationships formalized and documented?	No formal relationship with MH *or* SR service providers.	Formalized consultative relationship with MH *or* SR service providers.	Formalized consultative or coordinated relationship with both MH *and* SR service providers.	More formalized coordinated and collaborative relationship with both MH *and* SR providers with regular inter-agency or inter-program meetings. (If relationship exists with MH *or* SR providers, then lower rating to "3').	Most services for MH, SR, *and* co-occurring disorders are integrated within the existing program, and routine inter-agency meetings for collaborative services (If integrated services exist for either MH *or* SR, then lower rating to a "4").	_____ MH _____ SR _____ Both _____ Neither

1. CLINIC STRUCTURE, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
1D. Financial incentives. How do billing structures limit or incentivize services for persons with MH *and/or* SR disorders?	Bills for physical health care services only.	Bills for either MH *or* SR but not both.	Bills for both MH *and* SR, but not routinely. – Or – Partial reimbursement for MH *or* SR services available.	Routinely bills for MH *and* SR services but not for both at the same time or for the same patient.	Routinely bills for MH *and* SR treatments, and for combination and/or integration of MH/SR care for co-occurring patients.	_____ MH _____ SR _____ Both _____ Neither
2. CLINIC MILIEU						
2A. Routine expectation of and welcome to treatment for both disorders. How are patients with MH, SR *or* co-occurring disorders expected and welcomed? How is this reflected in agency documents?	Documented expectation of physical health care needs only; no acknowledgement of persons with MH, SR *or* co-occurring disorders, who are either referred or deflected.	Documented expectation and welcoming of persons with either MH *or* SR disorders (e.g. admission criteria, target population), but not both. Neither MH *nor* SR patients share common areas with physical health care patients.	General expectation for both MH *and* SR, but differential documentation for one or the other. Either MH *or* SR (but not both) share common areas with physical health care patients.	More equivalent and documented expectation for both MH *and* SR patients with some shared common areas with physical health care patients.	Clearly equivalent and documented expectation of MH, SR *and* physical health care patients who share common areas (e.g. waiting rooms, exam rooms).	_____ MH _____ SR _____ Both _____ Neither
2B. Display and distribution of literature and patient educational materials. What kind of information is posted on walls, on display in waiting areas, and included in patient and family handouts and printed materials?	Information relating to physical health issues only.	Some information available for MH *or* SR disorders.	Available for both MH *and* SR disorders but not equivalently distributed, and significantly less than for physical health issues.	Available for MH *and* SR disorders with equivalent distribution, but less than for physical health issues.	Available for both MH *and* SR disorders, as well as the interaction between both MH *and* SR disorders. Distribution is equivalent with physical health issues.	_____ MH _____ SR _____ Both _____ Neither

3. *IDENTIFICATION & TRIAGE*

	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
3A. Routine screening methods for MH *and* SR symptoms. Are there routines or systems to screen for MH problems? Are standardized screening instruments used?	No formal screening for MH *or* SR problems.	Routine screening for either MH *or* SR problems.	Routine screening questions for MH *and* SR, but not well-integrated with medical providers (i.e., not readily accessible or not utilized).	Standardized, formal screening measures for MH *and* SR, more integrated with medical providers for MH *or* SR but not for both.	Standardized or formal screening measures for MH *and* SR problems, and both well-integrated with medical providers.	_____ MH _____ SR _____ Both _____ Neither
3B. Routine assessment if screened positive for MH *or* SR symptoms. If a patient screens positive, are more detailed assessments triggered? Are these assessments formalized and integrated into routine protocols?	No assessment follow-up to positive screens for either MH *or* SR.	Assessment of MH *or* SR disorders is variable, and typically a clinician driven follow-up to positive screens for either MH *or* SR problem.	Informal assessment of both MH *and* SR disorders occurs but with some variation and neither is well-integrated with medical providers (i.e., not readily accessible or not utilized). Documented in 50-69% of the records with a positive screen.	Formal assessment of both MH *and* SR, more integrated with medical providers for MH *or* SR but not for both. Documented in 70-89% of the records with a positive screen.	Standardized or formal integrated assessment for MH *and* SR, routinely conducted, and well-integrated with medical providers. Documented in at least 90% of the records with a positive screen.	_____ MH _____ SR _____ Both _____ Neither
3C. MH *and* SR diagnoses made and documented. If assessments are conducted, are MH and SR diagnoses made and recorded?	Neither MH *nor* SR diagnoses are made or recorded.	Either MH *or* SR diagnoses are made variably.	MH *and* SR diagnoses are made variably, but neither diagnosis is well-integrated with medical provider documentation (i.e., not readily accessible or not utilized). Behavioral health diagnoses are documented in 50-69% of records with a positive screen.	More routine diagnoses of both MH *and* SR, more integrated with medical provider documentation for MH *or* SR but not for both. Behavioral health diagnoses are documented in 70-89% of records with a positive screen.	Systematic and routine diagnoses for MH *and* SR, routinely and well-integrated with medical provider documentation. Behavioral health diagnoses are documented in at least 90% of records with a positive screen.	_____ MH _____ SR _____ Both _____ Neither

