

ORGANIZED, EVIDENCE-BASED CARE:

Behavioral Health Integration

October 2014

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Introduction

Whether a primary care practice is just beginning the Patient-Centered Medical Home (PCMH) journey or is an established medical home, integrating behavioral health care is a critical effort, necessary for true transformation. This Implementation Guide provides guidance and tools a primary care practice can use to develop a vision for integrated care and a customized implementation plan reflective of its goals and resources.

In addition to this guide, the following companion pieces are available:

- [Behavioral Health Integration Executive Summary](#) provides a concise description of this component of Organized, Evidence-Based Care, its role in PCMH transformation, and key implementation activities and actions.
- Behavioral health integration additional content:
 - [Making the Case for Change and Overcoming Resistance](#)
 - [GROW Pathway Planning Worksheet](#) and [GROW Pathway Planning Example](#)
 - [Common Barriers and Strategies to Support Effective Health Care Teams for Integrated Behavioral Health](#)
 - [Resources to Support Behavioral Health Integration](#)

- Case study examples:

[Dorchester House Multi-Service Center Integrates Behavioral Health into Adult Primary Care](#)

[Tiburcio Vasquez Health Center Adapts to Integrate Behavioral Health with Primary Care](#)

[Integrating Behavioral Health into Primary Care: Lessons Learned from Central City Concern's Old Town Clinic](#)

[At CareSouth Carolina, Behavioral Health Care Meets the Health Needs of the "Whole Person"](#)

The Change Concepts for Practice Transformation: A Framework for PCMH

"Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement. The Safety Net Medical Home Initiative established a framework for PCMH transformation to help guide practices through the transformation process. The framework includes eight change concepts in four stages:

- Laying the Foundation: [Engaged Leadership](#) and [Quality Improvement Strategy](#).
- Building Relationships: [Empanelment](#) and [Continuous and Team-Based Healing Relationships](#).
- Changing Care Delivery: [Organized, Evidence-Based Care](#) and [Patient-Centered Interactions](#).
- Reducing Barriers to Care: [Enhanced Access](#) and [Care Coordination](#).

The Change Concepts for Practice Transformation have been extensively tested by the 65 practices that participated in the Safety Net Medical Home Initiative and used by other collaboratives and practices nationwide. They were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. They are supported by a comprehensive library of training materials that provide detailed descriptions and real examples of transformation strategies. These resources are free and publicly available. To learn more, see [Change Concepts for Practice Transformation](#).

Key changes for Organized, Evidence-Based Care

The eight Change Concepts represent the critical dimensions of PCMH transformation. Each concept includes multiple "key changes." These describe the general directions for the changes—the core elements a practice undertaking PCMH transformation must adopt. The key changes for Organized, Evidence-Based Care are:

- Use planned care according to patient need.
- Identify high-risk patients and ensure they are receiving appropriate care and case management services.
- Use point-of-care reminders based on clinical guidelines.
- Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.

Behavioral health integration is a key component of the Patient-Centered Medical Home (PCMH) Model of Care, which seeks to provide patient-centered, well-coordinated, comprehensive, whole-person care.

Message to Readers

Practices beginning the PCMH transformation journey often have questions about where and how to begin. We recommend that practices start with a self-assessment to understand their current level of “medical homeness” and identify opportunities for improvement. The SNMHI’s self-assessment, the [Patient-Centered Medical Home Assessment \(PCMH-A\)](#), is an interactive, self-scoring PDF that can be downloaded, completed, saved, and shared.

Readers are encouraged to download additional Organized, Evidence-Based Care materials available from the Safety Net Medical Home Initiative:

- [Organized, Evidence-Based Care Executive Summary](#) provides a concise description of the Change Concept, its role in PCMH transformation, and key implementation activities and actions.
- [Organized, Evidence-Based Care Implementation Guide](#)
- The Organized, Evidence-Based Care supplement, [Improving Care for Complex Patients: The Role of the RN Care Manager](#), provides practical recommendations about providing care management services to high-risk patients.

The Case for Behavioral Health Integration

There are several compelling reasons why a medical home should provide integrated care.

The ability to treat common health problems is a core value of the PCMH Model of Care.

Behavioral health problems are common and significantly impact patient health and quality of life. National studies estimate that in a one-year period, up to 30% of American adults suffer from one or more mental health problems.¹

Behavioral health problems present in primary care and rarely present in isolation.

Behavioral health problems are often co-morbid with physical health problems, and if behavioral health problems go un- or under-treated, it is more challenging to address patients’ physical health problems.² Treating behavioral health and medical problems together can improve outcomes for both.³



Currently, most patients don't get effective treatment for their behavioral health needs. Improvement is needed

Most treatment for common mental disorders is provided in the primary care setting, and is frequently not effective.⁴ For example, as few as 20% of patients started on antidepressant medications in usual primary care show substantial clinical improvements.^{5,6}

Unfortunately, simply referring a patient to a mental health specialist is not effective for achieving better outcomes or improving access. When patients are referred to mental health specialists by a primary care provider, almost half do not follow through with the referral⁷ or drop out of treatment early.⁸

The PCMH will not reach its full potential without adequately addressing patients' mental health needs.⁹

Integrated care is patient-centered care

In 2014, a number of primary care organizations endorsed a set of joint principles for integrating behavioral health into the PCMH.¹⁰ The principles were intended to supplement the Joint Principles of the PCMH formulated in 2007 by the American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics, and the American Osteopathic Association.¹¹ The National Committee for Quality Assurance (NCQA) further emphasized integration in its PCMH 2014 Recognition Program by adding the expectation that primary care practices collaborate with behavioral health care providers and communicate behavioral health care capabilities to patients.¹²

Benefits of Integrated Care

Integrating behavioral health in primary care provides the opportunity to improve health outcomes and patient experience without substantially increasing healthcare costs.^{13,14} Integrated care has also been shown to improve provider and staff satisfaction.¹⁵ Specific benefits for providers include improved clinic workflow and efficiency, increased support for providing care for the most challenging patients, and the ability to help more patients achieve wellness.

To read more about the case for integrated behavioral health, as well as methods to make the case for your organization and key stakeholders, review [Making the Case for Change and Overcoming Resistance](#).

What is integrated care?

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.

For more information on behavioral health integration definitions, review The Agency for Healthcare Research and Quality's (AHRQ's) [Lexicon for Behavioral and Primary Care Integration](#).

Behavioral health integration provides the opportunity to improve health outcomes and patient experience without substantially increasing healthcare costs.

Integrated Behavioral Health Care: What it is and How it Works

Integrated Care: The Spectrum

A number of initiatives have developed approaches for integrating behavioral health care in the primary care setting.¹⁶ These initiatives have defined, characterized, and classified integration in many different ways. In fact, there are almost as many different ways to define “integration” as clinics practicing integrated care. These different models and approaches form a spectrum for the degree of integration—i.e., how closely primary care and behavioral health providers partner together to address the needs of patients and families.

In models and approaches on the lower end of the spectrum, such as [Co-Located Care](#), on-site mental health providers see referred patients for medication management (seen by psychiatric consultant) and/or behavioral health specialist visits (typically for care management and/or brief psychosocial interventions). The care provided by the behavioral health specialists is largely independent of the primary care providers, although the co-located providers may consult with each other.

In models and approaches on the higher end of the spectrum, such as the [Collaborative Care Model](#), the primary care team and a behavioral health team form one “integrated care team” and actively partner together to share accountability for the total health care needs and outcomes of a panel of patients. They work together from a shared workflow to provide the

majority of mental health care in the primary care setting, including medication management and brief behavioral therapies. For patients needing more intensive treatment, there is the option to refer to specialty mental health or substance abuse services, but the integrated care team coordinates that care.

In this guide, we use the term “integrated care” to be inclusive of a variety of models and approaches for providing behavioral health care in the primary care setting. The higher the degree of integration, the more likely it will be for a primary care practice to effectively and efficiently manage behavioral health problems and improve patient health outcomes. However, not all primary care practices will be able to achieve a high degree of integration immediately. The most important action is to make a commitment to integration and to begin implementing processes that are likely to result in improved care for patients and their families.

This section describes how a primary care practice can develop a pathway for achieving integration that takes into account its patient population, integration goals, current capacity, and resources. As a practice experiences success with its initial integration efforts and builds up its capacity and resources, it is expected that the practice will be able to increase its degree of integration until it reaches full integration.

There is no one model of behavioral health integration that will fit all organizations. The goal is to identify a pathway to integration that will meet patients’ needs and a practice’s capacity and resources. As a practice experiences success with its initial integration efforts, and builds up its capacity and resources, it is expected that the practice will be able to increase its degree of integration until it reaches full integration.

Principles and Components of Integrated Care

The different behavioral health integration models and approaches share a set of core principles (described in **Table 1: Principles of Integrated Care**) and to varying degrees, a set of common components (listed in **Table 2: Components of Integrated Care**).

Table 1: Principles of Integrated Care

Principle	Description
Patient-centered team care	Primary care and behavioral health providers collaborate.
Population-based care	The care team shares a defined group of patients tracked in a registry to ensure no one 'falls through the cracks.' Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.
Measurement-based treat-to-target	Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are modified if patients are not improving as expected until the clinical goals are achieved.
Evidence-based care	Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.
Accountable care	Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Source: Principles of Effective Integrated Care. AIMS Center, University of Washington Psychiatry & Behavioral Science. Seattle, WA; 2013. Accessed July 2014.

Table 2: Components of Integrated Care

Component	Description
Practice space	Space is shared and providers function as one integrated system.
Communication	Providers communicate consistently at all levels (system, team, and individual).
Screening	Population-based medical and behavioral health screening is standard practice. Response protocols are in place.
Warm handoff	The primary care provider directly introduces the patient to the behavioral health provider at the time of the primary care visit.
Treatment plan	Patients have a single treatment plan, shared between medical and behavioral health providers.

Defining Scope

Behavioral health care may range from addressing common social needs or health behaviors, to treating mental health or substance use conditions frequently observed in primary care (e.g., depression, anxiety, problem drinking), to addressing more complex disorders such as bipolar disorder or prescription opioid misuse.

As a primary care practice begins to consider integrated care, it is important to clearly define the type of care it expects to provide. Again, there are many different ways to define and categorize both behavioral health problems and behavioral health care services, and there is no single correct definition—rather, it is important for each primary care practice to clearly establish its own definition of behavioral health and its own scope of behavioral health care.

