EXECUTIVE SUMMARY

ORGANIZED, EVIDENCE-BASED CARE:
Behavioral Health Integration

October 2014

For more information, see the
Organized, Evidence-Based Care Supplement: Behavioral Health Integration Implementation Guide

Whether a primary care practice is just beginning the PCMH journey or is an established medical home, integrating behavioral health care is a critical effort, necessary for true transformation. The goal of integrating behavioral health care in primary care is to provide better access, better outcomes, and a better experience for patients, families, and caregivers—and also to improve the efficiency and operations of the primary care practice itself.

What

What is behavioral health care?

Behavioral health care covers a wide range of patient needs. It can address common social concerns or health behaviors; treat mental health or substance use conditions frequently observed in primary care such as depression, anxiety, or problem drinking; or address more complex disorders such as bipolar disorder or prescription opioid misuse. As a primary care practice begins to consider integrated care, it will be important for it to clearly establish its own definition of behavioral health and its own scope of behavioral health care.

What is integrated care?

There are many different models and approaches to integrated care. 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 into primary care.

- Low degree of integration. On-site mental health providers see referred patients for medication management and/or behavioral health specialist visits. 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.
- High degree of integration. The primary care team and 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.

The evidence of effectiveness for integrated care is strongest among models that have a high degree of integration, such as the Collaborative Care Model.

Whatever model or approach the practice selects, the ultimate goal is the same: to develop processes and systems to identify patients that need behavioral health care and monitor those patients to ensure their treatments are effective and are having the desired effect (e.g., reduced depression symptoms).

Why

Behavioral health problems are common and significantly impact patients' health and quality of life. They 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. Treating behavioral health and medical problems together can improve outcomes for both.

In 2014, a number of primary care organizations endorsed a set of joint principles for integrating behavioral health care into the PCMH. The principles were intended to supplement the Joint Principles of the PCMH formulated in 2007. 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.

Implementation Overview

Create a vision for behavioral health care integration

Identify one or two individuals to lead the vision-building process and to recruit additional team members. 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 the risk for potential conflict among care team members over how to achieve goals.

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. The SNMHI recommends the GROW model: Goal setting; Resource assessment; Options; and Workflow development. A modifiable version of the GROW Pathway Planning Worksheet and a completed example are available.

- **Goal setting:** Consider the demographics of patients and the types of clinical problems in presenting patients, and establish a clear target population.
- **Resource assessment:** Identifying organizational opportunities and challenges may help in choosing the most realistic model for integration. Considerations such as geography, physical space, leadership support, care team and workforce development, shared workflows, HIT capacity, and financial resources will impact integration.
- **Options:** As a practice considers its approach to achieving integrated care, it is important to consider the options it has to improve both access to behavioral health care, and accountability associated with assessing, monitoring, and improving health outcomes.
- **Workflow development:** A practice must first assess the current workflow to identify waste and gaps, and then develop and test an integrated care workflow.

No matter where a primary care practice begins its integration effort, it must maintain a commitment to continuous improvement and enhancement of services.

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. A practice can use targets to gauge the impact of its integration efforts and identify opportunities for further improvement. These should include:

- Clinical quality measures
- Practice transformation measures
- Patient and provider experience measures

Practices should select relevant measures, adjust targets for continuous quality improvement, and share results with care teams and the community.

As part of monitoring the progress of integration, a practice should consider how it is addressing the social needs of behavioral health patients. For example, special considerations may be needed for vulnerable populations such as individuals who have experienced an adverse childhood experience (ACE), pediatric patients, patients with serious and persistent mental illness (SPMI), and substance use disorders.

Building Integrated Care Teams

Providing integrated behavioral health care requires the development and ongoing support of a well-coordinated integrated care team. An integrated care team typically consists of:

- An actively engaged patient
- An engaged primary care provider
- A behavioral health provider who functions as a care manager and delivers evidence-based behavioral interventions when needed
- Psychiatric expertise through a consultant or other provider who also possesses prescribing expertise
- Supporting care team members including front desk staff, MAs, and peer support specialists

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

Additional strategies for building strong integrated care teams include:

- Make patients and families active members of the care team
- Proactively address staff concerns
- Engage staff members in the integration process
- Provide training to build skills and confidence
- Find partners (e.g., referral resources) invested in the vision of integrated care
- Identify and hire staff who are open to learning evidence-based practices, enjoy collaboration, are open to feedback, and are willing to change strategies when needed

Leveraging Success: Spreading and Sustaining

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. Practices should adopt strategies for sustaining the integrated effort, including:

- Regularly assess team function in the domains of: shared goals, clear roles, mutual trust, effective communication, and measurable outcomes and processes. Take time to provide a 'tune-up' as needed
- Address provider burnout
- Maintain leadership support
- Prepare for turnover
- Continue to improve workflows
- Consider financial impacts and payment models

What Progress Looks Like: PCMH-A Level A

The PCMH-A is a self-assessment tool to help practices understand their current level of "medical homeness," identify opportunities for improvement, and track their progress toward practice transformation. It is also a learning tool that can help start conversations within a practice about patient-centered care. The PCMH-A is scored on a 1–12 scale, which is divided into four levels (D, C, B, and A). A "Level A" item score indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice. An overall Level A score indicates that the practice has achieved considerable success in implementing the key design features of the PCMH.

Level A PCMH-A Items

For more information, see the Patient-Centered Medical Home Assessment (PCMH-A).

20. Behavioral health outcomes (such as improvement in depression symptoms)… are measured and tracked on a population-level for the entire organization with regular review and quality improvement efforts employed to optimize outcomes.

31. Behavioral health services…are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.

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.

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.

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For more information about The Commonwealth Fund, refer to www.cmwf.org.

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