3. IDENTIFICATION & TRIAGE, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
3D. MH *and* SR history reflected in medical record. Are the chronologies and treatment courses of these disorders gathered and recorded?	Physical health history only.	Variable history of either MH *or* SR disorder history in record in narrative section.	Variable recording of history and chronology of course of MH *and* SR disorders and interaction with physical health problems, documented in 50-69% of possible records.	Consistent recording of history and chronology of course of MH *and* SR disorders and interaction with physical health problems, documented in 70-89% of possible records.	Specific section in record devoted to history and chronology of course of MH *and* SR disorders and the interaction with physical health problems, documented in at least 90% of possible records.	_____ MH _____ SR _____ Both _____ Neither
3E. Access re: MH *and* SR symptom acuity: low, moderate, high. What happens to patients who present for services with stable MH *or* SR problems, or who are not in acute distress or intoxicated? What happens to patients who present with unstable MH symptoms or who are intoxicated or in withdrawal?	Continued access to services for persons with no to low acuity in MH *or* SR symptoms.	Continued access to services for persons with low to moderate acuity in either MH *or* SR conditions, but not both.	Continued access to services for persons with low to moderate acuity in both MH *and* SR problems, but who are primarily stable.	Continued access to services for persons with co-occurring disorders who may be acute in either MH *or* SR problems, but not both.	Continued access to services for persons with relatively high acuity, including those unstable in their MH condition *and* SR disorder.	_____ MH _____ SR _____ Both _____ Neither
3F. Access re: Severity and persistence of disability: low, moderate, high. What happens to patients who present with histories or reports of severe and/or persistent MH problems *or* SR, including alcohol or drug use disorders?	Continued access to services for persons with no to low severity and persistence of disability from either MH *or* SR, but <u>not</u> both.	Continued access to services for persons with low to moderate severity and persistence of disability in either MH *or* SR disorder, but <u>not</u> both.	Continued access to services for persons with low to moderate severity and persistence of disability in both MH *and* SR.	Continued access to services for persons with co-occurring disorders who may have moderate to high severity and persistence of disability in either MH *or* SR problems, but <u>not</u> both.	Continued access to services for persons with moderate to high severity and persistence of disability in MH, SR *and* co-occurring disorder.	_____ MH _____ SR _____ Both _____ Neither

