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Advancing the Integration of Behavioral Health in Primary Care

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Integrated behavioral health (IBH) in primary care is shown to improve access and health outcomes for those with mental health conditions, and can help maximize valuable, yet scarce, mental health resources.

To further advance IBH, MN Health Collaborative partners have adopted a common framework which includes both key evidence-based elements needed for improved outcomes *and* how it can be adapted to meet local needs.

Summary

There is a high need and urgency for treating patients with mental health needs in Minnesota, yet there are not enough services or providers to meet the needs *(see sidebar).*

Given the fact that most patients initially present for mental health conditions in a primary care setting *(Kilbourne, 2018)*, providing care for patients with mental health concerns in primary care makes sense for many people. Decades of research and numerous randomized controlled trials have shown that patients who receive this type of care obtain better health outcomes, have higher satisfaction with care and have lower costs *(AIMS Center, 2014).*

In addition, patients consistently report that they prefer to receive care for mental health conditions in a familiar setting such as their primary care clinic, rather than attending a specialty mental health center *(Moise, 2018).* One-third to one-half of primary care patients will refuse referral to a mental health professional; meanwhile, many others do not go to their appointment when a mental health referral is made *(Moise, 2018).*

A robust integrated behavioral health program in primary care expands the continuum of care. It promotes improved alignment of mental health services with medical needs, improves access to mental health services, allows for more targeted referrals to mental health specialty care, enhances primary care, and promotes greater satisfaction among both patients and providers. Task sharing within primary care teams, particularly related to behavioral therapy and self-management education, has been shown to reduce burnout in primary care providers *(Kim, 2017).*

Up to one in five Minnesotans, both children and adults, experience mental health illness. (MDH, 2017)

Half of Minnesotans with mental illness are not receiving any treatment Nationally only 25% of patients receive effective mental health care, including in primary care settings. (Unutzer, 2013)

Access to high-quality mental health services is severely limited across the state, particularly in rural areas and for children. (MDH, 2017)

While Minnesota has been a national leader in integrating behavioral health into primary care, the benefits of IBH have not been fully realized. Competing models of care, lack of clarity regarding necessary key elements, inconsistent insurance coverage, complex billing requirements, workforce shortages and continuing stigma have all contributed to limiting complete integration of behavioral health in many primary care settings.

In recognition of these significant needs and challenges, MN Health Collaborative partners have come together and adopted a shared framework for IBH to improve access and care for mental health needs in primary care. This framework, based on the Integrated Behavioral Health Agnostic Framework developed by Stephens et al. includes:

- evidence-based processes and structures needed to improve outcomes
- implementation guidance allowing adaptation for local needs
- specific integration stages to support clinics' ability to build toward full integration over time

The recommendations in this Call to Action continue to be implemented and tested in real-world settings as organizations advance IBH. Because IBH is a population-based approach in a fee-for-service world, the MN Health Collaborative is also collecting strategies to enhance financial sustainability of behavioral health integration, as well as measurement for outcomes. Preliminary discussion regarding IBH measures have been initiated. Results and lessons from this work will be shared.

Definition: Integrated Behavioral Health

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 health care utilization.

(Peek, 2013)

Background

Minnesota has been at the forefront of integrating behavioral health in primary care since 2009, with the ICSI-led DIAMOND initiative. This work resulted in widespread adoption of the PHQ-9 to screen for depression, and adoption of a depression care measure for statewide reporting through Minnesota Community Measurement (this measure was later adopted and is currently used by National Quality Forum (NQF); however, Minnesota Community Measurement's recent Depression Care in MN Report shows limited improvement in depressions outcomes *(Snowden, 2018)*.

MN Health Collaborative IBH working group members believe that full integration of behavioral health into primary care has been hampered in Minnesota by a number of systemic issues:

- Organizational structures often separate mental and physical health, limiting opportunities to co-create new models of care addressing the whole patient.
- Primary care teams have different beliefs regarding the importance of IBH. Meanwhile, mental health leaders may see it

as an attempt to replace specialty mental health services, rather than expanding a continuum of mental health care.