Table 3: Descriptions of Care Types

Type	Description
Behavioral health care	An umbrella term for care that addresses any behavioral health problem affecting health, including mental health, substance use disorders, stress-linked physical symptoms, and health behaviors.
Mental health care	Care to help people with (or at risk for) mental illness to reduce suffering and to live healthier, longer, more productive lives.
Social assistance	Addressing social issues that often contribute to suffering and make it difficult for patients to care for themselves. Common concerns include: unstable housing or homelessness, food insecurity, joblessness, domestic violence, social isolation, and other complicating factors (e.g., developmental delay, dementia).

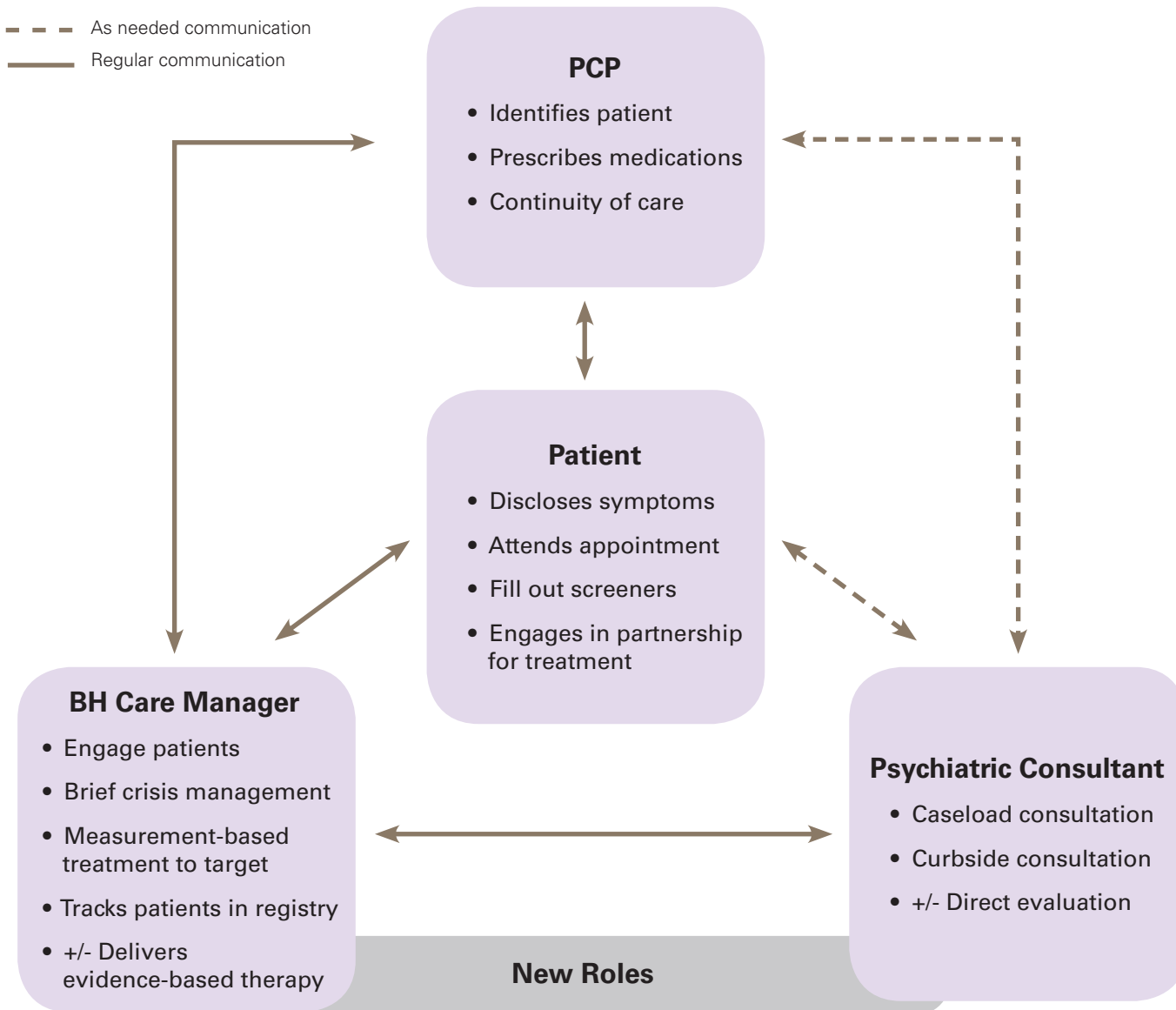


New Roles and Relationships

Integrated behavioral health care is provided by a team of primary care and behavioral health care providers and support staff. Depending on the resources of the practice, and the needs of the specific patient population, the team may be comprised of a wide variety of different staff.

What differentiates an integrated care team from a typical primary care team is the relationship between medical and behavioral health providers and the addition of specific functions (e.g., standard assessment). **Figure 1: Model Behavioral Health Integration Team** provides an example of how individuals work together on an integrated care team. To learn more about the roles and responsibilities of members of an integrated care team, see [Building Integrated Care Teams](#).

Figure 1: Model Behavioral Health Integration Team



How Integrated Care Works: Case Examples

This case example illustrates how integrated care differs from usual care and describes the benefits of behavioral health care integration for patients, their families and caregivers, providers, and care teams.

Ms. G—Usual Care in Clinic A

Ms. G is a 54 year-old single female, non-smoker, who weighs 285 lbs, and lives alone in subsidized housing. She has been a patient at Clinic A for many years and comes in at least once a month. She wears clothes from second hand stores including poorly fitting shoes and frequently unmatched socks. Her problem list includes obesity, diabetes, high blood pressure, arthritis of the knees and hips, and depression.

Ms. G's primary care team has had a difficult time engaging Ms. G in care and helping her reduce her HbA1c level to below 9. She has trouble walking because of her arthritis and her weight. She says that she cooks for herself in her apartment and denies having a sweet tooth. She has been offered a referral to the nutritionist, but says she knows what to eat. She claims to monitor her blood sugar at home, but seldom brings in any record of the readings. When asked what numbers she gets, she waives her hand dismissively saying, "Oh, after I eat it always goes over 200 or so."

She has a superficial jovial affect and generally deflects suggestions for behavior change with comments like, "Oh, we tried that once, but it didn't do anything." She has been on a moderate dose of a selective serotonin reuptake inhibitor for years, which she doesn't want to stop, and her PHQ-9, (a screener for depression designed specifically for use in the primary care setting)¹⁷ which is consistently over 12, is hard to interpret because of her jovial affect and humorous acceptance of her symptoms. She has never followed through on referrals to psychiatry despite the care team's best efforts, stating that she doesn't have coverage, the psychiatrists are too far away, they don't know what they're doing, and she doesn't really need help.

The care team is concerned because her risk of a cardiac event is very high, and they are frustrated because her poor glycemic control and elevated blood pressure are preventing them from meeting quality standards established by the clinic.

Ms. G—Integrated Care in Clinic B (using the Collaborative Care Model)

Because of a change in public transportation, Ms. G is forced to transfer her care to Clinic B where the providers have integrated behavioral health care into the primary care setting using the Collaborative Care Model. The team consists of a social worker present in the clinic daily, as well as a Masters-level therapist who is on-site several half days weekly and who works in close association with a psychiatrist off-site.

On Ms. G's second visit to the new clinic, the social worker spots her during a huddle and encourages the provider to bring Ms. G to her office after the visit to introduce them. In the initial conversation the social worker is able to schedule Ms. G to come back and spend an hour with her in the clinic the following week. During that conversation, and several others that follow over the next month, the social worker discovers that Ms. G was sexually abused as an adolescent. She is able to connect Ms. G to a specialized counseling resource for her in the community. The social worker also introduces to Ms. G to the female Masters-level therapist at the clinic, and Ms. G keeps the appointment. In that encounter the therapist, in collaboration with a consulting psychiatrist, suggests a minor change in Ms. G's medications, which the primary care team makes, and sets up a series of behavioral therapy sessions that focus on her depression.

continued on page 10

The primary care team continues to work with Ms. G on her diabetes management, cardiac risk factors, and depression, while the behavioral health team provides talk therapy interventions. All members of the integrated care team are able to view each other's documentation in the electronic health record. Over the course of the next year, Ms. G's engagement in managing her diabetes gradually improves. Her blood pressure, which had been consistently over 140/90, starts to come down closer to the target of 130/80. She begins walking daily, and starts losing weight. The care team notices that the PHQ-9 scores begin to come down slowly, and before long are in the 7 to 8 range.

OBSERVATION: Ms. G's untreated depression and her underlying post-traumatic condition resulting from child sexual abuse were barriers to the care team's effort to engage her in behaviors essential for the effective management of diabetes. Her health was not improving and much of the care team's effort was unproductive. The behavioral health team's intervention reduced that barrier, and allowed the care team's efforts to have their intended outcome.

Implementing Integrated Behavioral Health Care

This section presents a method and provides a tool that will enable a medical home to develop a customized behavioral health integration implementation plan reflective of its goals for integration and its current resources. This section begins with guidance on how to create a vision to guide the overall integration effort and concludes with strategies a practice can use to prepare for successful implementation of its customized pathway.

Create a Vision Statement

Creating a vision statement is an important first step for a practice's integration effort. Having a clear vision for what the practice wants to achieve through integration provides focus for the work and builds a shared understanding of purpose. A clear vision also helps foster communication and commitment among staff, and reduces risk for potential conflict among care team members on how to achieve goals.

Ask: How might our practice provide the most effective care for patients and meet patient outcome goals?

To begin, identify one or two individuals to lead the vision building process and to recruit additional team members. The team should include all staff who are involved in patient care, and administrative support staff as needed. The team should have a clear understanding of the basics of integrated care.

Some of the key features of a powerful vision statement include:

- A compelling reason for change.
- A picture of the future that appeals to the long-term interests of all stakeholders.
- A message that can be communicated easily.

A useful example of a strategic plan and vision comes from [Care South Carolina](#). More information about creating a vision is provided in the [Engaged Leadership Implementation Guide](#).

“Leaders can provide the vision and belief that this will make a difference. They need to be willing to step out in front, take financial risks, and use data to make the case.”

Ann Lewis, CEO, Care South Carolina



Questions to consider:

- Why do we want to implement integrated behavioral health care? Consider the different cases for integration: improved health outcomes, increased patient satisfaction, increased provider satisfaction, increased employer/purchaser demand, improved performance indicators, financial incentives for quality care, cost savings.
- How will integrated behavioral health care contribute to our existing PCMH efforts?
- How will we define behavioral health?
- What will be the scope of our integrated behavioral health program (e.g., number of sites, practices, providers, patients)?
- What services will we offer? To what services can we refer patients?
- What strengths do we think our practice already has to facilitate behavioral health care?
- What are our greatest hopes for implementing behavioral health care?
- What challenges do we anticipate in implementing behavioral health care?
- Is our organization ready for the disruption of adding a new process?
- What changes do we think we can actually accomplish?
- What resources (both personnel and financial) do we have to devote to this effort at this time?