3. IDENTIFICATION & TRIAGE, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
3G. Stage-wise assessment. Is the stage of motivation assessed and documented? How does it influence treatment or how a patient is approached?	Not assessed or documented, OR assessed & documented variably by individual clinician, focus either MH *or* SR motivation.	Routinely assessed and documented stage of motivation for either MH *or* SR.	Variable assessment of stage of motivation for both MH *and* SR, documented in 50-69% of possible records.	Routinely but not systematically assessed for both MH *and* SR, documented in 70-89% of possible records.	Systematically assessed for both MH *and* SR motivation, documented in at least 90% of possible records.	_____ MH _____ SR _____ Both _____ Neither
4. CARE DELIVERY						
4A. Integrated treatment plans. Do treatment plans show an equivalent and integrated focus on both MH *and* SR disorders (along with physical health conditions)? Or, is there a focus on physical health disorders alone?	Listing of physical health disorder(s) only (neither MH *nor* SR listed).	Routine listing of physical health disorders as primary, variable listing of MH *or* SR disorders.	MH *and* SR disorders variably listed.	MH *and* SR disorders routinely listed.	Integrated treatment plan or problem list: Co-occurring MH *and* SR problems, like physical health problems, are listed as primary.	_____ MH _____ SR _____ Both _____ Neither
4B. Assess and monitor interactive courses of both disorders. *Are changes and/or progress with status and symptoms of MH* and *SR problems followed (and documented)?*	No attention or documentation of progress with either MH *or* SR disorders.	Systematic clinical focus in narrative (treatment plan or progress note) on either MH *or* SR disorders; or more variable reports of progress on either MH *or* SR disorders.	Variable focus on interaction between MH *and* SR disorders or systematic focus on both MH *and* SR, but not their interaction or impact on physical health.	More routine but not systematic focus on interaction between MH *and* SR disorders, and impact on physical health.	Clear, detailed, and systematic focus on change in both MH *and* SR disorders, their interaction, and impact on physical health.	_____ MH _____ SR _____ Both _____ Neither
4C. Procedures for MH *and* SR emergencies and crisis management. Are there definite protocols for MH crises, for SA-related crises, or for persons at high risk for either?	No guidelines conveyed in any manner, OR verbally conveyed in-house guidelines.	Documented guidelines: Referral or collaborations for one but not both disorders (to local mental health or addiction treatment program, detoxification or emergency department).	Variable guidelines and capacity to address acute states for both disorders.	Consistent guidelines and capacity to address acute states for both disorders.	Routine capability, or a process to ascertain risk for acute states; Can maintain patients in present medical service unless commitment is warranted.	_____ MH _____ SR _____ Both _____ Neither

4. CARE DELIVERY, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
4D. Stage-wise treatment Is stage of motivation assessed on an ongoing basis for both MH *and* SR problem change? Can treatment be revised based upon changes in motivation?	Not assessed or explicit in treatment plan, OR documented variably.	Stage or motivation routinely incorporated into individualized plan for either MH *or* SR issues, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualized plan for both MH *and* SR issues, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualized plan for both MH *and* SR issues, and some indications of specific stage-wise treatments.	Stage or motivation for both MH *and* SR problems routinely incorporated into individualized plan, and formally prescribed and delivered stage-wise treatments.	_____ MH _____ SR _____ Both _____ Neither
4E. Policies and procedures for behavioral health medication evaluation, management, monitoring and compliance. Are medications acceptable? Are certain medications unacceptable? Are medications for MH disorders (e.g., anti-psychotics, anti-depressants, etc.) *or* SR disorders (e.g., acamprosate, naltrexone, disulfiram, etc.) routine and integrated?	No or variable use of psychotropic or addiction medication by specific prescriber.	Policies exist regarding either psychotropic medications *or* addiction medications.	Some policies exist regarding prescribing of psychotropic medications *and* addiction medications.	Policies, well-developed and consistently implemented, exist regarding psychotropic and some types of addiction medications.	Policies, well-developed and consistently implemented, exist regarding a wide range of psychotropic and addiction types of medications, including the use of medications for persons unstable in either MH *or* SR symptoms.	_____ MH _____ SR _____ Both _____ Neither
4F. Specialized psychosocial interventions. Are therapies available that focus on physical health issues only, or that focus on MH, SR *or* co-occurring disorders?	None or interventions for either MH *or* SR problems based on judgment by individual clinician.	Either MH *or* SR intervention in program format as generalized intervention, e.g., stress management; Irregular penetration into routine services.	Both MH *and* SR intervention in program format as generalized intervention, e.g., stress management; More regular penetration into routine services.	*Some specialized integrated interventions by specifically trained clinicians, in addition to routine generalized interventions.*	Routine co-occurring symptom management groups; Individual therapies focused on specific co-occurring disorders; Systematic implementation of an evidence-based integrated treatment.	_____ MH _____ SR _____ Both _____ Neither