- Discerning the specific elements of a care model that affect outcomes has been difficult, and there is disagreement regarding which model of care supports the outcomes seen in the IBH literature. There is more empirical research on collaborative care versus primary care behavioral health *(Kroenke, 2017)*.

- A significant strength of well-delivered IBH is early intervention for mental health problems, which can reduce patients' time away from work, prevent use of higher cost services, and improve management of medical conditions. However, successful prevention of future problems is difficult to prove or obtain insurance reimbursement for.

- Financial coverage/payment for some of the IBH services is unclear or varies by insurance type, coding requirements are complex, and current reimbursement does not fully cover the cost of services. Fee-for-service billing systems do not support indirect services aimed at raising the capacity of the primary care system.

- There are too few mental health professionals and care managers who understand and are trained in collaborative care models vs. specialty mental health models.

- Clear information and options are not often provided to patients about possible models of care delivery so patients aren't able to access improved integration of care. In addition, stigma or fear of stigma still prevents some people from seeking care for mental health conditions.

- Organizations intending to integrate often start out with a co-location model due to the fee-for-service payment structure and limited resources. However, this choice can lead to defending and remaining in basic co-location without sufficient integration, which does little to improve access overall or raise capacity among the primary care team.

Building a Path Forward

As the MN Health Collaborative partners examined the issues and potential opportunities around IBH, they recognized a need to have a common definition and framework in order to make progress toward their shared goal of improving access and outcomes.

The Collaborative found that organizations were using different care models and had differing beliefs about the key elements needed to define and build fully integrated behavioral health. While the models in use all had an evidence base, there were also local variations based on available resources, staff, and patient populations. It was unclear whether these variations decreased or increased the effectiveness of their IBH initiatives.

The group conducted a literature review, a national environmental scan, and review of local practices, with the goal of discovering or informing the development of a framework for advancing IBH that all could adopt, meeting these criteria:

- Supported by current evidence showing improved outcomes, access and experience of care (both patient experience and provider experience).
- Supportive of local variation (not restricted to a single model of care) while clear on required evidence-based elements (fidelity).
- Supportive of a progressive approach over time, with defined stages.
- Specific enough to provide implementation guidance, whether starting anew or advancing an existing model.

Through this review the group identified several potential frameworks, including the CJ Peek and colleagues (2013) Lexicon for Behavioral Health and Primary Care Integration, a systematic effort to comprehensively describe IBH regardless of method of integration; and the SAMSHA model CIHS' Standard Framework for Levels of Integrated Healthcare *(Korsen, 2013)*. The Collaborative identified, reviewed, and discussed several frameworks, models, and resources during their work. Please see these additional links for consideration. [See Appendix C]

The national scan linked the MN Health Collaborative with Kari A. Stephens, PhD and her Patient Centered Outcome Research Institute (PCORI) funded research team, who are undertaking a project with similar goals. The Collaborative engaged with the research team to provide input into the evolving framework [publication pending]. This partnership resulted in MN Health Collaborative adopting Stephens and colleagues' Integrated Behavioral Health Agnostic Framework.

The IBH Agnostic Framework draws from the CJ Peek Lexicon, and the SAMSHA model, as well as the four most common models: Collaborative Care, Primary Care Behavioral Health, Co-Location, and Behavioral Medicine. The framework names key principles, structures and multiple specific supporting practices that correlate with improved outcomes and can be implemented regardless of the specific IBH model currently in use.

The MN Health Collaborative organizations each conducted validated Site Self-Assessment surveys adapted from Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey (Scheirer, 2010) to more clearly understand their primary care sites' level of integration in relationship to the Agnostic Framework, and are using this tool to assess progress in integration over time.

Recommendations

1. **MN Health Collaborative partners recommend using the Integrated Behavioral Health Agnostic Framework [based on Stephens, 2018] to implement IBH in primary care, and when designing changes to current IBH care delivery models**.

   Using this research-based framework enables adoption of key elements that improve outcomes, while also allowing for local adaptation and the use of different care models. The Agnostic Framework identifies key principles needed for successful outcomes, has multiple supporting clinic processes, and supports progressive steps to fully realized integration. See **Appendix A** for the full Framework.