Cherokee Health System Mission Statement:

To improve the quality of life for our patients through the blending of primary care, behavioral health, and prevention services.

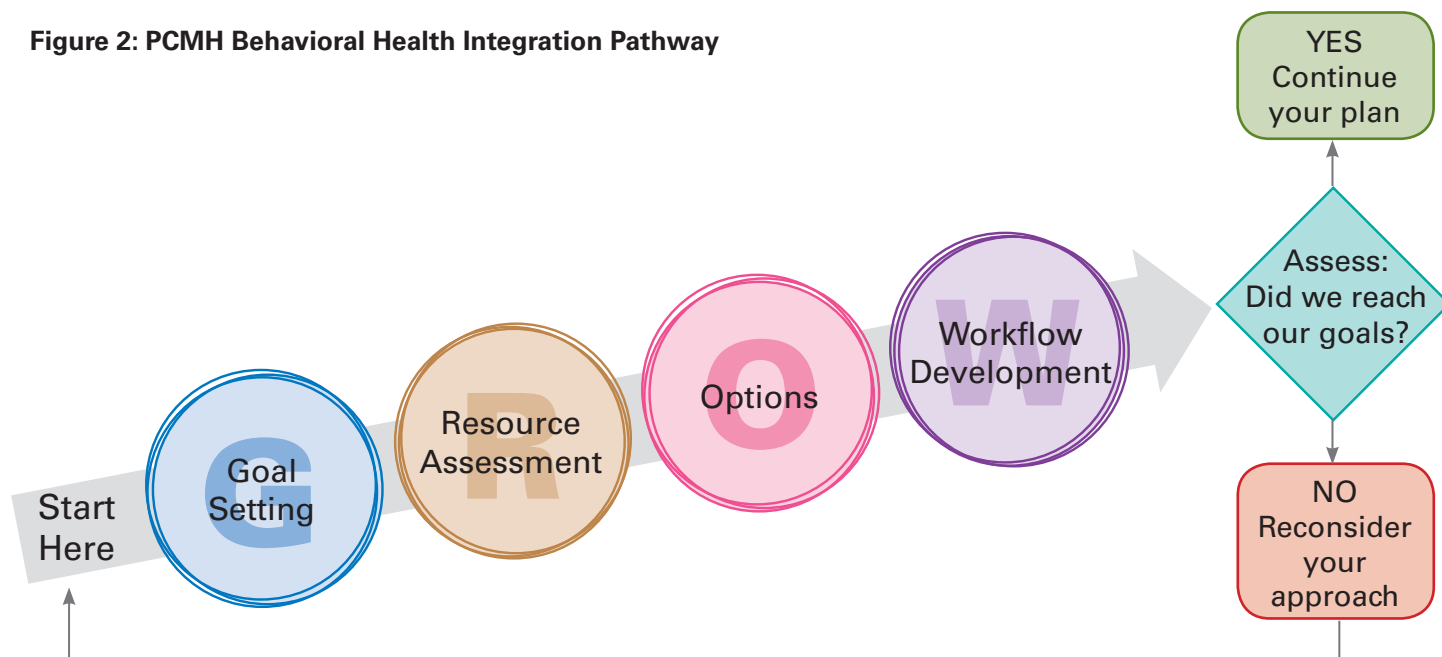
Develop a Pathway for Integration

Once a primary care practice has created a vision for its integration effort, it then needs to create a plan to define its approach for achieving integrated care. To do this, a practice must determine the following:

- Goal:** Which population(s) of patients will we target?
- Resources:** What resources are available to us? What resource challenges need to be addressed?
- Options:** What capacities do we have now and how can we create additional capacity?
- Workflow:** What changes will need to be in place to deliver integrated care?

Figure 2: PCMH Behavioral Health Integration Pathway is a visual representation of the method we present for defining an approach to achieve integrated care.

Figure 2: PCMH Behavioral Health Integration Pathway



This section includes a tool, the GROW Pathway Worksheet, which a practice can use to consider, discuss, and document its approach to integration. [A modifiable version of the GROW Pathway Worksheet](#) and [a completed example](#) are also available.

Goal Setting

Identify target populations

Consider the demographics of your patients and the types of clinical problems in presenting patients. Establishing a clear target population may help clarify which behavioral health integration capacities would be most helpful.

Questions to consider:

- What are the common behavioral health challenges faced by provider teams?
- What target populations must be addressed with a behavioral health integration effort?
- How do we prioritize the needs of these different populations in our organization?

Table 4: Setting Goals: Patient Populations to Consider

Patient Populations to Consider	
Patients in crisis and distress	Patients who present in acute distress often benefit from open access to on-site behavioral health care to help with connection to resources and management of safety concerns. If on-site services are not available, an organization will need strong connections to community resources. Patients often only need a few visits. Some patients may be identified with more chronic mental health disorders and will need transition support to connect to ongoing services.
Patients with common chronic mental illnesses such as depression and anxiety	Patients with chronic mental health conditions will benefit the most from proactive treatment. This includes identification, through assessment, measurement-based treatment-to-target and population level approaches, including the use of a registry. Access to expert consultation is often helpful to achieve optimal outcomes.
Patients needing support to manage serious, chronic, and persistent mental illness	Most primary care practices will need to work with outside organizations, such as community mental health centers, to help serve patients with serious mental illness. Targeting this population often involves using care coordination to facilitate referrals to community resources for mental health care while providing strong support to stay engaged in medical care with the PCP.
Other populations	Every practice will have a unique patient mix. Practices with a concentration of patients from a specific population may need to develop a behavioral health pathway to meet the unique needs of that population. Other populations to consider are: specific behavioral health disorders (such as substance use disorders), specific age groups (e.g., pediatric populations, geriatric populations), or patients with specific co-morbid medical diagnoses (e.g., postpartum depression and diabetes).

Resource Assessment

Identify organizational opportunities and challenges

Each practice will need to carefully consider available resources and anticipated challenges. Doing so may help identify the most realistic model or approach to adopt.

Table 5: Assessing Resources: Factors to Consider

Factors to Consider		
Geography	What other practices are nearby? How remote are the patients being served? Are there available community resources?	Clinics with close proximity to community resources may be able to leverage a strong referral process more fully than a remote clinic.
Physical space	Where are patients seen? Are the primary care providers seeing patients in the same part of the clinic? Is there space for collaboration and shared care planning? Are there physical barriers to sharing care?	Anticipating the need for in-person communication can strengthen a behavioral health integration effort.
Support of leadership	Are there champions for a behavioral health integration effort as part of PCMH transformation? Who needs to be included in decision making that is not yet convinced?	Early engagement of all members of the practice with integrating behavioral health can help a practice address barriers to transformation proactively.
Care team and workforce development	Are staff open to evidence-based approaches to integrated care? Does the practice have staff that can be made available for new workflows? Are there resources to hire new staff?	Integrated workflows will require staff to be open to changing the way they practice. Integrating behavioral health is a real job that will need dedicated staff time.
Shared workflows	Will community partners be willing to share care plans and records? Are there internal barriers to sharing care plans? Are there legal barriers? Are there cultural barriers?	Planning for a shared care plan that both medical and behavioral health providers can shape is critical to integrating behavioral health.
Available technology/ HIT	What technology resources are available? Are there barriers to sharing information? How will technology be incorporated into care planning?	Consider computers, Internet access, electronic medical records, e-mail, registries, dashboards, telemedicine capabilities and ease of access to quality improvement metric data.
Financial resources	What financial resources are available? For what services can the practice bill? Are there some costs that the practice is willing to cover for the availability of increased support around behavioral health?	Often there are early costs to starting a behavioral health integration effort. Expenditures may not be recovered until enough time or patient volume lowers other medical costs.

Options for Capacity

The first steps toward integrated care often involve building capacity within primary care in order to improve patient access. This can be accomplished by improving referral processes or by bringing a behavioral health provider on-site. Although these efforts are necessary to provide more integrated care, they may not be sufficient to achieve the improved outcomes, patient satisfaction, and lowered costs seen in more fully integrated care models, such as the Collaborative Care Model.¹⁸ In order to achieve improved quality of care, practices will likely need to consider workflow changes to enhance capacity for behavioral health accountability. As a practice considers its approach to achieving integrated care, it will be important to consider the options it has to improve both access and accountability.

Options to improve access

Refer to services with care coordination: All practices must have some capacity to provide referrals to services that cannot be addressed in primary care. Even if a practice has developed referral capacity, strengthening this process and making sure that patients who are referred actually engage in services can be an important target of improving behavioral health integration. Refer to the [Care Coordination Implementation Guide](#) for resources and tools on care coordination.

Create co-located or on-site behavioral health services: Adding an on-site behavioral health provider is a significant capacity-building step early in the integration process. This approach offers the advantage of patients not having to travel to an unfamiliar site

To deliver integrated behavioral health care, a primary care practice must have the capacity to provide patients with access to behavioral health services (access) and the capacity to assess, monitor, and improve health outcomes (accountability).

to receive behavioral health care. Providers may also be able to more easily address acute crises in the practice. However, co-location does not by itself result in integration and workflow for these on-site providers must be carefully considered.

Options to improve accountability

The ultimate goal of any type of health care is to improve health and well-being and to minimize discomfort and disability. For behavioral health care, the goal is to identify patients that need care and monitor those patients to ensure their treatments are effective and are having the desired effect (e.g., reduced depression symptoms). This approach, called measurement-based treatment-to-target, can be done on an individual level (single patient) or a population level (panel or patients).

Measurement-based treatment-to-target

for individuals. Providers use behavioral health measurement tools (e.g., PHQ-9) and proactively adjust treatment until targets are achieved for individual patients. This is an important strategy to manage chronic mental health disorders, such as depression and anxiety. Often this work is done in collaboration with an expert consultant to the primary care team. Supporting this work with a behavioral health provider serving in a care manager function can be an important intervention to maximize patient outcomes.

“I am a great advocate of decreasing barriers: There are no referral forms and we have made access very easy. We do warm handoffs from anyone on the team that sees behavioral health concerns; patients can sign up for an appointment themselves. I will see anyone who wants to see me for whatever reason.”

Susan Marie, PhD, Behavioral Health Medical Director, Old Town, Central City Concern

Measurement-based treatment-to-target for populations.