4. CARE DELIVERY, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
4G. Patient education about MH *or* SR disorder & treatments, or co-occurring MH *and* SR disorder and treatments. Is patient education information available on how MH impacts a SR disorder and vice versa? Is information available about how either influences the course of physical health problems, medications, or medical procedures?	For physical health problems only.	Present for either MH *or* SR disorder in generic format and content, and delivered in individual and/or group patient education formats.	Present for MH *and* SR but variably for co-occurring disorders and impact on physical health.	Routine but not systematic for MH and SR issues, their interaction, and impact on physical health.	Systematically delivered specific content for specific disorder comorbidities and impact on physical health, including protocols for individual and/or group patient education formats.	_____ MH _____ SR _____ Both _____ Neither
4H. Family education and support. Do family members receive educational information available on how MH impacts a SR disorder and vice versa? Is information available about how either influences the course of physical health problems, medications, or medical procedures? What kind of support is available for family members broadly defined?	For physical health problems only, or variably for either MH *or* SR disorders or by individual clinical judgment.	Either MH *or* SR disorders regularly but informally incorporated into family education or support sessions. Available as needed.	Family education and support offered on-site for families on MH *and* SR disorders but variably on co-occurring issues and impact on physical health.	Behavioral health (MH *and* SR) disorder family group exists but not integrated into standard program format, or with clear guidelines on impact on physical health.	Routine and systematic behavioral health disorder (MH *and* SR) family group integrated into standard program format, with emphasis on impact on physical health and treatment.	_____ MH _____ SR _____ Both _____ Neither

4. CARE DELIVERY, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
4I. Specialized interventions to facilitate use of peer recovery support groups. Is there any effort to facilitate a connection to peer recovery group support? How are these linkages made? Is there any consideration for persons with co-occurring disorders in making these connections?	No facilitated connection to either MH *or* SR peer recovery support groups.	Generic format for facilitated connection to MH *or* SR peer recovery support groups off-site, variably used.	Present, generic format for facilitated connection to MH *and* SR, or co-occurring, peer recovery support groups off-site.	Routine facilitation of connection to MH and SR or co-occurring peer recovery support groups off-site, and some provision of on-site peer recovery support group.	Systematic facilitation of connection to MH and SR or co-occurring peer recovery support groups on and off-site, with a range of on-site peer recovery meetings.	_____ MH _____ SR _____ Both _____ Neither
4J. Peer recovery supports for patients with co-occurring disorders. Are peer supports and/or role models (patient advocates, volunteers) available for patients with MH *and* SR disorders? If so, are they on or off-site, integrated with routine protocol?	Not present, or if present not recommended.	Off-site, recommended variably, some co-occurring focus, but primarily either MH *or* SR (e.g., AA, NA) peer recovery.	Off-site and facilitated with contact persons or informal matching with peer supports in the community, co-occurring focus with MH *and* SR (e.g., AA, NA) peer recovery.	Off-site, integrated into plan, and routinely documented with co-occurring focus.	On-site, facilitated and integrated into program (e.g., alumni groups; mentors; patient advocates); Routinely used and documented with co-occurring focus.	_____ MH _____ SR _____ Both _____ Neither
4K. Practices and policies for schedule IV medications (narcotics), or other medications with abuse liability, balance needs and risks for persons with MH *and* SR disorders.	No to limited and restrictive use of narcotic or other medications with abuse potential for persons with MH *and* SR disorders. (Either has or does not have policy restricting use of schedule IV medications).	Variable use of narcotic and other medications with abuse liability but some sensitivity to abuse potential for persons with MH *and* SR disorders. (Either has or does not have policy restricting use of schedule IV medications).	Consistent use of narcotic and other medications with considerations for abuse potential for persons with MH *and* SR disorders, but no formal policy.	Formal policy for narcotic and other medications with abuse potential for persons with MH *and* SR disorders, but not routinely followed, or providers unaware of its existence.	Formal policy that is consistently implemented and monitored for narcotic or other medications with abuse potential for persons with MH *and* SR disorders.	_____ MH _____ SR _____ Both _____ Neither