   In short, the five principles are:

   1. **Patient-centric care:** Ensure patients are well engaged with the entire care team, understands the various roles for themselves and their providers, and are supported and guided to manage their lives, health, and treatment.

   2. **Treatment to target:** Ensure clear goals and measures are defined to guide and track care.

   3. **Use of evidenced-based behavioral health treatments:** Ensure the best evidence-based care is used across medical and mental/behavioral care.

   4. **Conduct efficient team care:** Ensure integrated behavioral healthcare is efficient and comprehensive, supported by appropriate policies and procedures.

   5. **Population-based care:** Ensure limited services reach the most patients while targeting the patients most in need.

   The Integrated Behavioral Health Agnostic Framework also identifies nine core structures:

   1. Effective fiscal strategies.

   2. Administrative support and supervision.

   3. Regular review of provider and clinic level outcomes for quality improvement.

   4. Shared access across electronic health record systems.

   5. Reasonable and appropriate work space.

   6. Qualified behavioral health providers.

   7. Protected time to review and manage caseload.

8. Patient panels are monitored in order to drive care improvements.

9. Tracking system for panel management.

Source: Stephens et al., 2018

2. **Full integration should be the goal as the optimal form of care.**

It is also expected that practices need to mature towards full integration over time, especially with significant systemic limitations remaining.

- In the literature, fully integrated physical and mental health care models are the ones which have shown to improve outcomes. These models have been extensively studied and successfully implemented in varied settings for more than 20 years *(Butler, 2008)*.

- Optimal integration may vary in different organizations, considering a clinic's patient population, existing structure and roles, available staffing and other resources.

Full Integration – What Does It Look Like?

- *shared reception area*
- *shared electronic health records*
- *shared treatment plans*
- *shorter therapeutic visits*
- *regular warm hand-offs with primary care*
- *jointly scheduled appointments*
- *regular team meetings*
- *open time for consultation/flow for handoffs, crisis, etc.*
- *access to specialty mental health referrals (IBH Working Group)*

(Scheirer, 2010)

3. **Where full integration is not immediately possible, aiming for co-location in primary care may improve care and access, as long as care is taken to plan for fuller integration over time**.

- Co-location can support significant improvements in access and satisfaction, and could provide a foundation for full integration in time *(Ion, 2017; Njoroge, 2016; Heath, 2013; Robinson, 2009).*

- While co-location and integration of behavioral health services appear similar in the sense that a behavioral health professional is seeing patients in the primary care clinic, these are two distinct care delivery approaches. In basic co-location, the behavioral health professional and medical care team function in parallel, yet rarely intersect. In integration, the behavioral health professional is incorporated into the system of the medical practice, improving the capacity of the medical providers to address mental health needs, changing the culture of the clinic to be mental health-aware, elevating the experience of patients with mental health concerns and ensuring they get the care needed to effectively address their mental health needs. To create a more complete care continuum, health systems will need an adequate combination of integrated care, co-located, and specialty mental health providers.

Definition: Co-Location

Behavioral health and primary care providers deliver care in the same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration.

(Peek,2013, Blount, 2003)

- While co-location may be simpler initially, requiring fewer infrastructure changes, health systems should beware of structures and pathways built for co-location that may later become barriers to full integration:
  - A co-location model often becomes a satellite outpatient mental health site, and as such may become similarly bottlenecked and do little to improve access.
  - Some co-located behavioral health models may not make the pivotal change to providing the brief interventions of a full collaborative care model.
  - It may be difficult for the co-located professional to make the fundamental shift needed from traditional psychotherapy to the team-based care, flexibility needs, and language of the medical setting.
  - The co-located behavioral health professional may not be embraced as a full member of primary care teams with the close relationships needed to co-manage patients' physical and mental health conditions.
  - It may be difficult for professionals and the clinic to shift the expectations, roles and workflow from co-location to full integration.
  - The financial modeling for co-location is much different than integration.
- Co-location along with intentional, structured collaboration and electronic medical record (EMR) integration is a good start, as this promotes improved care coordination and service delivery.