Most evidence-based integration approaches apply the measurement-based treatment-to-target approach to the entire patient population in combination with other system-level approaches, such as:

- Systematic screening of a target population to proactively identify patients in need of care.
- Use of a registry to track a defined population of patients with identified behavioral health needs.

Care management. A care manager supports routine screening to identify patients and a registry to track patients to make sure that all patients are proactively managed. Frequently this work is done in collaboration with an expert consultant to the primary care team. This approach has the strongest evidence for improving patient outcomes, patient and provider satisfaction and, over time, lowering costs.

Workflow Development

Assess current workflow to identify waste and gaps

The first step for building an integrated care workflow is to assess current workflow and staff responsibilities.

- Generate a list of tasks the practice will need to accomplish to provide integrated care (e.g., screen all patients for depression). This list should be tailored to the practice's specific vision and goals.
- Survey staff to identify their perceptions of current strengths and gaps relative to these tasks. For each task on the list, each staff member should respond to a series of questions designed to determine:
 - Which tasks are they doing now? Which tasks are other staff members doing?
 - How important is the task?
 - Would they like to do the task and what training is required for them to do this task?
 - Will the task ensure effective patient care by the team?
 - If not part of the individual's role now, whose role is it?

- Summarize results. The information in the summary can help pinpoint tasks that are not currently covered, tasks that are being duplicated, and staff and training needs. This overview can be used to start considering if and where workflow changes are needed.

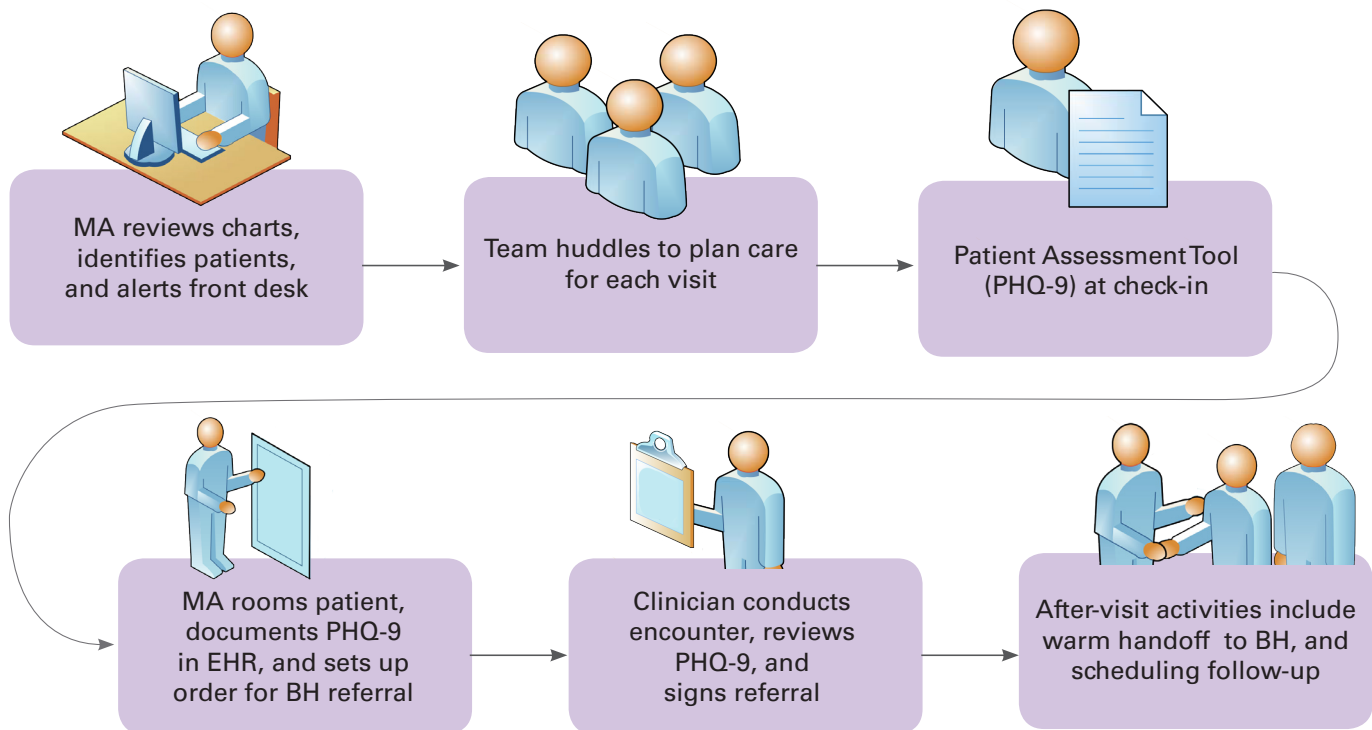
For an example template, see step 2 of the [AIMS Center Plan for Clinical Practice Change](#).

Develop an integrated care workflow

The detailed task list can now be used to inform specific clinical and operational workflows.

Questions to consider:

- Do staff need to be hired? What types of staff?
- Do existing or new staff need to be trained?
- What facilities, HIT, and other resources are required to implement the integrated workflow?
- What materials are needed to introduce the new care delivery pathway to patients and organization clinicians and staff?
- What internal communication materials and protocols, and clinic-specific guidelines and protocols for psychiatric emergencies are needed?
- How will visits be scheduled? Will follow-ups be interspersed with open access appointments to facilitate time for just-in-time consultations and warm handoffs?
- How will the physical space foster collaboration? Should providers share a pod?

Figure 3: Sample Workflow for Depression Screening in Primary Care

Workflow Redesign 101: Depression Screening Example

Workflow redesign means changing the process by which care is delivered with the intention of improving the result. Before making a workflow change, a practice needs to have a clear answer to the question, “What are we trying to accomplish?” In the case of integrated behavioral health, a reasonable answer might be, “We are trying to ensure that every patient with any one of a defined list of chronic conditions, including depression, on the problem list, has a PHQ-9 (a screener for depression designed specifically for use in the primary care setting¹⁹) performed as part of every ambulatory visit.”

As part of this quality improvement approach to behavioral health integration, a practice should have a way of measuring the percentage of patients in each of the defined populations whose care meets the desired goal. This allows the effectiveness of workflow changes to be easily assessed.

The primary care visit workflow for integrating behavioral health has to accomplish three things:

1. It must identify patients for whom a behavioral health assessment is indicated (in this example, a PHQ-9) and it must carry out the desired action.
2. It must ensure that patients who assess positive are treated appropriately (in this example, a referral and warm handoff to the behavioral health team).
3. It must not decrease the value of the visit to the patient, by distracting from higher priority issues.

A primary care visit is comprised of three main segments: the time before the provider enters the exam room, the time that that provider is in the exam room with the patient, and the time after the provider leaves the exam room. The job of the prepared, proactive practice team is to do as much of the behavioral health assessment as possible before the provider enters the exam room. This allows the provider to use his or her time with the patient to set the agenda for the visit, which may, or may not involve integrating information obtained during the behavioral health assessment process. Many of the actions dictated by screening will be things non-provider care team members can perform at the end of the visit. The goal is for the targeted behavioral health issue to be addressed before the patient leaves the clinic, without requiring the provider to remember.

Table 6: Sample Workflow for Depression Screening in Primary Care

Before the provider enters exam room	
Scrubbing the chart	Medical Assistant (MA) reviews charts and identifies patients with target chronic illness and finds their last PHQ-9, indicating patients followed by behavioral health providers.
The huddle	Care team decides which patients will receive PHQ-9 assessments and notifies the front desk.
After the patient checks in	Front desk gives the patient a paper PHQ-9 form to complete.
Rooming the patient	MA reviews the PHQ-9 with the patient, and enters it in the chart. If the score is above threshold, MA sets up orders for referral to behavioral health provider.
Provider in exam room with patient	
Provider discusses referral to behavioral health provider with patient and signs the order entered by the MA. Provider may decide to discuss a behavioral health issue based on PHQ-9 score.	
After the visit	
Warm handoff to someone on the behavioral health team. Referral processed.	

Figure 4: GROW Pathway Planning Worksheet

A [modifiable version](#) of this GROW Pathway Planning Worksheet and a [completed example](#) are also available.

Goal: Which populations of patients are we targeting?	
	Do we serve this population now? How do we want to serve this population better?
Patients in crisis and distress	
Patients with common chronic mental illnesses such as depression and anxiety	
Patients needing support to manage serious, chronic and persistent mental illness	
Other populations	

Resources: What are the resources available to us? What resource challenges need to be addressed?	
	What resources does our organization have?
Geography	
Physical space	
Support of leadership	
Care team and workforce development	
Shared workflows	
Available technology/ HIT	
Financial resources	

Options:**What capacities do we have now and how can we create capacity to integrate behavioral health?**

		Do we do this?	How can we do this?
Access	Facilitated referral		
	Onsite behavioral health provider		
Accountability	Measurement-based treatment-to-target for individuals		
	Commitment to population outcome improvement		

Workflow:**What changes will need to be in place for us to deliver integrated behavioral health?**

Do staff need to be hired? What types of staff? Do existing or new staff need to be trained?	
What facilities, HIT, and other resources are required to implement the integrated workflow?	
What internal communication materials and protocols, and practice-specific guidelines and protocols for psychiatric emergencies do we need?	
How will our physical space foster collaboration? Should providers share a pod?	
What materials do we need to introduce the new care delivery pathway to patients and practice clinicians and staff?	
How will we schedule visits? Will we schedule follow-ups interspersed with open access appointments to facilitate time for just-in-time consultations and warm handoffs?	
When and how will we evaluate our progress? What would be the next step if we don't reach our goal? How will we know we are not just going through the motions?	

Key Strategies for GROWing a Pathway

- Start somewhere; start small. You can't do everything for everyone all at once.
- Be specific in how any change will be implemented to maximize success.
- Your practice may need to start with a small target population and then gradually spread the improved process. "You don't want to turn on the faucet and find more problems than you can handle."
- Focus on evolution and continuous improvement. Fully integrated behavioral health often happens over time—it is a journey.
- Know and understand your population/community and their challenges and needs.
- Stress the goal of true transformation. One solid practice change with measureable outcomes is better than a large effort that does not result in improvement. Ask: How will your practice know it's are not just going through the motions?
- If your initial effort does not meet expected outcomes, consider implementing a more intensive approach.

Make Adjustments

No matter where a practice begins its integration effort, it must maintain a commitment to continuous improvement and enhancement of services. A practice might need to repeat the GROW cycle several times in order to achieve its stated goals.

Ask:

- When and how will we evaluate our progress?
- What would be the next step if we don't reach our goal?
- How will we know we are not just going through the motions?