5. *MONITORING & COORDINATION*

	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
5A. Ongoing management and monitoring of MH *and* SR problems. Throughout periods of MH *and* SR symptoms and remission, are both conditions monitored?	Not addressed or monitored.	Either MH *or* SR is addressed or monitored during when patient is symptomatic.	Both MH *and* SR are routinely managed during symptomatic periods, and variably monitored during periods of stability or remission.	Both MH *and* SR are routinely managed during symptomatic and asymptomatic (remission) periods, but not systematically.	Both MH and SR are routinely and systematically managed using a chronic disease model.	_____ MH _____ SR _____ Both _____ Neither
5B. Capacity to continue care through acute episodes of MH *and* SR disorders. Is treatment terminated or suspended for intoxicated, drug-seeking, non-compliant, disruptive, or obstreperous behavior?	No mechanism for managing either MH *or* SR acute episodes.	No formal protocol to manage either acute MH *or* SR issues, but some individual clinicians may provide extended care until appropriate linkage takes place; Variable documentation.	Routine practice is to manage both MH *and* SR acute care needs indefinitely, but variable documented evidence that this is routinely practiced, typically within the same program or agency.	Routine and typical practice but no formal protocol to manage acute MH *and* SR or co-occurring needs indefinitely.	Formal protocol to manage acute MH *and* SR or co-occurring needs indefinitely and consistent documented evidence that this is routinely practiced, typically within the same program or agency.	_____ MH _____ SR _____ Both _____ Neither
5C. Focus on ongoing recovery issues for both disorders. Are MH *and* SR disorders seen as acute or chronic, short term or long term, primary or secondary? How is recovery envisioned and planned?	Routine focus is on resolution of physical health issues; co-occurring issues are viewed (if at all) only as potential complicating issues for medical recovery.	Routine focus on either MH *or* SR management and recovery but not as interactive conditions that impact physical health.	Routine focus on both MH *and* SR management and recovery but not as interactive conditions that impact physical health.	Routine but not systematic focus on both MH *and* SR management and recovery, and as interactive conditions that impact physical health.	Routine and systematic focus on MH illness management and recovery *and* SR recovery, both seen as primary and ongoing, and critical to physical health and well-being.	_____ MH _____ SR _____ Both _____ Neither
5D. Facilitation of peer recovery support groups for MH *and* SR is documented. Is the potential for peer support linkage anticipated and planned? How is it dealt with?	No, or only rarely.	Routine focus on either MH *or* SR peer recovery support group connection (engagement in meetings or functions off-site).	Variable focus on both MH *and* SR peer support community connection (engagement in meetings or functions off-site).	Routine focus on both MH *and* SR peer support community connection (engagement in meetings or functions off-site).	Routine and systematic focus, at least 90% of the time, on MH, SR or co-occurring disorders peer support recovery support group connection (engagement in meetings or functions off-site).	_____ MH _____ SR _____ Both _____ Neither