Implementation Considerations

The IBH Agnostic Framework does not prioritize timing as far as which element must be done before another, which provides organizations the opportunity to start making improvements wherever is best for their organizational and population context. However, the MN Health Collaborative found that if the supporting structures are not addressed the ability to advance all of the key principles of IBH is limited.

Assess the current state

Use an assessment tool to clearly understand where primary care sites are on the spectrum from no integration, to co-location, to full integration. Assess the organization's model against the IBH Agnostic Framework's key principles and core structures.

Even within systems with enterprise-wide models there can be wide variation in actual practice, as site resources and culture vary and can change quickly in the event of staff turnover. Assessments can stimulate conversations among care team members about where they would like to be along the continuum of integrated care.

- Crosswalk the clinic's current model of behavioral health care delivery with the IBH agnostic framework. Looking at each principle, process, and structure of the framework, take a deep dive into the organizations' current strengths, weaknesses, and opportunities.
- The validated Site Self-Assessment Survey (SSA) was a helpful tool used by the MN Health Collaborative to understand their progress along the continuum of integration. [See Appendix B].
- Assess environmental and organizational factors to understand their impact on how to begin or advance IBH. This includes understanding the organizational strategic priorities, the needs of the population, the resources (staff, space, financial, etc.) available and the readiness and capacity of primary care sites to undertake this change.

Plan for the future state

The IBH Agnostic Framework does not prioritize one process over another; this provides organizations the latitude to start making improvements wherever is best for their organizational and population context. **Give careful consideration, however, to the structures found to support IBH, such as fiscal strategies, administrative support, leadership committees needed, etc. If structures are not addressed, the ability to advance all of the key principles of IBH is limited.**

- Based on the gaps found during the assessment, determine:
  - Where to begin making changes.
  - Which evidence-based tools and practices to use to improve health outcomes.
  - Which metrics wil be used to monitor and report.
- The framework principles 1-5 may already be in common use in primary care for medical conditions. Understanding the use of these principles for managing chronic or acute diseases, and building upon embedded ones, can accelerate the adoption of these principles for serving patients' mental health needs.
- Involve Primary Care providers and other team members early in this work to facilitate partnership and engagement. Using data from site assessments or provider satisfaction surveys can also be valuable.

- For clinics beginning without any IBH services, a decision should be made as to whether there is an intermediate goal of co-location as a stage on the path to full integration or whether co-location is the goal.

- Prepare talking points from this Call to Action along with your own organizational context to engage all members of the care team in advancing changes in alignment with the IBH Agnostic Framework.

Appendix A (attached)

Integrated Behavioral Health Agnostic Framework

Appendix B

Site Self-Assessment Survey

Scheirer MA, Leonard BA, Ronan L, Boober BH 2008, revised 2010. Site Self-Assessment Tool for the Maine Health Access Foundation Integrated Care Initiative. Augusta, Maine: Maine Health Access Foundation. (Adapted from the PCRS developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesinitiative.org, also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.)

Appendix C

Resources:

Agency for Healthcare Research and Quality (AHRQ) Playbook from Integration Academy https://integrationacademy.ahrq.gov/products/playbook/about-playbook

Agency for Healthcare Research and Quality (AHRQ) The Academy Integrating Behavioral Health and Primary Care https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas/framework-measuring-integration-behavioral-health-and-primary-care

AIMS Center Advancing Integrated Mental Health Solutions: http://aims.uw.edu/collaborative-care/implementation-guide

AIMS Center Advancing Integrated Mental Health Solutions: https://aims.uw.edu/stepped-model-integrated-behavioral-health-care

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INTEGRATED BEHAVIORAL HEALTH AGNOSTIC FRAMEWORK

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Objective

We developed a model agnostic framework that describes key processes and structures for integrated behavioral health in primary care. Our framework is based on the evaluation of multiple models of integrated behavioral health and input from a national representation of domain and policy experts, patients, clinicians, and healthcare administrators.