We recommend using quality improvement strategies to inform the development and implementation of the behavioral health integration pathway. For more information and tools on quality improvement, including the Plan Do Study Act (PDSA) model to make small tests of change, see the [Quality Improvement Implementation Guide](#). To learn more about monitoring program effectiveness, continue to the next section.



Strategies to Prepare for Successful Implementation

Once the vision statement and integration pathway are established, it is important to share them across the whole practice in order to build engagement and shared understanding. In addition, consider the following strategies to prepare for success.

Develop an inclusive integration team

Ensure the team leading the integration effort includes physicians, nurses, behavioral health professionals, support staff, and IT staff.

Acknowledge the change

Integration will be a significant change for the entire practice and may present challenges. Plan to set aside time in provider and care team meetings to assess and build staff comfort with behavioral health issues in general.

Build and maintain engagement to battle change fatigue

Draw upon past experiences with previous change processes. What worked? What could be improved? Identify champions and engage them to foster excitement and commitment to the process. Identify vocal skeptics and identify and address concerns as part of the planning process.

Bridge the cultural divide

All major practice changes are challenging, but behavioral health integration presents an additional challenge: merging two cultures—primary care and behavioral health. Differences include the historical limited sharing of mental health notes in contrast to open shared workflow in primary care; formulation of patient diagnosis from a bio-psychosocial perspective by behavioral health providers in contrast to the biomedical model used by most primary care providers; and longer visits by behavioral health providers in contrast to the fast pace of most primary care practices. All members of the team, including the patient, will need clear orientation to the goals of integration as well as acknowledgement that this new way of working together might take some negotiation.

Monitoring Progress

Practices working toward integrated care should regularly monitor their progress and the impact changes are having on patients and families, staff, and practice operations. This section suggests targets a practice can use to gauge the impact of its integration efforts and identify opportunities for further improvement. For more information on quality improvement, data collection, and using data to drive decisions, see the [Quality Improvement Implementation Guide](#).

Quality improvement is a foundational element of the PCMH Model of Care. A commitment to continuous quality improvement is also a critical element of effective integrated behavioral health care.

“You must give behavioral health integration adequate planning time. Regular on-site meetings that include leadership help to sort out problems early with the decision makers present to resolve questions as they occur. This is the only effective way to work out the kinks as you work your way through the integration process.”

Janet Rasmussen, Director of Accountable Care and Behavioral Health, Clinica Family Health Services

Potential Targets for Monitoring Program Effectiveness

Clinical quality measures

- Number and proportion of patients screened for mental health and substance use disorders using validated screening tools.
- Number and proportion of patients with improvement in rating scales for behavioral health—for example, the proportion of empanelled patients with clinically significant decreases in PHQ-9 depression scores.

Practice transformation measures

- Number and proportion of patients enrolled in behavioral health panels.
- Access measures such as wait times for behavioral health visits.
- Number and proportion of behavioral health patients with avoidable ED utilization.
- Number and proportion of behavioral health patients with avoidable hospital admission or re-admission.

Experience measures

- Patient and family experience.
- Provider and staff experience.
- Measures of team communication.

For other examples, see page 92 of the [MHASD Healthcare Integration Report](#). This resource identifies and defines measurements for behavioral health improvement across a variety of domains including structured approaches, clinical processes, and patient outcomes.

Strategies for Monitoring Progress

Thoughtfully select measures

- Ideally, existing data sets should be designed to make data collection as easy as possible.
- Measure outcomes that can be compared with published literature in similar populations and settings.

Adjust targets over time

As the practice achieves its initial goals and pursues higher degrees of integration, targets should evolve.

Collect and share stories

Patient and team stories can help a practice assess the impact of integration on patients and families, and identify areas for ongoing improvement. Regular opportunities to collect and share stories should be incorporated into team meetings or huddles.

Patient and family stories can be powerful motivators. They can demonstrate need, impact, or improvement opportunities. Identify ways to collect stories from patients and families. View [Daniel's Story](#) for an example.

Creating an environment where it is safe to share stories of successes and challenges is critical, as it takes both examples to get an accurate assessment of team functioning. Sometimes a team will struggle or a challenging patient will need care. Often teams can learn just as much from a failure as from a success and creating a non-judgmental environment can help a team learn from challenging situations. Success stories can inspire the team to continue to invest energy in the hard work of integrating behavioral health. Teams can also use these stories to reinforce new ways of practicing by highlighting how integrated behavioral health was successful.

Share results with the team and community

Sharing data can help others understand the value of integration. Ideally, data and stories should be summarized to present highlights. Pay special attention to how data are displayed and discussed, as some members of the team or community may not be familiar with data charts or tables, or with behavioral health terminology.

Consider including whole-person outcomes as potential measures, such as patient-centered goal attainment.

Case Study: The Institute for Family Health Improves Suicide and Depression Detection, Tracking, and Treatment

Background

The Institute for Family Health is one of the largest community health centers in New York state, with more than 900 staff providing services for 450,000 patient visits annually, at 27 locations. The service area includes Manhattan and the Bronx in New York City, and the mid-Hudson river valley. Patients are racially, economically, and socio-culturally diverse; predominantly immigrating from Africa, Central and South America, and the Caribbean.

In 2010, several patients committed suicide. Staff members wanted to better understand how those patients seen in primary care had interacted with their providers prior to killing themselves, and whether they had been identified as suicidal at those visits. The goal was to identify any additional interventions that could have been provided to prevent a suicide attempt. According to Virna Little, PsyD, LCSW-R, SAP, Senior Vice President, Psychosocial Services and Community Affairs at the Institute for Family Health, staff wanted to better understand how to effectively engage depressed patients in shared care planning as a strategy to prevent suicide, and to use the information to train staff and family practice residents to effectively screen and address suicidal ideation.

Technology and tools identify and measure patients at risk

Because the Institute was already using an electronic health record (EHR) software program, there was interest in using technology to help identify patients with depression and with a history of suicidal thoughts so that these patients could be flagged and easily identified by all providers seeing them; the goal being to ensure that they were assessed and supported at every contact.

The practice uses the Patient Health Questionnaire (PHQ)-2 for annual screening and the PHQ-9 when depression is identified. The PHQ-9 can be repeated quarterly or semi-annually. The Columbia Suicide Severity Rating Scale is also used and documented in the patient's EHR. The scale was translated into a smart

form that is accessible in the patient's problem list. The data in the form are stored at a problem level until the problem is resolved, and are readily available for all members of the care team.

To help all members of the primary care team quickly identify if a patient is at risk for suicide, the EHR patient header is color-coded to red as an alert. This is done for all patients with an active diagnosis containing one of the following words: suicide, suicidal, self-harm, mutilation, or self-inflicted. This signals that these patients should be assessed at every visit to help ensure their safety.

Patients are monitored and assessed

For patients who are suicidal, Patient Safety Plans are signed by both patient and provider. The plans are accessible online by both providers and patients through the patient portal. Copies are given to patients as part of their after-visit summaries.

Depression and suicidal ideation are consistently assessed and monitored. Decision support tools and resources are also readily available. It is possible to graph the results of the PHQ over time, providing a strong visual to patients to demonstrate their progress in treatment, which can be very empowering. If there is no change in scores, it provides an avenue for the provider to discuss treatment approach and goals.

Staff training promotes better communication

A three-hour training session is mandatory for all non-clinical staff, including front desk, administration, and facilities staff so that all staff have basic skills to identify and address patients at risk for suicide. All clinical staff complete a two-day suicide first aid training, and are also trained in shared treatment decision-making with patients. The training helps improve patient-provider communication and ensure that patients feel heard and respected as safety plans are developed. The Improving Mood Promoting Access to Collaborative Treatment (IMPACT) evidence-based depression care management program is used.

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Lessons Learned

At the Institute for Family Health, implementing successful processes to detect, treat, and prevent suicide and depression was a high priority. Dr. Little acknowledges some important lessons that can help other practices as they carry out the same goals.

- Changing the practice culture is challenging. Champions and leaders must possess the skills and authority to bring people along, including board members; senior managers; and clinical and support staff; in order to infuse culture change everywhere.
- Don't underestimate the importance of training and the extent of training required to fully implement integration. Team care, psycho-pharmacology, how to write a billable note, and depression diagnostics are all elements to be incorporated into successful training programs.
- Find the right people to be champions. Just assigning someone is not effective, and placing the right person in the role can make a significant difference.
- Leaders have to remain tireless, focused, and fearless. Beware of competing priorities when trying to change the culture.
- Productivity is important, but assess capacity realistically. It is important to hire billable providers to work toward creating sustainable behavioral health services.

Special Considerations

Addressing social needs

One of the most common needs in a busy practice is to address the social issues that often contribute to suffering and make it difficult for patients to care for themselves. Common concerns include: unstable housing or homelessness, food insecurity, joblessness, domestic violence, social isolation, and other complicating factors (e.g., developmental delay, dementia). Each practice will need to determine how to address these common concerns.

Questions to consider:

- Will the behavioral health care manager address these needs for some patients or all patients?
- Are there additional social work resources available in your system to address these needs? How will these efforts be coordinated?
- Are there community connections that could be made to help address these needs (connections with food banks, local non-profits, domestic violence shelters, etc.)?

Vulnerable populations

Although common mental health disorders (like depression and anxiety disorders) are present at similar rates across cultural groups, minorities are less likely to receive needed care than are Caucasian populations; with disparities highest among those without private insurance.²⁰⁻²² Other sources of vulnerability often seen in safety net practices include food insecurity, unstable housing or homelessness, social isolation, severe mental illness, or co-morbid substance use.

Safety net populations have a disproportionately high number of individuals who have experienced an adverse childhood experience (ACE), and it is well established that such ACEs have long-term adverse effects on patients' health, social, and behavioral outcomes. Individuals who have experienced an ACE have high rates of mental disorders such as depression, anxiety, posttraumatic stress disorder, alcohol and substance abuse, and prescription drug misuse.²³ These high-risk populations may particularly benefit from an integrated program that addresses both health and behavioral health problems. Practices serving vulnerable populations should consider their unique needs and build a pathway plan that addresses those needs.

Pediatrics

Meeting the mental health needs of pediatric patients may need additional consideration and resources or even a separate integration pathway plan. Many states offer support to practices in delivering behavioral health services to pediatric patients through a phone consultation model. Research from the Partnership Access Line (PAL) Program in Washington State demonstrated that primary care providers used PAL for psychosocial and medication treatment assistance for particularly high-needs children and were satisfied with the service. Further, PAL was associated with increased use of outpatient mental health care for some children.²⁴

There is now a national network of the states providing this type of service. To learn more visit: [National Network of Child Psychiatry Access Programs](#) (NNCPAP).