5. MONITORING & COORDINATION, CONT.						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
5E. Ongoing access to psychotropic and addiction medications. How is the need for medications post an acute treatment episode dealt with?	No psychotropic or addiction medications available.	Psychotropic or addiction medications available but variably by prescriber on-site, and necessitating off-site prescriber referral.	Psychotropic and addiction medications typically available from on-site prescriber for acute episodes only, and from an off-site prescriber for ongoing coordinated care.	Psychotropic and addiction medications are available from on-site prescriber for acute and longer term care, but not systematically prescribed or monitored.	Psychotropic and addiction medications are available from on-site prescriber for acute and longer term care, and monitored systematically in overall plan.	_____ MH _____ SR _____ Both _____ Neither
6. WORKFORCE						
6A. Physician specialist. What is the relationship with a psychiatrist or addiction specialist (addiction medicine; certification in addiction psychiatry) or other expert medication prescriber (e.g., APRN).	No board certified or specialized psychotropic or addiction medicine prescriber on-site.	No board certified or specialized psychotropic or addiction medicine prescriber on-site but prescribing takes place.	Routine prescriber use of addiction and psychotropic medications, with formal board certification in psychiatry *or* addiction specialty, primarily in consultative role.	Routine prescriber use of addiction and psychotropic medications, advanced credentialed prescribers in addiction and psychiatric specialties, and some interaction and coordination with other medical staff members.	Routine prescriber use of addiction and psychotropic medications; advanced credentialed prescribers in addiction and psychiatric specialties, and integrated on-site for clinical, supervision, treatment team, and/or administration.	_____ MH _____ SR _____ Both _____ Neither
6B. On-site behavioral health clinicians with MH *and* SR treatment (co-occurring) certification, licensure or expertise. Are any behavioral health licensed or certified to provide MH *or* SR counseling services?	None.	1-24% of behavioral health clinicians can provide MH *and* SR counseling services and have appropriate expertise.	25-33% of behavioral health clinicians can provide MH *and* SR counseling services and have appropriate expertise.	34-49% of behavioral health clinicians can provide MH *and* SR counseling services and have appropriate expertise.	50% or more of behavioral health clinicians can provide MH *and* SR counseling services and have appropriate expertise.	_____ MH _____ SR _____ Both _____ Neither

6. WORKFORCE, CONT.

	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
6C. Access to integrated behavioral health (MH *and* SR) supervision or consultation. What is the arrangement for existing staff to receive supervision/consultation regarding their patients' co-occurring MH *and* SR problems?	None.	Off-site contractor or consultant is available, but variable supervision in integrated MH *or* SR treatments.	Provided as needed or variably on-site by consultant, contractor or clinical supervisor with integrated behavioral health treatment expertise.	Routinely provided (at least twice monthly) on-site by clinical supervisor with integrated behavioral health treatment expertise.	Regularly provided (weekly) on-site by clinical supervisor with integrated behavioral health expertise and utilizing direct observation, adherence/competence monitoring or other systematic practice reviews.	_____ MH _____ SR _____ Both _____ Neither
6D. Integrated treatment team or utilization review procedures emphasize and support integrated behavioral health treatment. Is there a protocol to review the progress or process of treatments (or outcomes) for persons with co-occurring MH *and* SR disorders?	No.	Variable review of cases, often precipitated by negative event or outcome.	Behavioral and physical health care providers have integrated team meetings as needed to discuss specific cases.	Behavioral and physical health care providers have regular integrated team meetings to discuss specific cases and agency policy issues.	Behavioral and physical health care providers have regular integrated team meetings to discuss patient care issues, grand rounds or joint continuing medical education sessions, and sessions on agency policy issues.	_____ MH _____ SR _____ Both _____ Neither
6E. Peer/Alumni recovery supports are available for persons with MH *and* SR disorders. Are role models available for persons with co-occurring MH *and* SR disorders (volunteers, peer supports, advocates)?	No.	Informal peer recovery network of individuals with MH *or* SR recovery experience is utilized by some providers, typically by off-site referral.	List of peer recovery volunteers or contact individuals with MH *and* SR recovery experience is available and frequently used by providers to facilitate connections on-site.	Volunteers or peer recovery specialists in MH *and* SR are available on-site, but not well-integrated or utilized by treatment team or providers.	Volunteers, peer recovery specialists or patient advocates with MH *and* SR recovery experience are available on-site, and routinely integrated into patient care, support and education.	_____ MH _____ SR _____ Both _____ Neither