Primary Care – Core Processes

Principle 1: Patient-centric Care

Ensure patient is well engaged with the entire care team, understands the various roles for themselves and their providers, and are supported and guided to manage their lives, health, and treatment

#	Principle Title	Description
1	Orient patient to integrated care culture	IBH team knows their **roles and responsibilities** on the integrated behavioral health team; they **orient patient to integrated care team** (e.g., explains to patient what the roles of each IBH team member are, standardized brief role descriptions for each IBH team member; scope of care, common clinic activities, documentation standards, coordinated team (both IBH as well as rest of primary care team) based clinic behaviors desired)
2	Patient participates in making decisions related to care plan and treatment	IBH team get feedback from the patient about the care plan to make sure the patient is well engaged, in agreement with the plan, and that they use **shared decision making** (e.g., standardized protocol based on best current evidence, that lists specific questions/concerns and documentation for each team member to be used to ensure patient is engaged in care plan decisions, shared care plan is documented)
3	Promote patient autonomy	IBH team targets giving and supporting **autonomy of the patient** as they move through treatment (e.g., self-management plan in individual care plans)
4	Patient reports changes in health, symptoms, function over time	Patient fills out appropriate **metrics** prior to and during IBH team treatment engagement, tailored to the patient addressing what drove the engagement in IBH and keeps the care team informed of progress and changes with health and function (e.g., behavioral health and function **screeners and symptom measures**); encouraged to use a primary care appropriate measure that has a global as well as specific subscale (e.g., anxiety, depression, insomnia, relationship, life function) that could be given to every patient on every appointment

Principle 2: Treatment to Target

Ensure clear goals and measures are defined to guide and track care

#	Principle Title	Description
1	Provide care focused on improving overall health and quality of life	IBH team makes sure to **target patient centered goals that address overall health, function, and quality of life** related outcomes (e.g., employment, family conflicts, spiritual health, etc.)
2	Provide stepped care with intensity based on outcome data	IBH team monitors patient outcome data (including patient reported outcomes measured at baseline and follow-up) for improvement, if improvement is not occurring (e.g., measure scores are not improving), then **steps up care** (e.g., intensifies treatment course, refers to specialists, refers to outside mental health provider if needed care is beyond the scope of primary care (e.g., psychiatric hospitalization needed) and adjusts treatment plan)
3	Focus on small changes through patient-centric goal setting or priorities, emphasizing function	IBH team **sets achievable goals** (e.g., using SMART format) with patients, documented in the care plan to ensure success at assessing and monitoring small changes, working towards larger goals, with emphasis on improving or maintaining function

4	Conduct accurate assessment	IBH team conducts appropriate **assessments** (e.g., screeners administered, assessment interviews tease out appropriate differential diagnoses) of medical (e.g., assessment of physical drivers affecting mood and function like anemia, thyroid function, sleep apnea, etc.) and psychosocial issues (e.g., psychiatric diagnoses, social stressors/needs, trauma and developmental history, substance use, etc.) to guide care
5	Address barriers when goals are not being met	IBH team actively investigates and works together to **resolve any barriers to care** (e.g., deliberately assess and address cultural and logistical barriers to care, patient-provider relationship issues that may limit engagement in care)
6	Define desired outcomes of care	Based on medical and psychosocial issues and patient's goals/preferences, the IBH team sets **measurable targets** (symptoms/function within a given time frame) for care
7	Measure desired outcomes of care - continuous monitoring (use a tracking system)	IBH team uses a **tracking system** (e.g., electronic health record system, registry, spreadsheet) to: measure outcomes regularly (e.g., at each visit as appropriate), support clinical decision making over time (e.g., measures tracking triggers stepping up care as patients are noted as not improving), and support management of their patient panel (e.g., doing outreach to patients who are not showing for care, removing patients regularly to ensure caseloads have population reach in the clinic)
8	Conduct patient caseload management	IBH team does **outreach regularly to patients** on their panel (including phone and letters if necessary) who have not shown for care regularly (e.g., missed two or more consecutive appointments); IBH team helps **coordinate care** within the clinic (e.g., regular communication between behavioral health and primary care providers to ensure care plans are both in synergy with patient goals and feasible for patients) and with referrals inside and outside of the clinic; IBH team uses systematic tracking (e.g., weekly caseload review to identify patients who are not improving or falling through the cracks to proactively step up care) to inform clinical decision making overtime

