INTEGRATED BEHAVIORAL HEALTH CROSS-MODEL 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 is 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