Sample Consultation Programs:

- The [Massachusetts Child Psychiatry Access Project \(MCPAP\)](#) is a system of regional children's mental health consultation teams designed to help primary care providers (PCPs) meet the needs of children requiring psychiatric care.
- The [Maryland Behavioral Health Integration in Pediatric Primary Care \(B-HIPP\)](#) supports the efforts of primary care providers to assess and manage the mental health needs of their patients from infancy through the transition to young adulthood through four main components: phone consultation, continuing education, resource and referral networking, and social work co-location.
- The [Washington State Partnership Access Line \(PAL\)](#) program is a telephone based child mental health consultation system funded by the state. A resource guide for addressing common pediatric behavioral health needs is available on the program website.

Resources:

- NIHCM: [Strategies for Supporting the Integration of Mental Health into Pediatric Primary Care](#)
- NAMI: [Integrating Mental Health and Pediatric Primary Care. A FAMILY GUIDE.](#)
- SAMHSA-HRSA: [Integrating Behavioral Health and Primary Care for Children and Youth: Concepts and Strategies](#)

Serious and persistent mental illness (SPMI)

The focus of this guide is to facilitate the integration of behavioral health into primary care settings. However, equally important is improving access to good medical care for patients with SPMI who are cared for in community mental health centers (CMHCs).²⁵ For more information on this topic, review [Integrating Behavioral Health and Primary Care for Children and Youth: Concepts and Strategies](#).

Substance use disorders

Addressing substance use disorders in primary care settings will likely require a variety of approaches. There is evidence to support the effectiveness for both screening and brief intervention approaches (e.g., SBIRT) or for more comprehensive medication-assisted treatment for patients with alcohol or opioid addictions that can be provided in primary care.^{26, 27} Treatment for substance use disorders might need to be facilitated through a strong connection to local resources. Each practice will need to evaluate what level of service it can provide and which services will be addressed through referral. Below are several resources to help guide decision making.

Resources:

Treatment: [Addiction Treatment Providers Working with Integrated Primary Care Services](#)

CADCA (Community Anti-Drug Coalitions of America) and the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) developed Coalitions and Community Health: [Integration of Behavioral Health and Primary Care](#)

- [Screening, Brief intervention, and Referral to Treatment \(SBIRT\)](#)

SBIRT screens for all types of substance use conditions. The SBIRT process provides information and assistance in conjunction with an individual's lifestyle and basic needs. CIHS provides numerous resources on SBIRT and topics related to SBIRT.

- [Medication Assisted Treatment \(MAT\)](#): The use of medications, along with counseling and behavioral health therapy, creates a whole-person approach to the treatment of substance use disorders. CIHS provides various resources on MAT and topics related to MAT.
- [Tobacco](#): According to a SAMHSA report, adults aged 18 or older who experienced any mental illness or who have had a substance use disorder in the past year are more likely to smoke and to smoke more heavily than others. CEBP provides various resources on tobacco cessation and topics related to tobacco use.²⁸

Building Integrated Care Teams

Providing integrated behavioral health care requires the development and ongoing support of a well-coordinated integrated care team. Strong teams share several common features, described in more detail in the [Continuous and Team-Based Healing Relationships Implementation Guide](#):

- Clearly defined roles and responsibilities.
- Training to inspire confidence in self and others.
- Opportunities for communication and relationship building.

This section presents strategies and tools of particular relevance for integrated care teams.

Care Team Roles

All staff can contribute to integrated care. Some team members will provide direct care while others will provide critical forms of support. The following is a list of members of the care team and a brief description of their role and functions.

Direct care team members

- **Actively engaged patient:** The patient who is actively participating in his/her care and responsible for actively working with the primary care provider and care manager to achieve collaboratively set goals in a care plan and tracking clinical progress. In some cases, a family member or caregiver may also play a part in this role, especially for pediatric patients or those who may not be able to fully engage in their own care due to illness or other factors.
- **Engaged primary care provider:** Usually a family physician, internist, nurse practitioner, or physician assistant who has been oriented to the integrated behavioral health transformation. Typical responsibilities include making an initial diagnosis and initiating treatment, often psychopharmacological treatment or referral for behavioral mental health care.



- **Behavioral health provider:** A behavioral health care manager (CM) (in some practices also called a Behavioral Health Professional [BHP] or Behavioral Health Consultant/Counselor [BHC]), such as a nurse, clinical social worker, or psychologist, who is based in primary care. This role has two main responsibilities that may be delivered by one person or split into two different jobs. There is no one correct way to structure this role, but ideally BOTH roles will be covered.
 - **Care management:** Coordinates the efforts of the integrated mental health team. Provides patient support, tracks patient care (including supporting treatments such as medications initiated by the primary care provider), and facilitates referrals.
 - **Behavioral interventions:** Ideally evidence-based therapy interventions, such as Problem Solving Treatment and Cognitive Behavioral Therapy are delivered in the primary care setting by a trained practitioner.
- **Provision of psychiatric expertise:** In an integrated behavioral health team, psychiatric expertise can be spread over a population to provide more input to more patients by combining direct assessment (seeing patients for consultation encounters) and indirect assessment (consulting to the care team without seeing the patient).
 - **Psychiatric consultant:** A psychiatric prescriber, typically a psychiatrist or psychiatric advanced registered nurse practitioner (ARNP), who advises the primary care treatment team with a focus on patients who present diagnostic challenges or who are not showing clinical improvements.
 - **Other options:** Although it is ideal to have a psychiatric prescriber as part of the team, in some organizations this is not possible. This function can be filled with a primary care provider who develops a deeper expertise with psychiatric prescribing and consultation services.

Supporting care team members

- **Front desk staff:** This is often the first person a patient will encounter and often the person that explains to a patient how all practice systems work. It is particularly important that front desk staff are engaged and understand the integration effort. Typical roles may include introducing behavioral health care and distributing screening instruments.
- **Medical Assistant (MA):** As a core member of the primary care team, this team member is often the first provider that a patient engages with during a visit. Typical roles include administering mental health screeners (such as the PHQ-9) as part of general vital sign measurements. An MA may also play an important role in introducing the integrated behavioral health team.
- **Peer support specialists:** Trained patient peer support specialists who engage and support patients has developed from a successful model in community mental health centers. There is emerging interest in developing a role for peer support team members in the PCMH. For more information, see [Peers for Progress](#).

“We carefully selected behavioral health providers who were adaptable, flexible—who were comfortable being visible and comfortable in approaching providers with offers of assistance. Then when they were invited to see a patient, they would just do it.”

Janet Rasmussen, Director of Accountable Care and Behavioral Health, Clinica Family Health Services

Strategies for Building Strong Teams

Make patients and families active members of the care team

Whatever your approach for achieving integrated care, it will be important to orient the patient to their role on the team and introduce the other team members and their roles, especially the role of the primary care provider as the prescriber of medications and the care manager as a resource for behavioral health support.

Proactively address staff concerns

Concerns about scope of work and licensing issues are common, especially early on in the integration process. It is important to address and acknowledge the limits of each professional's scope of practice while at the same time encouraging team members to consider stretching their skill sets to facilitate effective collaboration. For example, a care manager from a social work background can be asked to use behavioral skills around medication adherence. He or she should be familiar with the names and common doses of psychotropic medications, but should defer questions related to medication side effects, dose changes, or other direct prescribing questions to the primary care provider or psychiatric consultant. The goal is to ensure that all staff are comfortable with their own skills and have trust in the skills and abilities of other members of the integrated care team. For more on training resources, refer to [Training for Integrated Care Delivery](#).

It is particularly important to address any PCP concerns—especially the concern that offering behavioral health care will equate to more work. Providers should be reassured that offering integrated care can result in efficiencies and that it will help them provide even better care for their patients. PCPs may also benefit from training in how to work with care managers effectively.

Engage staff members

One of the most important steps in team building is to think about members of the team that may not be direct care providers but will play critical roles in the success of the integrated behavioral health program. Consider training and educating all staff about the vision and goals of the program. For example, if routine screening for depression is part of your program, the front desk staff will play a critical role in completing this task. You may need to provide training and education on why this intervention is important as they will be both the person to distribute forms and answer initial patient questions about the form.

Find the right partners

Ideally, a partner (e.g., referral source) should be invested in the vision and goals of the practice's behavioral health integration effort. The physical location of the provider or group may be less important than the lines and effectiveness of communication between the primary care practice and the outside behavioral health provider. Using primary care practice staff to support communication, track referrals, and develop relationships between staff in primary care and behavioral health specialty care programs may be an additional role for your organization to consider. Regular meetings between primary care and mental health specialty providers to examine and improve partnerships and interactions can be very helpful, especially early on.

Hire the right staff

Anyone who is part of an integrated care team should possess core attributes including: openness to learning evidence-based practices, enjoyment in and appreciation for collaboration, openness to feedback, and a willingness to change strategies when needed. This is particularly true for behavioral health providers, many of whom may not have been trained for practice in the primary care setting and may need support in order to partner effectively with primary care providers and support staff.

As you hire new behavioral health staff, consider ways you can gauge their commitment to providing integrated care. Attributes of ideal candidates and sample interview questions are provided in **Table 7: Attributes of Ideal Integrated Behavioral Health Care Team Members**.

Building integrated care teams can be challenging, in part because of the differences in training and philosophy among primary care and specialty behavioral health providers and staff. These barriers can be overcome with communication, training, and relationship-building. To learn more, review [Common Barriers and Strategies to Support Effective Health Care Teams for Integrated Behavioral Health](#).

“The most important groundwork is bringing in behavioral health providers who are committed to being active team members. Integrate them from the beginning to break down the silos so that the behavioral health providers are seen as full members of the team.”

John Muench, MD, Family Medicine Director of Behavioral Health; Myong O, LCSW; and Demetrio Sanchez, LCSW, Oregon Health and Science University, Richmond Clinic

Table 7: Attributes of Ideal Integrated Behavioral Health Care Team Members

Behavioral Health Care Manager	Psychiatric Consultant
This role requires a talented individual and most people hired or re-deployed for this position must be willing to be flexible and creative and able to engage effectively with their team members. This job is often a difficult transition for a behavioral health provider that has been working as a therapist full-time.	The ideal candidate embraces the uncertainty that is common in primary care consultation and appreciates that she may be asked to provide diagnostic and treatment recommendations for patients she has not examined personally.
Training: Typically MSW, LCSW, RN, MA, PhD or PsyD	Training: Typically psychiatrist MD/DO or psychiatric ARNP
Personal Attributes: <ul style="list-style-type: none"> Organized, persistent, creative and flexible. Willingness to learn, strong patient advocate. 	Personal Attributes: <ul style="list-style-type: none"> Creative and flexible, strong communication skills, ability to tolerate uncertainty.
Interview Tips: <ul style="list-style-type: none"> Consider using case scenarios to assess flexibility and creativity. Ask the candidate to describe a time they struggled in working with a co-worker and how they handled it to assess for ability to manage team dynamics. Ask about experience using brief behavioral interventions or work in primary care settings. 	Interview Tips: <ul style="list-style-type: none"> Does the candidate have experience in clinical leadership roles at the interface of mental health and the rest of health care? Does the candidate enjoy sharing, communication, and teaching? Assess if the candidate is comfortable working with, relying on, and sharing clinical duties with other health care providers.

Training for Integrated Care Delivery

Teams will need training on how to work together to provide integrated behavioral health care. They may also need training on new tools (e.g., administration of the PHQ-9) or clinical skills. Ideally, all members of the team should train together, even if they are learning different skills.

Critical components of training

Typical topics for training will include:

- Fundamentals of the PCMH behavioral health integration effort, particularly the practice's vision and goals.
- Proposed integrated care workflows.
- Team communication strategies, which are particularly important early in the integration effort.
- Clear processes for patient handoffs.

Some team members may need special training for their new roles. For example, the behavioral health care manager may need to be trained in brief behavioral interventions appropriate for primary care settings. There are many training resources available:

- The [AIMS Center](#) provides Job Descriptions (Care Manager and Psychiatric Consultant) as well as training materials for each member of the team.

Using a mock patient to test your workflow and team functioning may be a helpful exercise before integrated care is launched.

The “integrated care” huddle. A huddle is a communication technique that helps ensure all members of the care teams are prepared for the day. The behavioral health team members in the practice should consider starting their day by sitting in on the huddles of as many primary care teams as possible, making sure that over the course of the week they are in the huddles of each primary care team at least once. This strengthens personal relationships with the care team members, affords behavioral health team members a greater understanding of the scope of behavioral health issues in the patient population, and allows them to assess the strengths and weaknesses of the care teams in managing behavioral health issues.

The warm handoff. One of the hallmarks of an integrated care approach is that patients are offered a warm handoff to a behavioral health team member. This means the patient is introduced to the behavioral health provider, in-person, by the primary care provider or a member of her team. To learn more, view a [Demonstration of a warm handoff](#) by Sierra Family Medicine Clinic.

“It is important to hire and train behaviorists to avoid the cultural pitfalls and to understand the differences between primary care and behavioral health. This includes how we view teamwork, confidentiality, length of sessions, episodic vs. ongoing care, and outreach.” Susan Marie, Medical Director of Behavioral Health, OldTown, Central City Concern

Leveraging Success: Spreading and Sustaining

Sustaining the Integration Effort

Behavioral health integration is sustainable when integrated care becomes business as usual, and when patients and providers can't imagine primary care without behavioral health care. This section presents strategies a practice can employ to sustain the changes they have made to integrate care; and, if the original implementation effort was a pilot, to spread improvements to other teams, practices, or related organizations.

“Now that I am on this side of the world, I can’t go back. I don’t think the traditional model is most beneficial for patients.” Emily Vellano, LCSW, Behavioral Health Program Manager, Clinica Family Health Services

Strategies for Sustainability: Clinical, Operational, and Financial Factors

Take time for a team tune-up

Regularly assess team function in the domains of: shared goals, clear roles, mutual trust, effective communication, and measurable outcomes and processes. Take time for “tune-ups” as needed. Some practices use regular coffee breaks (where the team meets for a team building exercise such as an art project and/or coffee once a month) to help build the communication skills needed for successful behavioral health integration.

Address provider burnout

No matter how proactive a practice is in identifying and addressing staffing, partnership, training, and other resource needs, working in an integrated care team can be challenging and burnout is a common problem. Care managers (in their central roles requiring frequent communication with patients), PCPs, and psychiatric consultants, are particularly vulnerable. **Identifying ways for team members to support one another will help maintain a strong team. Consider opportunities to build support mechanisms for peers.**

Maintain leadership support

Leaders play a critical role in supporting the implementation and sustainability of integrated care. Leaders should continue to devote regular scheduled time to assess progress, develop quality improvement plans, and celebrate successes. Leaders should also continue to promote a clear vision for the behavioral health integration effort—and to refine it as the practice grows and changes. To learn more about how leaders can support transformation efforts, review the [Engaged Leadership Implementation Guide](#).

Prepare for turnover

Turnover is inevitable. Consider resources and tools that can help team members efficiently train new personnel with minimal disruption.

Continue to improve workflows

Clinical workflows need to be reviewed regularly. Consider using provider meeting time to walk through a typical episode of care. This can help the team identify care transitions or other ‘pain points’ that could become the focus of a quality improvement effort.

Consider financial impacts

Maintaining financial viability can be a challenge, especially in resource-limited safety net settings. Ideally, financial considerations should be addressed in the initial planning stages. Practices should pay attention to which provider types are billable, what visit types are allowable, and other factors that might impact payment for behavioral health services provided in the primary care setting. Practices have successfully implemented integrated care under a wide array of payment models, indicating that integration is possible even in restrictive payment environments.

- **Fully capitated:** The primary care organization is paid a set amount for all behavioral health care costs for each enrolled person assigned to them, per period of time, whether or not that person seeks care. The costs for the PCP, care manager, and psychiatric consultation would all be paid by the primary care organization out of this payment. Example: [VA Health System](#)
- **Partially capitated:** Typically a health plan will pay the primary care organization on a fee-for-service basis for billing providers (usually just PCPs) and a set amount for all behavioral health care management costs for all enrolled people assigned to them, per period of time. The psychiatric consultation may or may not be included in this payment. This can be paired with financial incentives around caseload size, outcome or other quality metrics.
- **Case rate payment:** The primary care organization is paid a case rate for all behavioral health care costs for each enrolled person assigned to them, per period of time, whether or not that person seeks care. The costs for care manager and psychiatric consultation would all be paid by the primary care organization out of this payment. Example: [DIAMOND Program](#)

- **Fee-for-service:** The primary care organization bills for each practitioner type for services delivered to generate funds to cover the costs related to behavioral health integration. Typically, PCP and psychiatric consultants will bill for patients treated in person. The care manager can bill for appropriate psychotherapy, case management services, and health and behavior visits (as permitted on a state-by-state basis). Resource: [Supporting Bi-Directional Integration Through Potential Billing Opportunities: State-Based Interim Billing Worksheets](#)

Recent changes with healthcare reform (Affordable Care Act) may provide new opportunities to pay for integrating behavioral health. To learn more, visit the following resources:

- [Financing and Sustaining Older Adult Behavioral Health and Supportive Services](#). This brief describes resources available to organizations that provide care for older adults and recommendations for building a business case when few resources are available.

Spreading Improvements

Piloting an integration effort allows a practice to test its change on a small scale and refine its program before implementing it system-wide. For practices taking the pilot approach, we offer the following guidance:

- Consider spread from the beginning. Some organizations include a spread plan in their initial implementation plan. Consider using [IHI's Spread Planner](#).
- Identify key leaders to develop and support the spread plan.
- Collect impact data. Use that data and patient success stories to inspire new care teams.
- Use the pilot team to coach others. Identify training and mentorship opportunities.

Conclusion

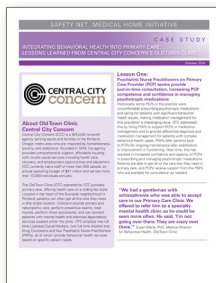
The goal of integrating behavioral health care in primary care is to provide better access, better outcomes, and better experience for patients, families, and caregivers—and also to improve the efficiency and operations of the primary care practice itself. The guidance, resources, and tools presented in this guide should help a practice begin the work of integration. Additional resources are provided in an annotated [Resource Guide](#). For lessons on integration from primary care practices already practicing integrated care, refer to the companion Case Examples:



[Dorchester House Multi-Service Center Integrates Behavioral Health into Adult Primary Care](#)



[Tiburcio Vasquez Health Center Adapts to Integrate Behavioral Health with Primary Care](#)



[Integrating Behavioral Health into Primary Care: Lessons Learned from Central City Concern's Old Town Clinic](#)



[At CareSouth Carolina, Behavioral Health Care Meets the Health Needs of the "Whole Person"](#)

HIT Appendix: Integrated Care Attributes and Corresponding Health Information Technology (HIT) Requirements

Jeff Hummel, Qualis Health

Health information technology (HIT) can be used to support integrated care in three primary ways: 1) to define goals, 2) to measure outcomes, and 3) to support interventions.

Defining the goals

Patient panels: The primary care team has a defined panel of patients. They understand the demographic composition and health status profile of their panel through clinical outcome reports and registry functionality. The organized, evidence-based care of a panel of patients starts by defining a sub-population and condition to be managed. For behavioral health, this would mean a panel report showing the number of patients with a problem list entry or some other marker for a behavioral health issue in the chart. The data to support panel management are encompassed in federal meaningful use requirements. They include provider/care team, demographic information, problem list, medication list, order entry and results reporting, among others. The health IT requirements for panel reports include a reporting database, reporting/analytic software, and a database analyst able to write, validate, and run the reports.

Evidence-based guidelines: The primary care team has an array of clinical quality standards to which they hold themselves accountable these include chronic illness process and outcome measures as well as preventive care measures. The efforts of a care team need to be aligned with the strategic priorities of the practice. Once the target is identified, the next step is to identify an evidence-based guideline to use as a standard for care, and translate the guideline into specific measurable actions. For behavioral health, a practice might choose to focus on adult patients with a diagnosis of depression. In that case, the effort might be based on the 2009 NICE guideline for depression, translated into an action standard stating that every patient with depression as a primary encounter diagnosis will have a PHQ-9 performed during that encounter, have their PHQ-9 score followed on subsequent visits, and be offered a visit with a collaborative behavioral health team member in the practice.