Principle 3: Use Evidence-based Behavioral Treatments

Ensure the best evidence based care is used across medical and mental/behavioral care

#	*Principle Title*	*Description*
1	Deliver care that maximizes evidence based treatment	**Health conditions are treated with a combination of all available evidence based treatments** (e.g., behavioral, pharmacological, surgical, etc.) **in a coordinated fashion** (i.e., coordinate behavioral interventions with medication treatments, care plan is developed and updated regularly) - routine consideration of behavioral health treatments in context of other treatments within the context of patient preference
2	Provide evidence-based behavioral treatments that are reinforced across the team	IBH team provides **evidence based behavioral health interventions** (e.g., behavioral activation, questioning unhelpful thinking, problem solving, communication skills training, relaxation training, health behavior change for obesity, physical activity, insomnia, tobacco use, substance misuse, chronic pain, etc.) by licensure/training, **tailored case management** (e.g., housing applications, community resource linkages, etc.), and coordinates **psychotropic medications and physical medicine** across the team, integrating psychiatric consultation as needed; IBH providers use appropriate interventions to common primary care issues (e.g., diabetes, obesity, chronic pain, tobacco use, chronic conditions, substance misuse, insomnia, depression, anxiety, personal conflict, etc.); IBH providers help patients learn strategies to minimize symptoms and improve function that can be used by the patient outside of the primary care clinic (e.g., skills for self-management strategies that address health and quality of life improvements, engaging family and support as appropriate); IBH providers support medication adherence and relapse prevention planning
3	Provide psychoeducation: Team provides education to the patient about the benefits and details of relevant behavioral health interventions	IBH providers **share evidence concerning core elements of treatment** (e.g., brief behavioral strategies that can address chronic pain, depression, lifestyle change, etc.) to achieve behavioral health related outcomes; this includes cross-sharing information with the patient and between disciplines of providers

Principle 4: Conduct Efficient Team Care

Ensure integrated behavioral healthcare is efficient and comprehensive, supported by appropriate policies and procedures

#	Principle Title	Description
1	Establish and maintain clear team roles and workflow	**Define and support the roles and responsibilities** of the IBH team in the practice (e.g., establish policies and procedures, define and implement triage strategies to IBH teams)
2	Conduct brief visits as appropriate	IBH providers **see patients as needed, keeping treatment focused** if possible (e.g., 1-6, 15-30 minute appointments for the majority of patients), and **refers out for more intensive treatment** (e.g., Cognitive Processing Therapy for PTSD to a specialty outpatient psychologist, community mental health) if focused treatment does not produce the expected results
3	Maintain strong team communication	IBH team uses **clear and consistent communication** (e.g., team meetings/huddles, EHR charting, etc.), particularly related to psychosocial issues across the team to facilitate care coordination (note that clear communication does not necessarily ensure care coordination, but is a foundational component needed if it is going to be done well and consistently)
4	Develop mutual trust among team	IBH team **identify and respond to problems in teamwork and collaboration** (e.g., address team frustrations), and further develop team functions (e.g., clarify triage and coordination practices as teams mature) to help **improve bonds and development of shared goals and tasks with patients**
5	Use a common medical/behavioral language	IBH team **uses descriptions of care and shared language** that help patients engage each providers' role and care (e.g., brief descriptions of different providers roles with no jargon)
6	Perform routine suicide/homicide risk assessment, management, and referrals	IBH team uses consistent steps and strategies (e.g., by following established policies and procedures) to **assess, manage, and refer patients to higher level of care at risk for suicide/homicide** (i.e., any serious risk to self or others) as indicated by level of evidence based standards of risk
7	Provide fast and easy access to behavioral health providers	**Patients are seen quickly and easily**, ideally at the point of primary care when a psychosocial issue is identified (e.g., same day appointments prior to or after the patient is seen by a primary care provider or within 24-48 hours per patient desire and availability), and follows up with the IBH team as needed in a timely fashion based on symptom and function severity and patient desire (e.g., as quickly as possible, typically within a week or two, based on the patient's availability and the urgency of the care)
8	Provide patient access and integrated care team consultation to psychiatry	Use **psychiatric consultation and care** as needed (e.g., consultation on new or non-improving patients with mental health issues) for psychotropic medication care recommendations, differential diagnoses, and treatment for co-morbid psychiatric issues