7. *TRAINING*						
	1 Minimal Integration (MI)	2	3 Partial Integration (PI)	4	5 Full Integration (FI)	BH Prioritization
7A. All agency staff members have basic training in attitudes, prevalence, signs and symptoms, detection and triage for co-occurring MH *and* SR symptoms and disorders. What percentage of *all staff members* have a basic knowledge of co-occurring disorders? What percentage know how to screen and assess for these disorders? Is this training organized and documented?	No agency staff members are exposed to basic information (0% trained).	Variably exposed to basic information, not documented as part of systematic training plan, but encouraged by management (1-24% of staff trained).	Trained in basic MH *and* SR knowledge and skills per agency strategic training plan, but not universal or continuous (25-50% of staff trained).	Routinely but not systematically trained in basic MH *and* SR knowledge and skills, certain select staff but not universal training plan (51-79% of staff trained).	New employee in-service and/or annual renewal of knowledge and skill in basic MH *and* SR knowledge and skills, monitored and enforced by agency (80% or more of staff trained).	_____ MH _____ SR _____ Both _____ Neither
7B. Clinicians who deliver *behavioral health services* have specialized training in knowledge and skill in integrated treatments for co-occurring MH *and* SR. Who is trained in integrated treatment approaches? (Advanced approaches include: medications, brief interventions, family interventions, other treatments). Is this training organized and documented?	No behavioral health clinicians have advanced training (0% trained).	Behavioral health clinicians are variably trained, and there is no systematic agency training plan for individual staff member election (1-24% of clinical staff trained).	Certain behavioral health clinicians are trained, encouraged by management and with systematic training plan (25-50% of clinical staff trained).	Many behavioral health clinicians are trained and monitored by agency strategic training plan (51-79% of clinical staff trained).	Most behavioral health clinicians are trained and periodically monitored by agency strategic training plan (80% or more of clinical staff trained).	_____ MH _____ SR _____ Both _____ Neither

BHIMC Index

VERSION 3.3

Behavioral Health Integration in Medical Care

BENCHMARK SUMMARY >>

Program: _____

Type: _____

Reviewer(s): _____

Date of Review: _____/_____/_____

1. Clinic Structure

A. _____
B. _____
C. _____
D. _____

Sum Total= _____
Total/4= _____

#MH: _____ #Both: _____
#SR: _____ #Neither: _____

2. Clinic Milieu

A. _____
B. _____

Sum Total= _____
Total/2= _____

#MH: _____ #Both: _____
#SR: _____ #Neither: _____

3. Identification & Triage

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

Sum Total= _____
Total/7= _____

#MH: _____ #Both: _____
#SR: _____ #Neither: _____

4. Care Delivery

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H _____
I. _____
J. _____
K. _____

Sum Total= _____
Total/11= _____

#MH: _____ #Both: _____
#SR: _____ #Neither: _____

5. Monitoring & Coordination

A. _____
B. _____
C. _____
D. _____
E. _____

Sum Total= _____
Total/5= _____

#MH: _____ #Both: _____
#SR: _____ #Neither: _____

6. Workforce

A. _____
B. _____
C. _____
D. _____
E. _____

Sum Total= _____
Total/5= _____

#MH: _____ #Both: _____
#SR: _____ #Neither: _____

7. Training

A. _____
B. _____

Sum Total= _____
Total/2 = _____

#MH: _____ #Both: _____
#SR: _____ #Neither: _____

BHIMC INDEX CLINIC CATEGORY	
% Criteria Met for MI (# of "1" scores/36):	_____
% Criteria Met for PI (# of "3" scores/36):	_____
% Criteria Met for FI (# of "5" scores/36):	_____
Highest Level of DD Capability (80% or more):	_____

BEHAVIORAL HEALTH PRIORITY		
#MH:	_____	*% MH (# of MH/36)*
#SR:	_____	*% SR (# of SR/36)*
#Both:	_____	*% Both (# of Both/36)*
#Neither:	_____	*% Neither (# of Neither/36)*

Top BH Priority (Category with highest %): _____

Additional Site Visit Notes:

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