Measuring current outcomes and monitoring improvement

Clinical quality measurement: The care team has to be able monitor reports showing the outcome measures they are achieving compared to the goals they have set for each measure. These reports identify individual patients whose care needs to be addressed in order to close a gap. The primary care teams and the behavioral health team will decide which reports they need in order to manage the population and the conditions the collaborative model is intended to improve. These reports will require defining the denominator, which in the case of depression might be any patient with a diagnosis of depression on the problem list. There may be patients taking anti-depressants for whom depression is missing from the problem list, and one of the tasks will include designing reports and workflow processes to identify find such patients and update their charts to ensure they are included in the outcome reports. There are many reports a PCMH might find useful. Examples include:

- Of those patients with a recent office visit for depression, how many have a PHQ-9 and a referral to the behavioral health team associated with the visit.
- Of those patients with a PHQ-9 score greater than 10, how many have scheduled a follow up visit (including telephone or electronic visit) with the primary care team.
- Of those patients with specific chronic illnesses such as diabetes, how many have been assessed for depression using a PHQ-9.
- Of those patients with complex mental health conditions such as bipolar disease or dementia, how many have seen the behavioral health team in the past year.

This requires the PCMH to identify a set of process and outcome measures for each population and condition the integrated care team is expected to manage collaboratively. Clinical quality reports need to be written and validated showing the care team's and practice's performance compared to the goal for each process and outcome measure selected. Whereas the primary care team is accountable for the outcomes of its panel, the population that the behavioral health team manages will likely be the entire population of the practice.

If, for example, the initial target is depression in adults, the behavioral health team might have the same goals as the primary care teams focusing on measuring and showing improvement with treatment of PHQ-9 scores for the entire practice. The behavioral health team would then be encouraged to support the primary care teams in treating all patients including those who are not referred to behavioral health. The behavioral health team might do this by responding to advice calls and curbside consults from the care teams as well as providing training in depression management directly to the primary care teams.

Supporting the intervention

Communication tools: HIT can support collaboration between the primary care and behavioral health teams by improving the ease of communication. This requires easy access to each other's records, preferably using a common electronic health record (EHR) platform. Concerns that behavioral health records require special security are unfounded because HIPAA laws have created a common high standard for privacy and security for both records, and explicitly permit the sharing of records between providers for treatment purposes.

Substance use: Primary care teams increasingly screen for chemical dependency with standard questions using the [SBIRT protocol](#), in which patients with drug or alcohol issues are encouraged to see a social worker in the practice for an initial assessment, and if appropriate, a referral for treatment. In some states, patient consent is required before medical records pertaining to chemical dependency can be shared with other providers, even in the same organization. Many practices keep chemical dependency records separate to avoid inadvertently releasing those records by mistake. All of the questionnaires used in the SBIRT program can be set up as data entry forms for use by primary care and behavioral health teams, and the information stored for both clinical and program management purposes should comply with state law.

Common meetings: The behavioral health team should meet regularly to plan and adjust the way they treat patients and support the primary care teams to meet common strategic goals. The primary care huddle is facilitated by several views of data in the EHR that are used to prepare for and conduct a huddle. The most important of these are the overview of the schedule for the day, and a "snapshot" view of the chart for each patient on the schedule that includes the problem list, medication list, preventive care gaps, and a view of the most recent chart note.

Clinical decision support tools: There are many kinds of clinical decision support (CDS) tools in EHRs that lend themselves to supporting a collaborative behavioral health model. Among such CDS tools are data entry forms (PHQ-9, GAD 7 and Mini-Mental Status) and templates that simplify the entry of critical information. Other types of CDS include data display tools, such as flow sheets and graphs to view data over time; order and prescription facilitators, such as dosage guides and referral check lists; protocol pathway support for making the guideline-based actions transparent to everyone, including the patient; reference information and guidance for complex questions; and finally, alerts to remind providers of risks such as medication interactions.

CDS tools are becoming increasingly sophisticated in EHRs, and need to be carefully integrated into planned workflows to get the right information to the right person at the right time, using the right medium and organized the right way. Other more validated tools may be available for identifying complex behavioral health problems including bipolar disease, dementia, post-traumatic stress disorder, psychoses, attention deficit disorder, and social disorganization to help the primary care team quickly identify patients with these conditions, and facilitate involving behavioral health providers early in their care.

The warm handoff: The warm handoff should be accompanied by a formal referral to behavioral health in the EHR. Categorizing the warm handoff in this way provides structured data for monitoring and a mechanism to standardize communication processes between the primary care and behavioral health teams including referral tracking. As with any referral, it will include the reason for referral and a continuity of care document. The behavioral health evaluation should be entered in the patient's chart and returned to the primary care team as a "resulted" order, marking a completion of the referral.

Care summary: Chart notes entered in the patient record by the primary care and behavioral health teams must be visible to both care teams and to the patient. EHRs document care in individual encounters notes over time often separated weeks, months, or even years making it a challenge to quickly understand the long term disease trajectory of chronic disorders. Both primary care and behavioral health teams need to agree on a single place in the EHR to record and quickly review the essential features of a chronic behavioral health issue. There are several options for doing this. EHRs increasingly include features such as a disease specific care plan and a continuity of care document (CCD), which can be used for behavioral health issues. Problem lists frequently allow a short synopsis to be written for each entry on the problem list including important milestones for the condition.

Ongoing primary care involvement of collaboratively managed patients: In the Collaborative Care Model, the primary care team continues to manage the medical aspects of behavioral health issues for patients, including laboratory tests to monitor blood levels and side effects of psychiatric medications. Behavioral health team members are encouraged to make personal contact with the care teams of patients they see during the day to share updates. Results of blood tests ordered by behavioral health team members need to be copied to the primary care team. Behavioral health team members without authority to sign orders can pend those orders and send them to the primary care provider to sign.

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Recommended citation: Safety Net Medical Home Initiative. Ratzliff A. Organized, Evidence-Based Care Supplement: Behavioral Health Integration. Phillips KE, Holt BS, eds. Seattle, WA: Qualis Health, MacColl Center for Health Care Innovation at the Group Health Research Institute, and the University of Washington's AIMS Center; 2014.

Featured in: *Safety Net Medical Home Initiative Implementation Guide Series*. 2nd ed. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute; 2013.

This implementation guide supplement was generously funded by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

Primary author Anna Ratzliff, MD, PhD (Assistant Professor, Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine) gratefully acknowledges the contributions of the Project Team: Jurgen Unutzer, MD, MPH, MA (AIMS Center, University of Washington); Jonathan Sugarman, MD, MPH (President & CEO, Qualis Health); Ed Wagner, MD, MPH, MACP (Director Emeritus, MacColl Center for Health Care Innovation); Kathryn Phillips, MPH (Program Director, Qualis Health); Jeff Hummel, MD, MPH (Medical Director, Qualis Health); Diane Altman Dautoff, EdD (formerly Senior Consultant, Qualis Health); Bre Holt, MPH (Project Specialist, Qualis Health); Tess Grover (AIMS Center, University of Washington).

Case examples provided by: Susan Marie (Old Town, Central City Concern), Ann Lewis (CareSouth Carolina), Laura Santel (Dorchester House Multi-Service Center), and Margie Burton (Tiburcio Vasquez Health Center),

Interviews conducted with: John Muench (OHSU Richmond Clinic), Virna Little (The Institute for Family Health), Dennis Freeman (Cherokee Health Systems), Janet Rasmussen (Clinica Family Health Services), Kristen Meisinger (Union Square Cambridge Health), Erin Hafer (New Programs Integration Community Health Plan of Washington), and Debra Morrison (Neighborcare).

Technical Advisors: A Technical Advisor Panel identified resources and tools. Advisors included representatives from the nation's leading medical associations, behavioral health organizations, academic institutions, community health centers, private and public health systems, and others. Gale Bataille, MSW (Emeritus County Behavioral Health Director and Consultant for the California Institute for Behavioral Health Solutions and the Integrated Behavioral Health Project); Chris Collins, MSW (Director, North Carolina DHHS, Office of Rural Health and Community Care); Laura Galbreath, MPP (Director, SAMHSA-HRSA Center for integrated Health Solutions, National Council for Behavioral Health); Alan Glaseroff, MD (Co-Director, Stanford Coordinated Care, Stanford School of Medicine); Charles Ingoglia, MSW (National Council for Behavioral Health); Virna Little, PsyD, LCSW-r, SAP (Senior Vice-President Psychosocial Services/Community Affairs, The Institute for Family Health); Benjamin F. Miller, PsyD (Director of Health Policy, Department of Family Medicine, University of Colorado School of Medicine); Harold Alan Pincus, MD (Professor and Vice Chair; Department of Psychiatry, College of Physicians and Surgeons, Co-Director; Irving Institute for Clinical and Translational Research, Columbia University); Kenneth S. Thompson, MD (Pennsylvania Psychiatric Leadership Council); Eric Van Houten, MCSW (formerly with Community Health Centers of Lane County); Mark D. Williams, MD.

Reviewers: An Expert Review Group provided valuable feedback and improvement ideas on early drafts of the supplement. Reviewers included representatives from the nation's leading medical associations, behavioral health organizations, community health centers, public and private health systems, academic institutions and policymakers and patient and family advocates. Martin K. Abdo (Certified Peer Specialist, Harborview Mental Health and Addictions Services); Johann Channin, RN, MSN, PCMH CCE (Director, Policy, Recognition Programs, National Committee for Quality Assurance (NCQA)); Lisa Chew, MD, MPH (Harborview Medical Center); Andrea R. Fox, MD, MPH (Chief Medical Officer, Squirrel Hill Health Center); Daniel Lessler, MD, MHA (Chief Medical Officer, Washington State Health Care Authority); Elizabeth Lever, LMSW (Director of Business Planning and Development, Psychosocial Services, Institute for Family Health); Benjamin F. Miller, PsyD (Director of Health Policy, Department of Family Medicine, University of Colorado School of Medicine); Debra Morrison (Behavioral Health Program Manager, Neighborcare Health); Mary Jane Nealon, RN, MFA (Partnership Health Center); Charla Soriano, MSW, LICSW (Harborview Medical Center, Pioneer Square Clinic); Kenneth S. Thompson, MD (Pennsylvania Psychiatric Leadership Council); Eric Van Houten, MCSW (formerly with Community Health Centers of Lane County); and Mark D. Williams, MD (Assistant Professor of Psychiatry and Psychology, Integrated Behavioral Health, Mayo Clinic).



MacColl Center for Health Care Innovation



Safety Net Medical Home Initiative

The Organized, Evidence-Based Care Supplement: Behavioral Health Integration is a component of the *Safety Net Medical Home Initiative Implementation Guide Series*.

The goal of the Safety Net Medical Home Initiative (2008-2013) was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon, and Pittsburgh), representing 65 safety net practices across the U.S. The partner sites and Regional Coordinating Centers that participated in the SNMHI were members of a learning community working toward the shared goal of PCMH transformation. The *SNMHI Implementation Guide Series* was informed by their work and knowledge, and that of many organizations that partnered to support their efforts.

The SNMHI was supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The Initiative also received support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center.

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