Principle 5: Population Based Care

Ensure limited services reach the most patients while targeting the patients most in need

#	Principle Title	Description
1	Use BHP resources for patients most in need	Focus use of BHP services to **address the behavioral health care needs across the spectrum of primary care patients**, including prevention, early at risk, and complex and high risk patients who could benefit most from combination of behavioral health and medical services (i.e., the practice selects target populations for care and defines strategies to identify and engagement); including engagement of disadvantaged and disparity affected populations
2	Use appropriate assessment of key indicators to triage patients to behavioral health resources	The clinic uses a **deliberate process to triage priority patients** into IBH team based care (e.g., clinic uses defined care paths and screening strategies for engaging patients in behavioral health services)

Primary Care – Core Structures

#	*Structure Title*	*Structure Description*
1	Financial billing strategies that net sustainability of staff and providers on the IBH team	The clinic has effective **fiscal strategies** for sustaining IBH provider and staff time
2	Administrative support and supervision for IBH team	The clinic provides **administrative support and supervision** to all IBH providers and staff as needed (e.g., clinical supervision for nurses, mid-level providers providing behavioral interventions and medication adherence support)
3	Routine examination of provider and clinic outcomes for quality improvement	The clinic regularly (e.g., quarterly) **reviews provider and clinic level outcomes** to improve care as needed (e.g., via quality improvement initiatives)
4	Interoperable EHR access for all of the IBH team	IBH team providers **share access across the electronic health record systems** in the practice
5	IBH team has available and appropriate space	IBH team providers have **reasonable and appropriate work space** allocated within the practice that supports productive work space and collaboration
6	Behavioral health provider (BHP) available to the clinic	IBH includes a **qualified behavioral health provider** (BHP) licensed / trained to provide evidence based behavioral interventions
7	BHP team has protected time to do outreach and follow-ups as needed	BHP team has **protected time to review and manage the caseload**, conduct outreach and follow-ups as needed (e.g., identifying cases at risk, triage to the right level of care / intensify treatment, do outreach)
8	BHP team has accountability for access and outcomes	**Patient panels are monitored** for timely access to care and outcomes are evaluated to drive care improvements
9	Tracking system for panel management	**Clinic tools** (e.g., registry, real time reports) are in place to support identifying, tracking, and monitoring IBH related cases

MN Health Collaborative Integrated Behavioral Health
Instructions for Completing the Site Self-Assessment (SSA) Survey

The purpose of this assessment is to show your clinic's current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site's *current* extent of integration for patient and family-centered primary care, behavioral and mental health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations should ask each clinic *site* that provides primary care to complete the SSA.

For this annual update of the SSA, please respond in terms of your site's *current* status on each dimension, as of November 2018. Obtain input from your team to complete this form. **At a minimum, ask clinicians from family practice and behavioral health to complete this with the site manager or operations.** The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff. Please rate your patient care teams on the extent to which they do each activity for the patients/clients. It is best to have similar staff roles complete this tool for consistency over time in order to show nuanced changes year to year.

Using the 1-10 scale in each row, circle one numeric rating for each of the 18 characteristics. NOTE: *There are no right or wrong answers.* Enter numerical answers into the electronic survey link provided. If you have questions, please contact Jeyn Monkman (jmonkman@icsi.org) at 952-883-7980. Thank you!

Identifying Information:

Organization: _____ What is the patient population at your clinic site (i.e. the number of unique active patients seen at your clinic site in the past 12 or 18 months): _____

If behavioral health services are provided at your site, who do they serve: age 0-12 years old___ 13-17 years old___ 18 years old and over___

Name of your site:_____ Date:_____

Name(s) of person(s) completing the SSA form:_____

_____

_____

I. Integrated Services and Patient and Family-Centeredness (Circle ONE NUMBER for each characteristic)				
Characteristic	**Levels**			
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services **1**	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist **2 3 4**	. . .are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services **5 6 7**	. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. **8 9 10**
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)	. . . are not done (in this site) **1**	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care **8 9 10**
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**
5. Patient/family involvement in care plan	. . . does not occur **1**	. . . is passive; clinician or educator directs care with occasional patient/family input **2 3 4**	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) **5 6 7**	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources **8 9 10**

6. Communication with patients about integrated care	. . . does not occur **1**	. . . occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style **2 3 4**	. . . occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent **5 6 7**	. . .is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in *how* to communicate with patients about integrated care **8 9 10**
7. Follow-up of assessments, tests, treatment, referrals and other services	. . . is done at the initiative of the patient/family members **1**	. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up **2 3 4**	. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments **5 6 7**	. . . is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments **8 9 10**
8. Social support (for patients to implement recommended treatment)	. . . is not addressed **1**	. . . is discussed in general terms, not based on an assessment of patient's individual needs or resources **2 3 4**	. . . is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs **5 6 7**	. . . is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources **8 9 10**
9. Linking to community resources	. . . does not occur **1**	. . . is limited to a list or pamphlet of contact information for relevant resources **2 3 4**	. . . occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral **5 6 7**	. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients **8 9 10**

II. Practice/Organization (Circle ONE NUMBER for each characteristic)				
Characteristic	**Levels**			
10. Organizational leadership for integrated care	. . . does not exist or shows little interest **1**	. . . is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care **2 3 4**	. . . is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings) **5 6 7**	. . . strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models **8 9 10**
11. Patient care team for implementing integrated care	. . . does not exist **1**	. . . exists but has little cohesiveness among team members; not central to care delivery **2 3 4**	. . . is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills **5 6 7**	. . . is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled **8 9 10**
12. Providers' engagement with integrated care ("buy-in")	. . . is minimal **1**	. . . engaged some of the time, but some providers not enthusiastic about integrated care **2 3 4**	. . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components **5 6 7**	. . . all or nearly all providers are enthusiastically implementing all components of your site's integrated care **8 9 10**
13. Continuity of care between primary care and behavioral/mental health	. . . does not exist **1**	. . . is not always assured; patients with multiple needs are responsible for their own coordination and follow-up **2 3 4**	. . . is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only **5 6 7**	. . . systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained **8 9 10**
14. Coordination of referrals and specialists	. . . does not exist **1**	. . . is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team **2 3 4**	. . . occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care **5 6 7**	. . . is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement **8 9 10**

15. Data systems/patient records	. . . are based on paper records only; separate records used by each provider **1**	. . . are shared among providers on an *ad hoc* basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps **2 3 4**	. . . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals **5 6 7**	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process **8 9 10**
16. Patient/family input to integration management	. . . does not occur **1**	. . . occurs on an *ad hoc* basis; not promoted systematically; patients must take initiative to make suggestions **2 3 4**	. . . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consider-ation; patients/families are made aware of mechanism for input and encouraged to participate **5 6 7**	. . . is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information **8 9 10**
17. Physician, team and staff education and training for integrated care	. . . does not occur **1**	. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic **2 3 4**	. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation **5 6 7**	. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration **8 9 10**
18. Funding sources/resources	. . . are only from a grant; no shared resource streams **1**	. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies **2 3 4**	. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training **5 6 7**	. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly **8 9 10**

19. If behavioral health services are offered at your clinic site, please rate how satisfied you are with those services:

Very Satisfied Satisfied Neither Dissatisfied Very Dissatisfied Not applicable

20. Please add any comments about integrated care implementation at your clinic site: