BH2I-2 Standards of Care Manual

BH2I
Behavioral Health Integration Initiative

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Executive Summary

Integrated care is a comprehensive, collaborative approach to health care that promotes patients' overall wellbeing. As part of its work to promote the health of American Indian and Alaska Native (AI/AN) people, the Indian Health Service (IHS) created the Behavioral Health Integration Initiative (BH2I) to aid IHS, Tribal, and urban Indian (I/T/U) clinics in further integrating behavioral health care with primary care. The aim of this initiative is to reduce the behavioral health disparities that AI/AN populations face by making care more accessible to AI/AN patients and helping to dispel stigma around these services.

Designed to guide I/T/U clinics in progressing toward greater levels of integration, this BH2I Standards of Care Manual outlines an integrated care framework that is structured as a continuum. This document elaborates on ten domains of integrated care, which are as follows.

I. Multidisciplinary integrated care team
II. Screening, case findings, and referral to care
III. Integrated service behavioral health care
IV. Documentation standards of care
V. Measurement-based care and stepped care
VI. Culturally adapted self-management support tools
VII. Linkages with community/social services
VIII. Systematic quality improvement
IX. Sustainability
X. Telehealth

This Standards Manual describes considerations for how I/T/U clinics can advance toward a greater level of integration within each domain. Some of these key strategies include the following.

- Developing a shared vision, values, and goals across the care team and establishing channels and protocols for sharing information with all team members
- Identifying an integrated care champion who can encourage buy-in from other providers
- Structuring a care team that is highly collaborative and centered around the patient
- Training all team members on the integrated care approach
- Selecting brief, evidence-based tools to use in screening for behavioral health conditions
- Designing an effective referral process
- Designing protocols that promote care coordination and a seamless patient experience
- Establishing and continually updating policies, procedures, and workflows to guide the team's efforts
- Using data to inform decision-making about treatment and to improve the program itself
- Incorporating traditional healing practices and other cultural components into care
- Screening for and addressing social determinants of health
- Implementing effective telehealth services

Introduction

The Indian Health Service (IHS) is an agency within the U.S. Department of Health and Human Services (HHS) that provides federal health services to American Indian and Alaska Native (AI/AN) people. The provision of health services to members of federally recognized Tribes grew out of the special government-to-government relationship between the federal government and American Indian and Alaska Native Tribes. This relationship, which formally began in 1787, is based on Article I, Section 8 of the U.S. Constitution and given form and substance by treaties, laws, Supreme Court decisions, and executive orders. IHS provides a comprehensive health service delivery system for AI/AN people and serves as the principal federal health care provider and health advocate for AI/AN people. Its goal is to elevate the health status of AI/AN people to the highest possible level.

IHS mission: To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Background

In 2017, IHS posted a notice of funding opportunity in support of shifting the mental health and substance use disorder services for AI/AN people "from being episodic, fragmented, and specialty- and/or disease-focused to incorporating them into the patient-centered home model." This shift is a major step toward addressing the nation's stark behavioral health challenges and their amplified impacts on AI/AN people.

AI/AN communities experience significant disparities in behavioral health conditions, including high rates of suicide, alcohol and substance misuse, homicide, domestic and sexual violence, mental health disorders, and behavior-related chronic diseases (Indian Health Service, 2011).

Dr. Denise Middlebrook with the Centers for Disease Control and Prevention (CDC) has reported several key statistics regarding the behavioral health disparities that AI/AN people face. The CDC periodically releases updated data; even though they may shift over time, the following points provide a general overview of trends and statistics related to mental health in AI/AN communities.

- AI/AN populations experience higher rates of depression compared to the general U.S. population. Approximately 14–16% of AI/AN adults report experiencing some form of depression, compared to about 8–9% of the general U.S. population.
- In 2020, the AI/AN population had the second-highest suicide rate among racial and ethnic groups in the United States. Moreover, the suicide rate for AI/AN youth (ages 10–24) is 2.5 times higher than that of white youth.

- Behavioral health visits, including those for depression, anxiety, and other mental health conditions—are underreported or underutilized in some AI/AN communities, though these rates are improving as awareness and cultural competence in health services increase.

Socially destructive behaviors, such as substance misuse and domestic violence, disproportionately affect AI/AN people. These behaviors are typically public health indicators that reflect the burden of trauma within communities and can culminate in chronic stress impacts to health over individual and community lifetimes. Further, recent studies show trauma can pass from one generation to the next, resulting in intergenerational and historical traumas (Yehuda & Lehrner, 2018). Barriers to seeking mental health treatment for the effects of trauma may include stigma, misunderstanding, and lack of available services. Left untreated, the lasting effects of childhood trauma often manifest physically, creating a variety of health consequences in adult populations (Yehuda & Lehrner, 2018).

Primary care facilities are crucial to addressing both physical and behavioral health care needs. The integration of behavioral health services and the application of a trauma-informed approach within primary care settings will improve access to mental health services for AI/AN children and families. A trauma-informed approach to care "takes into account an understanding of trauma in all aspects of service delivery and places priority on the person's safety, choice and control" (Substance Abuse and Mental Health Services Administration, 2015, p. 12). Integration of behavioral health care through a trauma-informed lens places the patient at the center of the care team. Behavioral health services delivered through primary care providers build on the existing trust between patients and primary care providers, reducing the stigma associated with receiving behavioral health care. Most people with behavioral health disorders who access treatment through an integrated primary care facility experience improved mental and physical health outcomes that correlate with increased engagement in their own treatment and wellbeing (Lewis & Myhra, 2017).

IHS designed the Behavioral Health Integration Initiative (BH2I) to help clinics serving AI/AN people to advance along the integrated care continuum.

- Through this initiative, IHS aims to support clinics in planning, developing, implementing, and evaluating the integration of behavioral health care within primary care, community-based settings, nutrition education, diabetes care, and chronic disease management.
- The purpose of this initiative is to improve the physical and mental health status of people with behavioral health conditions by developing an integrative, coordinated system of care between behavioral health and primary care providers.
- BH2I aligns with the IHS mission to raise the physical, mental, social, and spiritual health of AI/AN people to the highest level.

This BH2I-2 Standards of Care Manual (Standards Manual) describes considerations for IHS, Tribal, and urban Indian (I/T/U) clinics in forming integrated care programs. The Standards Manual is not meant to replace, circumvent, or supersede Tribal or federal standards of care policies. The target audience for this Standards Manual is BH2I Cohort 2 grantees (Tribal and urban clinics) and IHS facilities.

The Standards Manual supports the development of effective integrated care programs that will enhance health outcomes for patients and communities served by IHS. The information provided in the Standards Manual is based on empirical research and best practices gathered from the first BH2I cohort. Representatives from three Cohort 1 grantees, including the Indian Health Board of Minneapolis, Muscogee (Creek) Nation, and Yellowhawk Tribal Health Center, participated as subject matter experts in creating this Standards Manual.

Because integrative models of care vary according to the needs and capabilities of each community, this Standards Manual is intended to help address the unique challenges and circumstances that exist across many Tribal communities and sites. Further, this Standards Manual outlines the elements of integrated care and presents tools and resources to help organizations enhance clinical processes and workflows across multidisciplinary teams and advance further along the integrated care continuum.

What Are Standards of Care?

Standards of care, while defined as a set of practices accepted as proper, refer to informal or formal guidelines that experts in the medical community view as the most suitable approaches for the treatment of a disease or condition. They can help inform the development of clinical practice guidelines and formal processes for all health care providers to follow in diagnosing and treating a patient who has a certain set of symptoms or a specific illness. Based on scientific and clinical knowledge and data, these standards show the outcomes patients can expect from their care. Standards for Tribal communities promote culturally appropriate care and support overall wellbeing, cultural knowledge, and best practices.

Standards of care are critical to increasing coordination among health care and social service providers toward improving patient outcomes and satisfaction. For example, the IHS Ask Suicide-Screening Questions (ASQ) Toolkit serves as IHS' standards for suicide prevention. Whereas the ASQ provides guidance specifically related to screening for and addressing suicidality, this Standards Manual for integrated behavioral health care deals with behavioral health more broadly and how behavioral health care intersects with primary care.

What Is Integrated Care?

Integrated health care is an approach "characterized by a high degree of collaboration and communication among health professionals" regarding patient care (American Psychological Association, 2021, para. 1). The integrated health care team sets up a comprehensive treatment plan to address the physical, psychological, and social needs of the patient. Integrated health care teams include behavioral health providers (BHPs) and primary care providers (PCPs). Depending on the patient's needs, other care team members often include nurses, other health professionals and paraprofessionals, social workers, psychiatric consultants, case managers, care coordinators, and peer and cultural advocates (American Psychological Association, 2021).

While other care models involve workflows and communication structures that incorporate varying degrees of collaboration, highly collaborative teams are not necessarily integrated health care teams. Whereas an outpatient behavioral health provider model attributes all services to the PCP, for a health care team to work as an integrated behavioral health care team, they must apply the following approaches.

- Multiple team members contribute their insights and abilities to each patient's case, rather than relying solely on the PCP.
- The PCP delegates tasks to other team members so that each team member can provide services at the highest level allowed by their licensure and skills (Agency for Healthcare Research and Quality, 2013).

Stepped Model of Integrated Care

Figure 1: Stepped model of integrated care

Figure 1 shows the framework for the culture-based integrated behavioral health care model developed and used for BH2I Cohort 1 in Fiscal Years 2017–2020. This framework is culturally adapted from the stepped model of integrated care developed by the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center (AIMS Center, 2021). The AIMS Center model is in the appendix for reference.

Figure 1 names three elements provided by Tribal clinics: community, primary care, and specialty care. The types of services, providers, and facilities included in each element of the framework are as follows.

- **Community**: Community-based service and support systems, such as housing and Temporary Assistance for Needy Families (TANF) programming
- **Primary care**: PCPs, BHPs, and the collaborative care system
- **Specialty care**: Community mental health care, substance use disorder treatment, and inpatient psychiatric hospitals

It may be helpful to note that community mental health care is a type of specialty care rather than a community-based service. Community mental health centers offer a variety of mental health services, primarily in outpatient settings and occasionally through in-home care. These services often include mental health assessments, therapy, and rehabilitation, with 24-hour access to care (though not in a residential or inpatient context). In contrast, community-based services are a range of supports provided in patients' homes or communities that aim to address

their overall wellbeing and help them maintain residence in their homes rather than requiring out-of-home placements.

The community, primary care, and specialty care elements all have a place within BH2I projects, and the Cohort 1 grantees incorporated various aspects of these components into their projects as they moved toward fully integrated care systems within their clinics.

The BH2I Training and Technical Assistance (T/TA) Center team uses a continuum-based integrated care framework. The Comprehensive Healthcare Integration (CHI) Framework, which can be found on the National Council for Mental Wellbeing website, served as the foundation for the concepts shared in this document. The CHI Framework's domains do not include telehealth or integrated service. However, the BH2I T/TA Center team has included telehealth and integrated service as the ninth and tenth domains of integration. The domains included in this Standards Manual are as follows.

- Multidisciplinary integrated care team
- Screening, case findings, and referral to care
- Integrated service behavioral health care
- Documentation standards of care
- Measurement-based care and stepped care
- Culturally adapted self-management support tools
- Linkages with community/social services
- Systematic quality improvement
- Sustainability
- Telehealth

As BH2I Cohort 2 grantees begin their projects, they may see variances in implementation depending on where they start on the integrated care continuum. Integrated care may include the following basic elements.

- Use standardized universal screenings to screen all patients who enter the health system annually.
- Find symptoms and concerns in patients through screenings.
- Offer patients added services and referral support from a behavioral health professional.
- Use brief interventions and treatments when necessary.
- Refer patients to specialty psychiatric services when necessary.
- Support the integrated care team with psychiatric consultations for case staffing and guidance when necessary.

- Communicate continuously and regularly about patient progress.
- Conduct formalized meetings with the PCP, psychiatric consultant, and behavioral health professionals.
- Use a registry to track patient progress/decline, trends, and outcomes.
- Engage patients for follow-up and ongoing priorities.
- Move the patients along the continuum of care based on increased symptoms and lack of progress in current treatment (see Figure 2).
- Establish coordinated treatment goals between the care team and the patient through shared care plans.

Principles of Effective Integrated Care

In 2011, the AIMS Center, with support from national experts in integrated behavioral health care, defined five core principles of effective integrated care, as follows.

- **Team-based and patient-centered care**: The PCPs and BHPs collaborate effectively on care teams using shared care plans that incorporate patient goals.
- **Evidence-based care**: The integrated care team offers patients treatments that are based upon credible evidence showing effective treatment for the target condition. Examples of such treatments include brief psychosocial interventions and medications.
- **Measurement-based treatment to target**: Each patient's care plan includes measurable and clearly articulated personal goals and clinical outcomes that the integrated care team evaluates routinely.
- **Population-based care**: The integrated care team shares a defined group of patients whom the team tracks in a registry to ensure no one falls through the cracks.
- **Accountable care**: The providers are accountable and reimbursed for the quality of care and clinical outcomes.

The BH2I-2 Standards of Care Framework

This section describes the development of the BH2I-2 Standards of Care Framework (Standards Framework). The BH2I T/TA Center staff used observation, reflection, subject matter expertise, and literature review to identify the elements of community, primary care, and specialty care found in each grantee's approach to integrated care.

IHS required the BH2I T/TA Center staff to find an evidence-based framework that had similar elements to the BH2I grantees' methods. They identified the CHI Framework to support I/T/U clinics in achieving effective, evidence-based integrated care programs (Chung et al., 2020). The full framework is included in the appendix. The BH2I T/TA Center team adapted and

Indigenized the CHI Framework to include telehealth, added culturally based aspects, and renamed it the BH2I-2 Standards of Care Framework.

The Standards Framework is an evidence-based continuum for integrating behavioral health care into primary care. It shows preliminary, intermediate, and advanced characteristics of each domain component (or subdomain) and illustrates parallel paths toward integration. Each BH2I grantee can implement their project at different speeds, depending on strategic priorities and available resources. This Standards Manual presents information, considerations, tools, and resources to aid organizations in advancing along the integrated care continuum modeled in the Standards Framework.

Designed to convey "a sense of movement and momentum" (Chung et al., 2020, p. 7), the Standards Framework's continuum enables I/T/U clinics to initially perform a team-based self-assessment of their baseline integration status for each domain and subdomain. Following the self-assessment, the I/T/U clinics can then set realistic goals to advance within the domains. This flexibility helps BH2I grantee clinics organize their priorities based on existing strengths and resources. The Standards Framework outlines how providers can invest in training and workforce development by recognizing that capacities and available resources vary by clinic. The Standards Manual encourages all BH2I grantee clinics to attain elements that are customized to their community needs and achievable within a specific period (usually 6 months to a year). Applicants for BH2I grants tend to strive for the most advanced elements within each domain.

I. Multidisciplinary Integrated Care Team

The integrated care team centers around the patient. At the heart of an integrated care program is an effective, collaborative team who delivers patient-centered, team-based care. The PCP facilitates the introduction of the patient to other team members, who typically include BHPs, members of the extended behavioral health care team, and a psychiatric consultant. The extended behavioral health care team includes paraprofessionals like peer support specialists. Culture keepers are also members of the extended behavioral health care team. The culture keeper is known as a cultural knowledge keeper; they maintain the knowledge of Tribal traditions, ceremonies, and rituals, and they ensure information is shared in a culturally respectful and appropriate manner. They also work with other cultural health practitioners who have a deep awareness of a patient's culture, values, and world views; recognize and respect the patient's life experiences; and organize and share traditional medicines and practices. The integrated care team may also involve community support providers who engage in any element of the patient's life that may affect social determinants of health (SDOH), such as a school nurse, social worker, community health worker, or parole officer. Figure 2 illustrates the composition of an integrated care team.

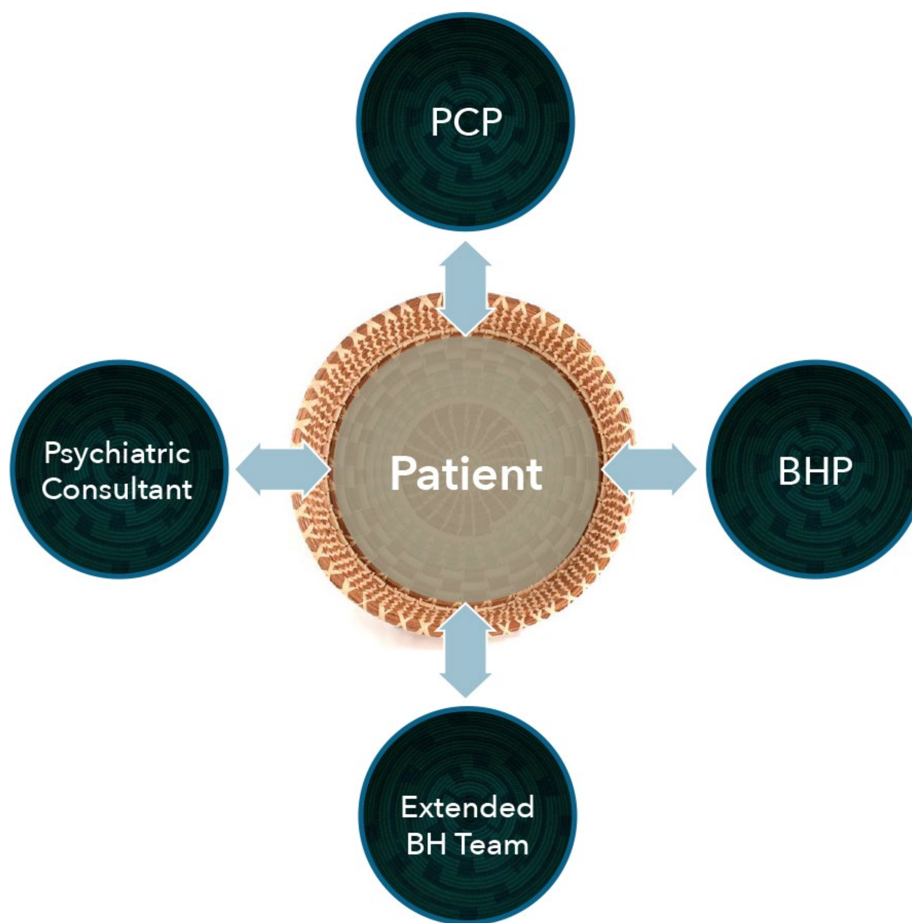

Figure 2: Composition of an integrated care team

According to Dr. Gina Lasky, "Collaboration between team members and patients is at the heart of the [integrated care] model and central to the broader mission of achieving improved team outcomes, improved quality of experience, reduced costs, and ultimately population health" (Raney et al., 2017, p. 61). Dr. Lasky also noted that team development and relationship building with the patient require a change in basic assumptions that shifts the team from an individual practice model to a team-based approach. Furthermore, Dr. Lasky stated that consistent research into integrated care teams over several years has shown this care model has "higher job satisfaction and … [is] efficient in achieving shared goals … and is currently an important element of health care transformation" (Raney et al., 2017, p. 61).

Understanding Team Norms

Although creating a patient-centered, team-based approach to integrated care may seem to be an easy change in theory, it can be difficult. The challenges facing a team in implementing this approach include establishing rules and standards that support a collaborative team framework, as well as formulating relevant policies and protocols. Most notably, change can become a barrier among team members, especially those uncomfortable with it. A change in office or department culture may occur in a switch to a team-based model of care. This culture change shows clear group standards, rules, and norms (Raney et al., 2017). Team norms can be formal (written) or informal (non-verbal expectations; Raney et al., 2017).

Multidisciplinary integrated care team norms serve four key functions.

1. Establish the core values of the team.
2. Set expectations for the team's activities to ensure predictability of behavior.
3. Create psychological safety by providing boundaries around appropriate behavior.
4. Establish the identity of the team.

Shared Vision

The culture change toward a successful integrated care program requires that organizational leadership be committed to team development and understand the need for concerted time and resources. Without this kind of leadership, organizations will find it much harder, if not impossible, to fully carry out their goals for collaboration. This outcome, in turn, can lead to a poor team culture and less-than-ideal patient outcomes (Raney et al., 2017).

In addition to setting up group rules or customs, it is essential to develop a shared vision for effective transition from the individual practice model to a team-based approach. The shared vision informs everyone about what to expect and outlines how the team will move toward the new practice model (Qualls, 2021). To complement the group rules and promote their adoption, teams should ensure policies or protocols are in place that support the shared vision before the

transition is complete (Perkins, 2021). Most grantees find that the shared vision is not in place at the beginning of a BH2I project. The implementation of the Plan-Do-Study-Act cycle facilitates the gradual integration of a shared vision and its components as the team develops cohesion and collaboratively engages in their tasks.

Shared Team Values and Goals

Defining shared values and goals helps all team members, including patients, unite around the organizational mission and make the best health care choices. It is important to consider who will be part of formulating the shared values and goals for the integrated care team. This process may include key stakeholders beyond the integrated care team, including those from medical and clinic leadership, nursing, finance, and central registration and electronic medical records departments. Shared values may articulate the underlying vision for quality care for a specific population or a shared prioritization of the reduction of health disparities (Raney et al., 2017, p. 70).

Considerations for developing a multidisciplinary integrated care team's shared values include the following.

- Expression and understanding of patient-centered care
- Communication about quality patient care for the population served
- Verbalization of the importance of equity in care or reduction in health disparities for the population served

Once the care team identifies shared values and links the values to the organizational mission, the next step is to develop goals. Each goal should advance the team toward outcomes that serve the values and mission. Raney et al. (2017, p. 70) provided the following goal types and examples of each type to consider when working on team goals.

- **Vision-based goal**
  - *Example:* Reduce health disparities for individuals with behavioral health conditions.
- **Outcome-based goal**
  - *Example:* 80% of the patient population will have controlled diabetes.
- **Process-based goal**
  - *Example:* The team will engage in universal screening, tracking of behavioral health and physical health metrics within a registry, progress reviews as a team, and ongoing cross-training.

These goal types provide the team with an approach to measure the success of their integrated care program.

Team Communication

Another way to ensure consistency in processes and mutual understanding around key issues is to set up clear communication channels. Consistent communication processes or procedures within the care team ensure the team does not miss vital information and staff do not have to search multiple systems to find the needed information. As a team, it is vital to find the best communication channels available for immediate use. Additionally, the team should decide if these communication channels need to be updated to include new avenues for communication. For example, updates to policies, protocols, and procedures are necessary for effective and efficient communications through multiple channels, such as email, a centralized electronic location (e.g., a shared drive on a cloud), and team meetings.

Several communication processes that are central to integrated care include the following (Qualls, 2021; Raney et al., 2017).

- Case reviews, which occur during registry review or team meetings
- Day-to-day clinical and operational communications through daily team huddles, clinical updates, schedule review, and coordination planning
- One-on-one communications about various information, such as updates on policies and procedures, clinical data about specific patients, requests for behavioral health consultations, staff availability, and program information
- Clinical data and routing of the patient note for sign-off within the electronic health record (EHR) system
- Shared electronic and physical calendars to communicate staff availability
- Transmittal of consultation requests via an internal messaging system

Effective and efficient team communication is vital to integrated team processes because it promotes consistency and informed decision-making.

Team Composition

Integrated and collaborative teams may function differently than other forms of interdisciplinary teams, delivering care through a shared approach within a joint space. Under this approach, team members may have different tasks associated with their roles on the team, but they share common goals with one another and with the patient.

The integrated team framework comprises the following components (Raney et al., 2017, pp. 64–66).

- A shared definition of problems and challenges and a mutual acknowledgement of the need for whole-person care
- Shared activities and space through which the team provides interventions
- Shared decision-making among team members and with the patient
- Diverse skills and knowledge among team members and mutual respect and appreciation for this diversity
- Shared responsibility for the care and outcomes, including
  - solutions and care plans the team agrees upon,
  - resolution of conflicts and disagreements, and
  - incorporation of patient preferences and input into the process

Role of the Primary Care Provider

The PCP's role is to lead the clinical care team and encourage them to efficiently and effectively obtain the behavioral health services the patient needs. Considerations about the PCP role are as follows.

PCP Tasks

Typical tasks for a PCP within an integrated BH (behavioral health) care team include the following.

- Identify individuals who need behavioral health support.
  - Utilize screening tools.
  - Conduct patient interviewing.
  - Develop a registry for patients using health population management tools.

- Engage patients in the treatment model by expanding the doctor-patient relationship to include the BHP.
  - Provide warm handoffs to the BHP.
  - Make referrals to the BHP.
  - Include the BHP in morning huddles.
  - Respond to feedback provided by the BHP.
- Provide medication management for common behavioral health conditions.
- Consult with a pharmacist and psychiatrist about complex conditions and potential medication side effects when needed.
- Track patient treatment statuses and adjust the treatment plans accordingly to improve patient outcomes.
  - Use screening tools.
  - Review the established registry to track treatment status.

PCP Key Attributes

Several attributes characterize a PCP who is likely to make valuable contributions within an integrated care team. Ideally, to maximize the team's success, a PCP should have the following capabilities.

PCP attributes should promote collaboration, flexibility, and patient wellbeing. The PCP should

- be comfortable using screening tools to track progress (e.g., the Patient Health Questionnaire [PHQ-9]),
- have sufficient knowledge of psychopharmacology and medication management,
- be flexible about clinic workflow and determining if and when to include the BHP,
- respect all team members and the skills and strengths they bring to the care team, and
- identify training resources and be willing to train team members to increase the entire team's overall knowledge and skills.

Other attributes that the PCP should exemplify include buy-in, championing of integrated care, and a clear understanding of the benefits of an integrated care approach for the patient and care team.

PCP Buy-In

PCP buy-in is essential for the integrated care model to succeed, especially at the forefront of early program planning and development. Without PCP support in the clinic, the model will be difficult to launch, and no amount of planning, visioning, or team engagement can take the place of an engaged PCP. The PCP serves as the leader of the care team, making their buy-in paramount. Further, a PCP champion inspires unity across other PCPs within the clinic.

PCP Champion

A PCP champion is someone who understands and appreciates the importance of integrated care and is passionate about the team-based approach to improving patient outcomes. In short, the PCP champion focuses on the "functions that need to be performed and who can best provide these functions to address the patient as a whole" (Raney et al., 2017, p. 129). The PCP champion respects the various roles of team members and must be willing to pilot integration and work out the challenges.

Ideally, the PCP champion is an MD/DO who has natural leadership skills (shows eagerness to learn, employs effective communication skills, is a team player, can effectively collaborate, has an independent mind, is flexible and creative, demonstrates effective decisiveness, has a clear vision, and encourages others) and whose opinion is respected by their colleagues and peers. To find a PCP champion, seek out a PCP who motivates, inspires, and respects **everyone** in the clinic.

In addition to providing leadership, understanding, and enthusiasm for the team-based model, the PCP champion supports the patient and engages them in the treatment process and optimization of the treatment plan (Raney et al., 2017). Furthermore, the PCP champion needs to be able to explain **why** and **how** the novel approach to health care delivery will provide better patient outcomes as well as higher job satisfaction among team members (Raney et al., 2017).

Importantly, the PCP champion needs time outside of direct patient care to truly lead the work by attending meetings, aiding in implementation, providing education to physicians and other team members, helping to recruit the consulting psychiatrist, and so on.

PCP Pitch

The "pitch" refers to the critical moment in which the primary care provider (PCP) takes the initiative to introduce the patient to the behavioral health provider (BHP). During this interaction, the PCP not only makes the introduction but also actively encourages the patient to explore and utilize the range of behavioral health services offered by the integrated care team. This interaction aims to foster a seamless transition and promote the patient's engagement in their mental and emotional well-being. The examples that follow are also on page 132 of Raney et al. (2017).

Warm Handoff Examples

Below are two examples of a PCP introducing a patient to the BHP in a way that promotes comfort and a sense of safety for the patient.

Example 1

PCP: This is our BHP, Margie, who I was telling you about.

BHP: Nice to meet you, Joe.

PCP: Joe has been struggling with pain and has not been able to do a lot of things that he enjoys because of it, like playing with his grandchildren. He has been using more pain medication than I prescribed, so he tends to run out early. I worry about overuse of addictive and risky medication. I think that some of the treatments that you do so well will help him manage his pain better so that he doesn't run out of his medicine while still being able to do the things he enjoys.

BHP: Definitely. Joe, I have a little time right now if you can stay a bit longer. Would that be okay?

Example 2

PCP: Julie, this is my colleague, Margie, a member of our team who collaborates with people on handling stress better.

BHP: Good to meet you, Julie.

PCP: Julie is now working two jobs and having a lot of headaches. She's taking up to 2,400 mg of ibuprofen daily, and I was telling her I'm concerned about the safety of taking this much every day. Do you think she'd have fewer headaches if you shared some stress management techniques with her?

BHP: Well, it won't hurt, and I'd like to talk with her about what else is going on in her life right now. Is that okay with you, Julie?

Addressing Chronic Problems

The following are two examples of how a PCP informs a patient that the BHP will be added to their care team or included in their visit to help address chronic issues.

Example 1

"We have been working on this problem for a while. I have run the tests, and I still need more information about what may be going on. Please excuse me while I go get our behavioral health team member to help us."

Example 2

"I can tell you've been depressed for a long time. I believe that [insert patient's concern] is a part of the picture here, and I'm going to include our BHP in your care."

Role of the BHP

The role of the BHP is to bring "behavioral health skills and interventions into the exam room and to the patient" (Raney et al., 2017, p. 91). Notably, the terms *behavioral health provider*, *behavioral health consultant*, and *behavioral care manager* are interchangeable, and this role is central to the integrated care model. "The BHP is truly the heart of the model. BHPs have training in culture change, building effective group norms, and team process. As a result, BHPs affect the development of the team and are the key member to keep the team's focus on further development" (Raney et al., 2017, p. 76). Typical BHP tasks, ideal BHP attributes, and other considerations about the BHP are as follows.

BHP Tasks

Typical tasks and activities for BHPs within an integrated care team include the following.

- Provide consultation for PCPs and other team members as needed.
- Be available to help with challenging visits, such as with patients who become emotionally dysregulated during their visit.
- Conduct patient risk assessments.
- Engage in brief interventions.
- Make referrals to specialty care for patients who have high-risk behavioral problems.
- Develop educational materials for patients and share them with the care team.
- Educate the team on the following.
  - The ways in which physical health and culture intersect with behavioral health
  - The fundamental aspects of motivational interviewing
  - The importance of protocols for brief interventions during patient visits

BHP Key Attributes

The ideal BHP for an integrated care team must have competence across a wide range of activities. To effectively strengthen and support an integrated care team, the BHP should have the following capabilities (Raney, 2019).

BHP attributes should promote team learning, patient trust, and maximum flexibility. The BHP should

- be flexible, adaptable, and prepared to provide interventions as needed and respond quickly to a wide variety of emerging issues;
- remain focused and organized amid intense stress and shifting, often simultaneous demands, such as concurrent patient visits;
- build rapport with patients and collaborate effectively with members of the care team; and
- deliver effective training, educate team members and patients on principal issues, and engage in continuous learning.

Other Considerations

The BHP's involvement ensures that behavioral health considerations are built in throughout all aspects of integrated care. They help prioritize this aspect of care by doing the following (Raney et al., 2017, p. 76).

- Encouraging the team to include behavioral health in all phases of care
- Reminding the team of the core model components
- Alerting the team when the core model components are overlooked
- Facilitating communication across the team and promoting the incorporation of new processes or procedures (e.g., warm handoffs, registry review, screening)
- Keeping patient goals at the center of the team's focus
- Monitoring progress and data for the team
- Presenting data to the team for review to inform treatment decisions
- Translating culture between the patient and the care team

The provision of brief interventions for patients is a key consideration for the BHP's role within the care team. A brief intervention is a short session in which the provider applies evidence-based approaches for bringing awareness to the patient about an existing behavioral health issue and motivating them to seek further treatment or make healthy changes. In these interventions, the provider may employ the following approaches.

- Motivational interviewing, which helps encourage patients to take the necessary actions to begin addressing a behavioral health challenge
- Development of distress tolerance and emotional regulation skills, which equip patients with healthy approaches to managing distress
- Behavioral activation, which promotes patient engagement in enjoyable, healthy activities
- Problem-solving therapy

BHP Extended Team

In some rural areas, the shortage of licensed providers and the high volume of work needed from BHPs are obstacles. To lessen these difficulties, integrated care teams may opt to assign certain tasks to paraprofessional staff who are part of a BHP extended team. Peer support specialists or community health workers on Tribal contracts often support BHP teams, aid with case management, provide transportation for patients, and engage with the community. In certain contexts, a chemical dependency counselor or other paraprofessionals who have received specialized training in intervention techniques may serve as the primary Behavioral Health Provider (BHP).

When having paraprofessionals perform BHP tasks, keep in mind that staff members who fill case management and care coordination categories may need certain training to qualify for billing. **PLEASE NOTE:** Set aside time for a thorough **review of billing codes in your area** so the team can learn about what is allowable for your project. Check the IHS *Indian Health Manual*, the service unit's accreditation standards, U.S. Office of Management and Budget (OMB) contracts, and Centers for Medicare & Medicaid Services (CMS) and state policies. For example, CMS' guidelines on behavioral health services list CMS-approved roles for paraprofessionals. State rules on allowable shared tasks typically expand on this CMS guidance in a way that addresses local needs. CMS and state agencies may require specific documentation for any work that paraprofessionals perform. Teams should document all shared tasks thoroughly to demonstrate that paraprofessionals are operating within their respective scopes of practice and under appropriate supervision.

Table 1 illustrates the tasks that can be delegated to paraprofessionals and those that must be completed by a licensed provider (Raney et al., 2017, p. 104). Allowable tasks differ from state to state, and BH2I sites must review what is allowable within their facilities and according to their accreditation standards, OMB contracts, and states, as well as what is permitted under CMS policies.

Staff Position	Allowable Tasks
BHP 1. Paraprofessional staff	• Screen patients and repeat measurement as needed. • Enter data into and maintain the patient registry. • Support engagement and follow-up. • Conduct phone follow-ups. • Engage in health promotion.
BHP 2. Paraprofessional staff with advanced training	• Conduct brief interventions for situational stress. • Educate patients on ways to promote their physical and behavioral health. • Help with care coordination.
BHP 3. Licensed BHP	• Assess for and address complex behavioral health needs. • Diagnose, provide education on diagnoses, and respond to any patient questions or concerns. • Conduct brief psychosocial interventions that may be billable.

Table 1: Allowable behavioral health care tasks by BHP staff position

Shared tasks that paraprofessionals may perform within an extended behavioral health care team may include the following.

- Coordinate closely with the PCP and, when proper, other BHPs to provide behavioral health care.
- Screen patients for common mental health and substance misuse disorders.
- Provide patients with behavioral health-related educational materials and service unit brochures.
- Engage patients in discussion about the roles that being active and improving nutrition can play in alleviating certain behavioral health symptoms and supporting medical treatment goals. Involve patients in related activities, such as taking them shopping for groceries or taking them on walks for exercise and companionship.
- Assess patients' social determinants of health.

- Create and maintain a list of local resources for patients' basic needs, such as housing, food, and transportation, and provide the information to patients or help them apply for these programs as needed.
- Document clinical outcomes and measure patients' symptoms to identify changes and gather information about treatment side effects or complications; involve other members of the treatment team as needed to address these issues.
- Participate in regular caseload consultation with the psychiatric consultant, focusing mainly on new patients or those not improving as expected, and communicate treatment recommendations from the consultant to the PCP.
- Refer patients to evidence-based psychosocial treatment (e.g., cognitive behavioral therapy, problem solving therapy, medication-assisted treatment) and follow up with the patient to ensure they have connected to the referred care.
- Facilitate and oversee referrals to specialty mental health services and transitions from specialty care back to primary care.
- Support patient engagement and follow-up care.
- Maintain an understanding of the behavioral health services available at the state level, including eligibility requirements for patients and the proper referral processes.
- Build relationships with other clinics in the area to understand all services available for patients locally.

The items in the above list are examples. BH2I grantees should review what is allowable within their facilities and according to their accreditation standards, OMB contracts, and states, as well as under CMS policies.

Role of the Psychiatric Provider

In integrated care settings, the psychiatric provider can play a variety of roles, including as a consultant to the primary care team or a direct care provider.

Key Psychiatric Provider Attributes

When hiring psychiatric providers, integrated care programs should seek candidates who are adept in the following areas (Raney et al., 2017).

The psychiatric provider should be capable of

- comfortably serving in a consultative capacity without assessing the patient in person;
- being consistently engaged, adaptable, and creative;
- collaborating effectively as part of a team; and
- educating other providers on a variety of topics pertaining to psychiatric care.

Consultative Approaches

The level of inclusion of psychiatric expertise in an integrated care team is dependent on several factors, such as psychiatric staff availability and related wait times, provider location, and degree of patient reluctance to accept psychiatric referrals because of stigma. Judicious use of scarce psychiatric resources helps promote access to direct psychiatric care for those who need it the most.

To best leverage limited psychiatric resources, many integrated care teams engage psychiatric providers as consultants in addition to referring patients for direct psychiatric care (Raney et al., 2020). When acting in a consultative capacity, the psychiatric provider primarily offers diagnostic clarity, psychopharmacologic recommendations, and education to the team. This support enables the team to manage common, less complex conditions while saving referrals for the direct care of patients who are not improving as expected and have complex conditions, such as serious mental illness, treatment-resistant depression, or complex post-traumatic stress disorder. To further increase access to psychiatric appointments, the team can have stabilized patients who are receiving treatment from the psychiatric provider return to the PCP for follow-up as needed, including for refills of psychotropic medications. Table 2 lists approaches that maximize the psychiatric provider’s role in integrated care settings (Raney et al., 2020).

Approach	Associated Provider/Team	Reduced Need for Referral
Didactic presentations on behavioral health diagnoses	PCP	Maybe
One-time consults with PCP on implementation of recommendations	PCP	Yes
e-Consults/curbside consultations	PCP	Yes
Psychiatry access line—child or adult	PCP	Yes
Case reviews with team, chart reviews with recommendations	PCP	Yes
Asynchronous consult with video stored and sent	PCP	Yes
Project ECHO: telementoring and education	Some sharing	Yes
Collaborative care management: registry review and recommendations for treatment adjustments	Shared	Yes

Table 2: Approaches to the use of psychiatric time in integrated care settings

Often, these consultative approaches do not have a billing code, but they are worth the expense. However, CMS approved the Psychiatric Collaborative Care Model (CoCM) as a billable service beginning in 2017. The CoCM is implemented by a primary care team that includes a PCP, a behavioral health care manager who has formal education or specialized training in behavioral health (with or without independent licensure), and a consulting psychiatric provider who engages in weekly case reviews or consultations with the CoCM team (Centers for Medicare & Medicaid Services, 2025).

The benefits of consulting with a psychiatric provider include improved patient and clinical access to psychiatric services, increased team collaboration and cohesion, and increased PCP confidence in treating patients' mental health conditions. If done adequately, consultations can lead to the PCP and BHP providing effective care for common, less complex conditions in a way that reduces emergency room and inpatient admissions. This consultative approach often results in increased job satisfaction for both the PCP and psychiatric provider. See the appendix for a detailed description of the consultation process.

Role of the Patient

Integrated care teams are patient-centered, and as such, the patient's goals define the treatment approach. In integrated programs, patients are regarded as active participants within the treatment team. They have the opportunity to establish goals, articulate their treatment priorities, and provide feedback throughout the duration of their care.

Patients also share in decision-making about treatment. Collaborative decision-making may be a learning process for both providers and patients who are accustomed to traditional care.

"In high-functioning health care teams, patients are members of the team, not simple objects of the team's attention; they are the reason the team exists and the drivers of all that happens" (Wynia et al., 2012, p. 1327).

As the patient becomes more comfortable as a member of their own health care team, they begin to feel psychologically safe. "Psychological safety concerns an individual's belief of whether it is safe to take interpersonal risks" (O'Donovan et al., 2021, para. 1). Many have found that "psychological safety in healthcare teams has become increasingly relevant and important due to the ongoing COVID-19 pandemic" (O'Donovan et al., 2021, para. 1).

BH2I Cohort 1 found that building a relationship with the patient and valuing their input on decisions about their health care are vital to attaining successful patient outcomes.

Please note that developing trust with the patient takes time, and because of patient individuality and personalities, the time needed to build trust may vary by patient.

Workflow and Process Formation

Another central consideration in developing an integrated care team is development of the processes and workflows the team will follow. BH2I Cohort 1 began by developing workflows and processes that placed the BHP in the primary care facility, and by the end of the second year, the programs had comfortable processes in place. Year 3 changed with the advent of COVID-19 and the increased use of telehealth to provide care to communities. The pandemic taught BH2I Cohort 1 to adapt its workflows and processes to crises workflows and processes.

Because workflows and processes are a central element in how integrated care teams work together, they are based on the clinic itself, the team's shared values and goals, and the population served. No universal workflows exist; instead, the team should collaboratively develop these approaches. Figure 3 is an example of a workflow for an imaginary clinic, and it provides a place for teams to start. Processes considered in workflow development that may need definitions include the following (Raney et al., 2017).

- Purpose and format of team huddles (a brief review of the day's schedule at the beginning of the day)
- Protocols for the use of screening tools, including the cadence of rooming patients
- Warm handoffs, including scripted introductions
- Purpose and format of team meetings
- Routine analysis of data and metrics

Behavioral Health Integration: Patient Intake and Assessment

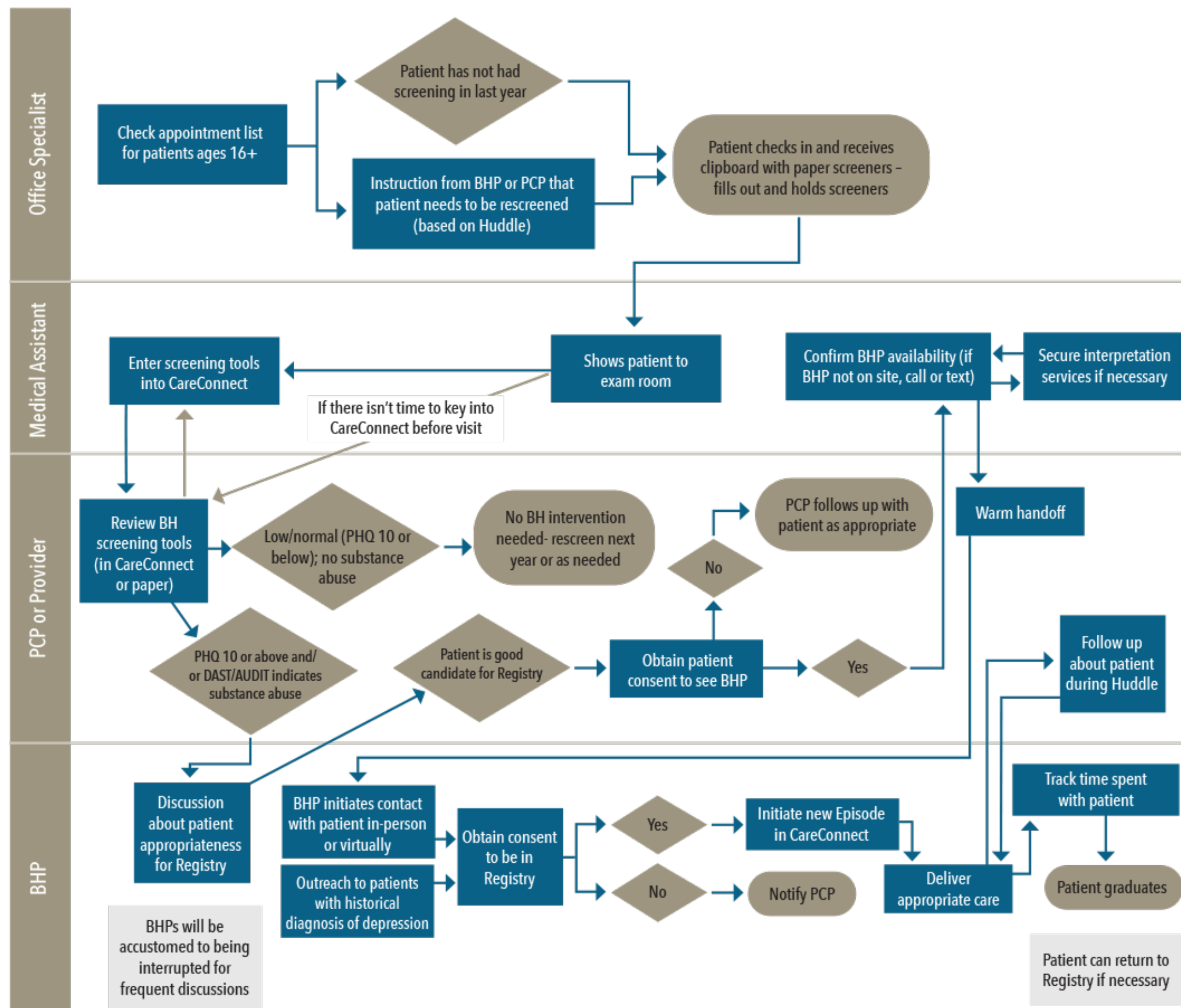

Figure 3: Behavioral health integration workflow example

II. Screening, Case Findings, and Referral to Care

To decide which patients in the primary care setting need behavioral health care, universal screening for common behavioral health conditions (e.g., depression, anxiety, substance use) is the recommended approach. Patients may directly report symptoms, but in many cases, patients can overlook physical symptoms if self-reporting is the only mechanism for determining who needs care. Screening all patients on a regular basis is particularly important; often, the recommendation is for patients to participate in one screening per year. Under the Zero Suicide prevention model, screening patients with a suicide risk assessment at every visit is highly recommended, except to patients who visit very often, such as several times per month. Check the IHS website for up-to-date information on a suitable screening tool.

According to best practices for common behavioral health condition screenings, the results should be handled by the reception or nursing staff and entered into the EHR system to ensure they are readily available when the PCP enters the exam room (Figure 3, above, illustrates this workflow). The PCP then reviews the results and develops an action plan for any identified behavioral health conditions. Action steps may include a warm handoff to a BHP.

A note on the use of the PHQ-2

Using a positive Patient Health Questionnaire-2 (PHQ-2) followed by a PHQ-9 is a common approach to the annual depression screening required in primary care. However, there are several limitations to following this process compared to administering the full PHQ-9, as listed below. Thus, the **recommendation is to replace the PHQ-2 with the PHQ-9** for annual depression screening to avoid missed opportunities in patient care as well as to gather data required under the Government Performance and Results Act.

- The PHQ-2 does not provide suicide screening or address suicidality.
- The PHQ-2 is not for anyone already diagnosed with depression or dysthymia, as they do not require screening for a condition they are known to have; they should receive the PHQ-9 each time.
- PHQ-2 and PHQ-9 scores are not interchangeable and, therefore, not comparable over time.
- The PHQ-9 identifies mild depression symptoms that the PHQ-2 may miss, creating opportunity for early intervention or treatment.
- The PHQ-9 picks up elevated levels of distress and can serve a broader purpose than single diagnosis screening. The PHQ-9 can identify other conditions, such as anxiety disorders, trauma, and substance use.

The PHQ-9 takes 3 to 5 minutes to complete and is not overly burdensome in comparison to the PHQ-2.

Screening Tools

Providers can screen both adult and youth populations. To choose proper, effective screening tools for clinician use that will work well for the intended population, teams should find tools that have the following basic properties (Fortney et al., 2017).

- **Efficient and brief**, taking no more than a few minutes to administer
- **Established** as reliable and valid
- **User-friendly** and reflective of how clinicians work
- **Clinically meaningful and useful,** covering the criteria and symptom domains of the disorder
- **Clinically relevant** to decision-making
- **Easily extractable** and not embedded in progress notes
- **Sensitive to changes** induced by medications or psychotherapy
- **Inexpensive** to administer

The communication channel for conducting the screening, such as questions asked aloud by staff, a pen and paper, or an online patient portal, are important considerations in the screening workflow. In addition, consider how the screening results will integrate with the EHR system or whether they will need manual entry.

Table 3 and Table 4, which follow on the next page, list the screening tools most commonly used in primary care settings, including those that are most appropriate for adults and those ideal for children. Depending on the population served or the disorders seen in the community, providers can add other tools. For example, if one of the planned interventions is to reduce depression in patients, the PHQ-9 is a common choice. If the focus is on collaborating with patients who have post-traumatic stress disorder (PTSD), however, the provider may need to use a different tool or a combination of tools, such as the PTSD Checklist—Civilian Version along with the PHQ-9, to adequately guide service planning. Tools for assessing substance use issues include the Drug Abuse Screening Test (DAST) and the Alcohol Use Disorders Identification Test (AUDIT). The provider may also want to assess a patient’s quality of life and use the Lehman Quality of Life Interview assessment.

Diagnosis	Tools	Cut-Off Score for Further Assessment
Depression	PHQ-9	> 9
Anxiety disorders	GAD7	> 9
PTSD	• PCL-5 • PTSD-PC	
Substance use	• AUDIT-C • DAST • NIDA Quick with modified ASSIST	
Bipolar disorder	• CIDI—Bipolar DO • MDQ	
Suicide risk	ASQ	

Table 3: Commonly used adult behavioral health screening tools

Diagnosis	Tools	Cut-Off Score for Further Assessment
Depression	PHQ-9 (or the PHQ-A for adolescents or the Edinburgh Postnatal Depression Scale [EPDS] for maternal mental health)	PHQ-9: > 9 PHQ-A: > 4 EPDS: > 13
Child anxiety-related disorders	SCARED (pediatrics)	> 9
PTSD	• CRIES-8 (pediatrics) • CRIES-13	17 30
ADHD	VANDERBILT	

Table 4. Commonly used pediatric behavioral health screening tools

Enhanced Referral—Tracking and Follow-Up

A purposeful and thoughtful design of the referral process can improve the quality of the patient's experience of the referral, provide more consistent communication with the referral partner, and result in a higher rate of successful referrals. The outcomes of a successful referral include the patient's attendance at the appointment and the integrated care team's receipt of the clinical documentation from that referred visit (Glossa & Raney, 2021).

Core Steps of the Enhanced Referral Process

To set up a referral process that promotes successful outcomes, care teams should establish protocols for the workflow components listed in Table 5 (an example of an enhanced referral workflow is available in the appendix; Glossa & Raney, 2021). The following table also presents considerations for ensuring effective implementation of each component.

Workflow Component	Implementation Considerations
Identify the need for a referral.	Develop this identification process by discussing and mapping out the steps of this workflow element.
Communicate about the referral.	As an initial step to implementing this component, identify all internal and external stakeholders who will need to be informed about the referral process.
Engage the individual.	Plan for successful engagement by identifying methods for enhancing the patient's engagement and keeping them at the center of the process.
Track the referral.	Create or find a suitable tracking tool and identify a staff member to oversee referral tracking.
Conduct performance monitoring.	To establish a performance monitoring process, articulate how performance will be evaluated and how those findings will be applied to improve performance.

Table 5. Referral process workflow components and considerations for their implementation

Referral Tracking

Tracking referrals and the related outcomes is essential to ensuring seamless care for patients and avoiding fragmented or duplicated services. To effectively track all internal and external referrals, care teams should choose a staff member to manage this task and should find or create a suitable tracking tool. Many EHR systems include instruments for tracking referrals; spreadsheets are also effective for housing the needed tracking information. Table 6 gives an example of a referral tracking spreadsheet (Glossa & Raney, 2021). This referral tracking spreadsheet template is also included in the appendix. The spreadsheet serves as a starting point for tracking referral completion, and it can also provide a high-level view of how a specific provider or organization is performing in terms of providing referred care (Glossa & Raney, 2021).

Patient Identifier	Provider	Organization/ Provider Referred to	Date Referral Sent	Referral Received	Patient No-Showed Appointment	Return Communication Received	Medications and Care Plan Updated

Table 6: Example referral tracking spreadsheet

Formalizing Referral Partner Relationships

Clear delineation of roles across organizations or departments promotes a smooth referral process. To formally clarify these roles, those involved may sign an agreement, such as a care compact or memorandum of understanding, in acknowledgement of who handles each aspect of the referral process. Such documentation helps the organizations work together efficiently and provides a reference if questions arise about the referral process. This agreement typically outlines mutual responsibilities, such as keeping accurate clinical records and transferring patients promptly, and it lists expectations for both the primary care referrer and the specialty provider who receives the referred patient. An example of an agreement between referral partners is in the appendix under Primary Care—Specialty Care Compact. The example includes shared tasks, primary care responsibilities, and specialty care responsibilities.

III. Integrated Service Behavioral Health Care

Each of the following subsections describes a different integrated service for behavioral health care.

Warm Handoffs/Patient Engagement

A warm handoff is the referral from the PCP to the BHP and is a form of patient engagement involving the PCP and BHP. The PCP does an in-person warm handoff or, as BH2I Cohort 1 found helpful, an e-warm handoff in a virtual care setting. The key point of a warm handoff is the patient's introduction to the BHP by the PCP. The purpose of this introduction is to underscore the BHP's credibility and respect from the PCP's perspective. It begins the trust building needed for successful BHP treatment delivery. The PCP Pitch subsection in Section I of this document provides example scripts for a warm handoff of the patient from the PCP to the BHP.

Evidence-Based Brief Interventions

The integrated care team provides onsite behavioral health care to ensure these services are available for patients who need them. According to the AIMS Center article *Evidence-Based Behavioral Interventions in Primary Care*, the key tenets of brief interventions are as follows.

- Include a patient engagement component. Skipping right to treatment does not work.
- Be efficient, running no more than 20 to 30 minutes per visit.
- Follow a structure-based approach. A modularized treatment with clear steps keeps the provider and patient on track despite the distractions in primary care.
- Minimize required clinical training. Non-specialists on the health care team can administer the treatment.
- Be relevant and applicable to the diverse patient populations found in primary care.
- Have a substantial research evidence base.

IHS uses the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach for evidence-based brief interventions. As listed in Raney et al. (2017, pp. 99–100), the following brief interventions are also evidence-based.

- Motivational interviewing
- Behavioral activation
- Cognitive behavioral therapy
- Solution-focused brief therapy
- Problem-solving treatment

- Mindfulness-based stress reduction
- Acceptance and commitment therapy

Several evidence-based practices were developed or validated using clinical trials with AI/AN populations. These interventions include culturally adapted motivational interviewing, culturally adapted cognitive processing therapy, and motivational enhancement therapy (Wendt et al., 2022). In addition, researchers have identified several culturally adapted interventions as practice-based interventions based on work in AI/AN communities. These practice-based interventions include motivational interviewing, family systems (i.e., network therapy), community reinforcement, mindfulness approaches, and cognitive behavioral therapy (Substance Abuse and Mental Health Services Administration, 2018).

Teams should take the time to decide which brief interventions will work within their projects.

Case Conferencing

Case conferencing is a targeted interaction between providers for sharing pertinent patient information to promote coordination of care. The Standards Manual recommends case conferences because they can be multidisciplinary and include providers internal or external to the PCP, a patient and their familial or close support, and other team members involved in the patient's care. According to Alves-Bradford (2016), the goal of case conferencing is to "provide holistic, coordinated, and integrated services across providers; reduce duplication; share information; and enhance patient care" (p. 5). Case conferencing is different from case coordination in a few ways, as delineated by Dr. Jean-Marie Alves-Bradford. It is

- formal,
- planned,
- structured, and
- separate from regular contacts.

Repeat Measurement/Longitudinal Assessment

Repeating measurements, or conducting longitudinal assessments, is one of the key principles of effective integrated care. On page 30 of an integrated care guide by Raney et al. (2017), within Tables 1–9, the authors noted that "measurement-based treatment to target identifies patients who are not improving, [and therefore] adjusting treatment with a caseload review by a psychiatric consultant" can take place. By tracking the measurement results in a registry, the integrated care team can assess whether the patient is improving over time (see a more detailed description in Section V of this document, which discusses measurement-based care).

Team Huddles

Typically held at the outset of the workday, team huddles are brief overviews of pertinent information intended to ensure that all team members are working from the same information. A team huddle typically lasts about 10 minutes.

Discuss the following items during a team huddle.

- Follow-up on any unfinished items from the previous day
- The status of clinic operations, such as staffing, any equipment or computer problems, upcoming or current unique events or meetings, and any cancellations or open slots
- Scheduled patients who have chronic conditions
- Patients who were recently hospitalized or in the emergency department
- Patients who have disengaged from therapy and may need encouragement to re-engage in services
- Patients who may benefit from a phone call from a peer support specialist or case manager
- Canceled appointments and backfill opportunities
- Patients who need BHP intervention or rescreening with the PHQ-9 or other behavioral health screening tools
- Information on the status of patients previously seen by BHPs and any additional follow-up needs
- Approaches for addressing workflow challenges
- Case presentation of new patients
- Communication or process adaptations
- Registry for individuals who are on the schedule for the day
- Outcome data for the patients on the day’s schedule

IV. Documentation Standards of Care: BHP Approach

A vital best practice for documentation in integrated care settings is the sharing of patient records with the entire clinical team. To provide effective, cohesive care, the PCP and other integrated team members must have up-to-date information on the treatment. Despite common misconceptions to the contrary, the Health Insurance Portability and Accountability Act (HIPAA) and other health information privacy regulations apply only to outside parties and **do not govern internal information sharing** among team members (Raney, 2021).

Recognizing that the primary care team members will review the patient documentation, the BHP should write notes according to the following concepts.

Patient documentation should adhere to the following guidelines.

- Be brief and not overly detailed, especially around sensitive details (for example, noting that a patient has a history of sexual trauma without going into the details of what happened)
- Focus on the symptoms, with comments included on the results of assessments through tools like the PHQ-9
- Contain information on the diagnosis, symptoms, interventions performed at visits, and follow-up plan
- Begin by describing the assessment and plan, with other details included at the end to enable busy PCPs to quickly review the notes and glean the key information
- Be completed during the patient's visit, rather than afterward, so that the patient can verify the included information

V. Measurement-Based Care and Stepped Care

Measurement-based care (MBC) is the practice of using data collected during a patient's treatment to inform the clinical care approach. In addition to its role in shaping treatment planning, MBC improves patient engagement by involving the patient in data review and treatment planning. This approach requires routine monitoring for the duration of a patient's care and the application of the resulting metrics in clinical decision-making. On a larger scale, a review of program-wide data often serves as an evaluation of the program, highlighting successes and areas for improvement.

Stepped care is a key part of MBC. Stepped care is a hierarchical system of interventions that progresses from the least intensive to the most intensive interventions. The stepped care model aligns with a patient's needs regardless of time spent in treatment and is bi-directional to support patients in transitioning to higher or lower intensity of service depending on how their needs change.

Under this model, the level of resources assigned matches the patient's needs, with the most intensive resources distributed to those with the most severe symptoms. Figure 4 (on the following page) illustrates the stepped care model from a presentation by Dr. Raney (2020).

A dynamic interplay between MBC and stepped care is evident, with each being dependent on the following components.

- Systematic and frequent outcome tracking across treatments
- Use of standardized measures, with more than one measurement applied where possible to inform clinical decision-making
- Use of benchmarks and targets for comparison with client-specific data
- Sharing of data with patients and treatment team members at each data collection point
- Use of data to inform treatment decision-making

The Standards Manual encourages provider teams to review measurement data **at least monthly** and more often at certain points, including post-intake, during status reviews, and for transition planning. The treatment that ensues should be an evidence-based practice (EBP), meaning that published, replicable scientific research shows that the intervention is typically efficacious in treating people who have a particular behavioral or mental health issue, such as isolated elders who have PTSD. The provider must implement the EBP according to the developer's specifications, such as the number and structure of sessions suggested in the model, to ensure fidelity. The Standards Manual encourages teams to follow the model in practice (see Table 3 and Table 4 on page 29 for a list of measurement tools by diagnosis).

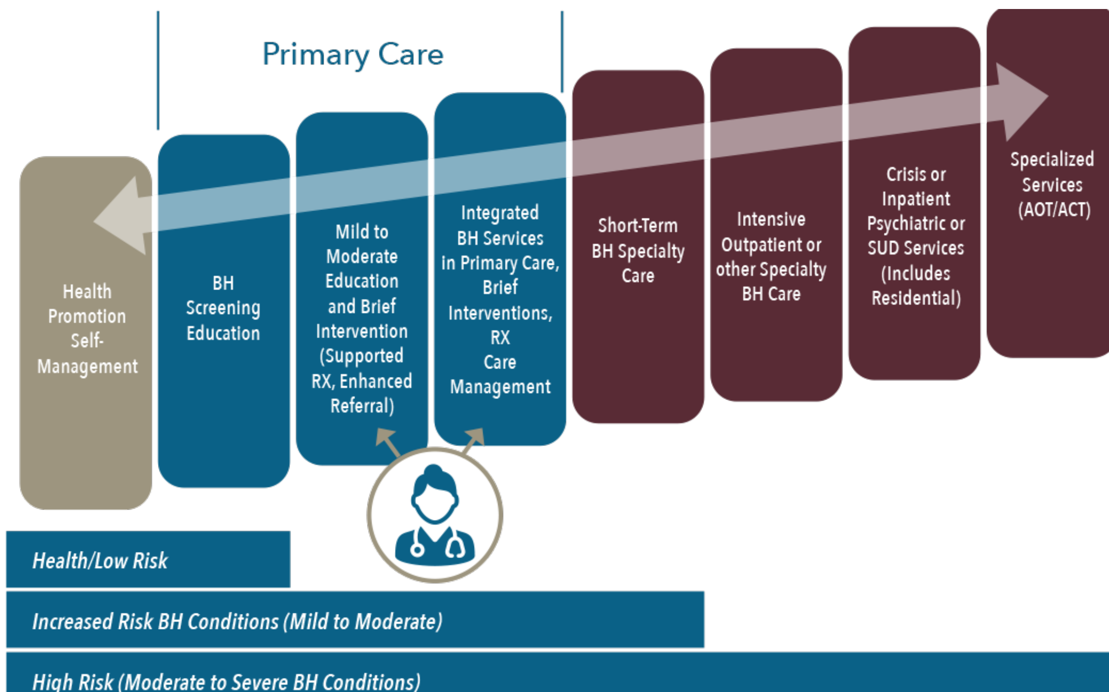

Figure 4. Stepped care continuum

The guidelines or protocols for implementing the EBP form a consistent clinical treatment plan across providers. Within an integrated care model, protocols may also include the introduction of medications as a treatment modality for such disorders as anxiety, depression, or PTSD. As illustrated in Figure 4, the protocols for lower-risk conditions may include health promotion and education, while at the other end of the spectrum, protocols for high-risk conditions may involve assisted outpatient treatment/assertive community treatment (AOT/ACT).

Registry software that tracks behavioral health measures may already be included in your EHR system, or it can be added as a module to the EHR system. Check with your EHR techs for availability. Either way, teams can use registries to augment data housed in the EHR system. Registries can log each item in addition to the composite score from standardized tools, such as the PHQ-9 or DAST. This software program or app allows the staff to look at specific items and find response patterns or examine aggregate data for a subgroup of patients receiving a specific treatment intervention. In addition to contributing to quality management, care coordination, and referral facilitation, registries are often helpful in outcome evaluation, as the integrated team can use the data to assess patient outcomes. Regardless of whether a team chooses to use a registry in their integrated care model, it is helpful to share information from the EHR system with the full team.

The use of the EHR system and other registry software may present unique challenges to interoperability across departments and disciplines. Integrated care teams should work with their IT departments to coordinate the use of the registry software because information-sharing strategies that contribute to whole-person care are a desirable part of any integrated care project.

VI. Culturally Adapted Self-Management Support Tools

The Standards Framework strengthened the culturally adapted self-management support domain "to emphasize patient activation and recovery with adaptations for literacy, language, and local community norms. [The Standards Framework also adds] reviewing symptom scores with patients and clarifies types of self-management supports and activities for goal setting" (Chung et al., 2020, p. 27).

> **Use of Cultural Conceptualizations for Explaining Behavioral Health Issues**
>
> BH2I Cohort 1 grantees found in their work that cultural conceptualizations made more sense and were consequently more motivating to patients.
>
> One grantee shared, "Care coordinator has been excellent with providing insight to ways culture can be included in programming."

Culture in the context of integrated care has more than one meaning depending upon the circumstance. For example, in primary care clinics, the medical culture may influence the actions of providers, while behavioral health has a culture of its own. Urban and rural cultural contexts differ from one another. For this domain's purposes, culture will refer mainly to general AI/AN culture and the incorporation of culture into the integrated care model as an added aspect of health in addition to physical and behavioral health. As shown in Figure 5, these three aspects of health, along with social determinants of health, are components of the four-way integration framework, which is a way to conceptualize and organize an integrated care system.

Four-way integration: A place-based organizing framework—Healthy People 2020

- **Primary Care**
- **Behavioral Health**
- **Social Determinants of Health**
- **Tradition Healing & Cultural Inclusion**

(Office of Disease Prevention and Health Promotion, 2020)

Figure 5: Four-way integration

Social determinants of health are typically thought of as the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness. In this framework, social determinants of health are given equal footing as necessary components of integrated health at the community level. In addition to enhancing access to care and addressing gaps found in standard care, motivating factors for delivering integrated care include promoting culturally appropriate services and addressing disparities and gaps affecting AI/AN people (Lewis & Myhra, 2017).

Integrated care often fits well with the holistic view of health common in AI/AN communities. In fact, one of the key motives for moving toward integrated care in Tribal communities is the disharmony between standard medical treatment and culturally appropriate care. Integrated care, which involves cross-disciplinary teams, is an ideal vehicle to bring about greater inclusion of culture and a more holistic perspective of care (Guilmet & Whited, 1988).

Adapt the Language

"Our behavioral interventionist changed language to change [the] preconceived notion of behavioral and mental health."

Consider: Is *suicide* a term used in the community?

Culturally adapted integrated care involves addressing culture in all aspects of practice. For example, the application of culturally appropriate screening practices requires careful consideration of the language used in the screening tool and management of the process (see Table 5 on page 30).

The T/TA Center team collected qualitative data from BH2I Cohort 1 grantees to understand lessons learned around culturally adapted self-management support strategies. This section of the Standards Manual provides a general process for including culture in integrated care, with examples from BH2I Cohort 1, and highlights selected quotations from this data collection effort. Notably, more than 95% of the comments about incorporating culture into care framed culture as a valuable and essential part.

The first step in the process is to ask the patient if they would like to involve a culture keeper or navigator as part of their care team. If they agree, then the team can seek a culture keeper who can help the patient identify the traits they would like to see in a culture keeper.

The second step is to engage a culture keeper or navigator. As noted on page 10 of this Standards Manual, they are members of the extended behavioral health team. Culture keepers hold the knowledge of culture and traditions embedded in the patient's heritage and can

Integrate Culture Into Educational Materials

"We have developed handouts to provide at Well Child Checks from newborn to year 5. The handouts include education from AAP's recommended anticipatory guidance, self-care tips for caregivers, and a section on cultural teachings that are applicable for each WCC age group."

"We explained the rationale for treatment, relevant cultural values, practices, and concepts in educational materials posted in treatment rooms and offered as handouts."

work with the integrated care team to ensure that information is handled respectfully and with awareness of the patient's cultural values.

Third, once the culture keeper or navigator is engaged, they may be unable to assist because of certain cultural conditions (e.g., clan affiliations, gender-based or familial relationships). If this is the case, then they may be able to provide a referral to another culture keeper or navigator who is more suitable to meet the patient’s cultural values and needs. This consideration is very important because an incorrect choice in cultural support may do more harm than good.

The last step is to involve the patient’s culture keeper or navigator in all integrated care activities (e.g., morning huddles, warm handoffs, patient briefings). This way, they can ensure that their support complements the patient’s care.

Several examples of how to include culture in integrated care are provided below:

- Foster a culturally responsive and welcoming environment by displaying cultural artwork, symbols, and artifacts that reflect the diverse communities served. These visible expressions of respect help clients feel seen, safe, and valued.
- Maintain a supply of culturally significant medicines used in traditional healing for emotional, mental, spiritual, and physical wellbeing, These items can include sage, sweetgrass, roots, and other plant-based remedies. Make these materials available in a respectful and informed way. Some clients may be deeply rooted in their traditional practices and only need access to these materials to engage in self-directed healing. Others may be unfamiliar with or disconnected from their cultural traditions and may benefit from support, education, or facilitated connections to cultural healers and navigators.
- Routinely ask clients if they engage in cultural or traditional healing practices. These discussions should be approached with cultural humility and incorporated into standard assessment and intake processes. Document this information in the EHR system in a standardized and easily identifiable format so providers can use it to inform care planning and referrals.
- Designate safe and accessible spaces within the clinic for cultural practices, such as smudging, and normalize their use as part of holistic and trauma-informed care. Provide guidance on how to respectfully access these spaces and engage staff and clients in these practices.
- Ensure that clinic workflows support warm handoffs to cultural navigators and traditional healers. Understand that referral processes to cultural healers differ from Western health care models and should be guided by cultural navigators in alignment with local Tribal customs. For example, initial requests for healing may begin with offering traditional medicine, such as tobacco.

- When making referrals to traditional healers, take care to ensure that there is a culturally appropriate fit between the client and healer, considering factors such as Tribal affiliation, clan membership, and family relationships. The therapeutic relationship in traditional healing is often based on these relational and cultural ties.
- Ensure staff know that compensation for traditional healing may not follow Western models (e.g., monetary transaction). It may involve gifting traditional medicines or other forms of non-monetary exchange in line with cultural norms and expectations.
- Recognize the broad purposes of traditional healing practices, which are not only for illness but also for spiritual and emotional grounding, daily ritual, and major life transitions, such as childbirth (e.g., umbilical cord care), rites of passage, and naming ceremonies.
- Actively advertise upcoming cultural activities and ceremonies hosted by the clinic or happening in the community. Use posters, digital signage, and staff outreach to promote engagement. Cultural events, such as drumming circles, seasonal ceremonies, and traditional teachings, should be seen not as supplemental but rather as central to healing. Integrate these approaches into treatment plans when appropriate. For instance, use behavioral activation to address depression by encouraging participation in community cultural activities or recommend grounding techniques, like smudging or connecting with elders, to support clients managing anxiety or trauma.
- Ensure that the clinic offers ongoing cultural activities as part of a whole-person, holistic model of care. These activities can include jingle dress making, drum making, singing groups, and traditional craft circles. Such activities not only support healing from grief, trauma, and mental health challenges but also strengthen identity, connection, and resilience.
- Embed cultural practices into everyday clinical care, demonstrating that the clinic honors traditional knowledge systems, empowers community healing, and fosters culturally congruent and effective mental health services.

The T/TA Center team analyzed the qualitative data and identified the following three key findings on culture in integrated care.

1. **Reduction of mental health stigma** in AI/AN clinics
2. **Increased cultural sensitivity** among providers and other staff because of cross-sharing of cultural insights
3. **Increased patient consent for sharing information** between primary care and behavioral health care personnel

The three key findings from the qualitative study support the importance of understanding culture in integrated care. The first finding is important for patient outcomes because reduced stigma promotes patient retention. Increased cultural sensitivity among the care team is also vital to patient outcomes, given research that shows significantly improved patient engagement in treatment when providers participate in training about culturally appropriate approaches. Such

training makes providers more likely to recommend non-Western treatments (Arora et al., 2017). Cultural sensitivity for AI/AN patients may include providing written summaries of patient notes and treatment plans, involving families in treatment planning, and obtaining patient permission before sharing information with external providers.

In terms of tools that support self-management, BH2I Cohort 1 data named both clinic-based interventions and community-based integrated care cultural interventions. These approaches included

- using trauma-informed processes,
- increasing access to traditional healing, and
- leveraging community cultural programming.

Provide Trauma Training

"Our IHS staff attended trauma-informed integrated care training specific to Native American historical trauma."

Using Trauma-Informed Processes

Acknowledgement of and sensitivity to the historical trauma sustained by AI/AN people is critical in delivering care to this population. As reported in the U.S. Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health*, trauma associated with cultural factors, racism, discrimination, and poverty has contributed to the many mental health challenges for Indigenous peoples (Substance Abuse and Mental Health Services Administration, 2001).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the key principles of a trauma-informed approach to care include

- safety;
- trustworthiness and transparency;
- peer support;
- collaboration and mutuality;
- empowerment, voice, and choice; and
- understanding of cultural, historical, and gender issues.

Trauma-informed processes and practices enhance patient motivation and self-management. Knowledge about community trauma is important to successful integrated care in AI/AN communities.

Improving Access to Traditional Healing in Integrated Care Settings

Since time immemorial, many Tribal cultures have effectively applied myriad healing approaches that preceded Western medicine. In this context, traditional healing refers to Indigenous healing ceremonies, customs, practices, and beliefs specific to Tribes and rooted in pre-contact history.

Traditional healing approaches vary by Tribe, and many Tribal clinics offer them alongside Western medical approaches. Fostering holistic health is a primary focus of traditional healing. Challenges to including traditional healing in integrated care can involve difficulty finding community-trusted traditional healers and billing for service, as well as credibility concerns from the medical community around traditional approaches not researched through a Western lens.

> **Increase Access to Traditional Healing**
>
> *"IBH team and PCPs are more commonly offering traditional medicines to patients."*

Despite these challenges, dedicated support for traditional healing in medical clinics is a positive trend in many AI/AN communities. For example, the Puyallup Tribal Health Authority successfully integrated both mental health care and traditional medicine into their primary care system (Guilmet & Whited, 1988).

Integration of culture and tradition, like the integration of behavioral health into primary care, occurs on a continuum. For example, in 2005, the Native American Health Center in San Francisco integrated cultural healing, substance abuse treatment, mental health services, and HIV/AIDS services across two key providers through a holistic network to serve the spiritual, psychosocial, and medical needs of the AI/AN population (Nebelkopf & Penagos, 2005). This example shows that many AI/AN communities are taking important steps toward care approaches that reflect the history and cultures of Indigenous peoples.

Leveraging Community Cultural Programming

Revitalization of culturally based interventions is a crucial factor contributing to healing in AI/AN communities. Prior research has shown that strong AI/AN cultural identity is positively associated with beneficial mental health outcomes in AI/AN youth. Many culture-based community programs promote health by including activities such as beading circles, drum circles, and talking circles. For example, the South Dakota Urban Indian Health Clinic (SDUIH), a 2017 recipient of the BH2I grant, has formally integrated a cultural health department within their clinic. With the goal of caring for each patient's mind, body, and spirit, the department works in tandem with

> **Develop and Implement Cultural Programs That Support Patient Self-Management**
>
> *"Youth yoga program taught by Native woman local to the community who emphasizes culture and a trauma-informed approach to practice."*

behavioral health and primary care personnel to provide traditional medicines, spiritual guidance, smudging, and a warm and welcome space for relatives to come and talk. Additionally, SDUIH screens patients for social determinants of health. (See Table 7 on the following page for more examples of cultural components of integrated care used by BH2I Cohort 1.)

One powerful community-based intervention that supports cultural identity development and holistic healing is the Gathering of Native Americans/Gathering of Alaska Natives (GONA/GOAN). SAMHSA developed the GONA/GOAN in 1992–1994 as an intertribal strategy to support substance abuse prevention (Pucci, 2009). The SAMHSA Center for Substance Abuse Prevention conducted eight focus groups with intertribal teams, and data from the focus groups developed the footprint of the GONA/GOAN, including the curriculum and instructor training materials (Kauffman and Associates, Inc., 1999). Indigenous people developed the GONA/GOAN for Indigenous populations, making it a culturally embedded practice.

The GONA/GOAN is a versatile group intervention used for a wide range of purposes, from cultural identity development to sobriety support, because it revolves around four AI/AN themes, which are Belonging, Mastery, Interdependence, and Generosity. Cultural storytelling by elders or local spiritual leaders during the GONA/GOAN provides a powerful base, offering alternative stories and corrections of cultural misunderstandings from the mainstream population. The stories provide a safe space for cultural connectedness and healing.

The Standards Framework describes preliminary, intermediate, and advanced strategies for culturally adapted self-management support tools. Table 7 offers AI/AN-specific examples of each of the three levels of cultural adaptation within the Standards Framework.

Component description: Use of tools to promote patient activation and recovery with adaptations for literacy, language, and local community norms		
Integration Continuum	**Level Description**	**AI/AN Example**
Preliminary	Brief patient education on the behavioral health condition by the PCP	Educational materials that use a medicine wheel or similar construct to explain the relationship between the mind and physical health issues
Intermediate	Brief patient education on the behavioral health condition, including materials/handouts and symptom score reviews, with a limited focus on self-management goal setting	Use of culture-based conceptualizations of mental health in educational materials given at primary care appointments
	Patient education and participation in self-management goal setting (e.g., sleep hygiene, medication adherence, exercise)	Relationship building with the patient, including listening and providing them with support to develop practical goals; use of informal conversation or talking circles or a similar cultural construct as a means of patient education
Advanced	Systematic education and self-management goal setting with relapse prevention and case manager support between visits	Consistent follow-up calls or visits by clinic staff or family advocates conducted in a culturally sensitive way to communicate respect and ongoing support for self-managed goals; communication about and understanding of the barriers to consistent self-management while assisting the patient with revising the self-management plan until they discover the strategies that work within their unique life situation; encouragement of patients by communicating "*Don't give up*"

Table 7: Culturally adapted self-management tools with AI/AN culture adaptation

For small practices and those where culture has received less attention, the primary strategies listed above in Table 7 may be a suitable, achievable goal. As listed in Table 8 below, BH2I Cohort 1 grantees shared examples of cultural elements to consider incorporating. It is important to acknowledge that Tribal communities possess unique terminology for their traditional medicines. However, it is noteworthy that they may not have established names for medicinal substances that are not indigenous to their ancestral lands. For this reason, English names for these medicines are provided in the table that follows. For the ceremonies, the table includes two examples from the Lakota Nation, which SDUIH used. Other Tribal communities may have similar ceremonies.

Cultural components with examples used by BH2I Cohort 1 grantees		
Traditional Activities • Regalia making—beading, moccasins • Language classes • Smudging/praying with patients in the clinic	**Traditional Wellness Groups** • Mothers' wellness groups • Recovery groups • Indigenous parenting groups • Cultural reconnection group	**Traditional Medicines** • Flat cedar • Sage • Sweetgrass • Bear root • Bitter root • Sage bundles
Cultural Elements • Medicine wheel • Singing and drumming groups • 4 Directions group	**Trainings** • Staff trainings on historical trauma and cultural awareness • Community historical trauma trainings • Cultural sensitivity trainings • Cultural education sessions	**Ceremonies** • Healing, Wiping of Tears (Lakota) • *Inipi*: Purification Ceremony (Lakota)

Table 8: Cultural components

VII. Linkages With Community/Social Services

Connecting patients to community or social services is a vital part of integrated care. At times, the patient's external environment can contribute to behavioral health issues. The care team addresses these external issues with other services found in the community. Some of the support services can include housing, employment, and TANF. The integrated care team should have knowledge about the community they serve in terms of social determinants of health (refer to Figure 6).

Figure 6: Social determinants of health

Universal screenings for SDOH enable care teams to find unmet social needs that would otherwise go undiscovered but can affect overall health and wellness outcomes for patients. For many integrated care programs, social workers, case managers, care coordinators, and other paraprofessionals routinely gather SDOH information from patients. PCPs and BHPs engage in training on SDOH to better understand these determinants and how to address related patient needs. A few SDOH screening tools are as follows.

- PRAPARE Screening Tool
- Social Needs Screening Tool
- Self-Sufficiency Outcomes Matrix
- HealthBegins
- Health-Related Social Needs
- Community Paramedicine Pilot Health Assessment
- Social Needs Assessment

One of the grantees from the BH2I Cohort 1 chose a unique approach by forgoing the use of standardized Social Determinants of Health (SDOH) screening tools. Instead, they developed a tailored checklist for Behavioral Health Professionals (BHPs) to complete. This checklist is informed by the insights gained from patient interviews and the BHP's deep understanding of the specific community they serve.

When a BHP encounters an SDOH-related challenge during treatment that hinders the patient's progress, they are required to document a concise justification for requesting assistance from the appropriate Tribal agency. For instance, if a patient is experiencing asthma symptoms that are exacerbated by pest control problems in their home, the BHP must articulate how these pest issues are interfering with the patient's treatment journey. This justification should clearly outline the connection between the pest problem and the patient's health difficulties and argue how securing pest control services would facilitate better treatment outcomes.

By providing this targeted support, the program not only addresses immediate health concerns but also empowers patients by connecting them to services they may be unaware of, ultimately fostering a more comprehensive approach to their care.

In addition to connecting patients with community supports, integrated care teams can collaborate with outpatient behavioral health clinics through referrals, effective communication, and continued conversations with the patient about what kinds of services they prefer and need.

VIII. Systematic Quality Improvement

Systematic quality improvement is an organized and methodical approach for assessing clinic progress toward the goal of improving services and programs. Various models are available for collecting and analyzing the data that forms the foundation on which quality improvement is based. The IHS Office of Quality encourages the use of the Model for Improvement, developed by Associates in Process Improvement. This model consists of two parts. Figure 7: Model for Improvement on the following page provides a visualization of the two-part model.

Part 1 of the Model for Improvement asks the following three questions.

- What are we trying to do?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Part 2 of the model is the Plan-Do-Study-Act (PDSA) cycle (per the IHS website, section on Improving Patient Care), a process often used in the health and human services field. The PDSA cycle is iterative and assesses the quality of an implemented service or program. The team finds the modifications needed and alters the service or program accordingly. The PDSA cycle then begins again. The cycle includes the following components.

  - **PLAN** the intervention by identifying the key elements of the service. These elements can include the
    - population(s) of focus,
    - patient flow from outreach and enrollment to discharge and aftercare,
    - staffing requirements,
    - assumptions about the number of patients and the team's ability to serve them,
    - frequency and use of assessment tools,
    - collection of descriptive data, and
    - length of time services will be available.
  - **DO** by implementing the service as a pilot if the service is new or fully implementing the established service or program. Components of **Do** include the following two items.
    - Establish baselines by collecting data and administering assessments (e.g., PHQ-9, DAST) as early as possible—before or soon after services begin. The key is to have a true baseline to compare against improvements.

        - Plan on repeat measurement, including regular completion of assessments for the duration of a patient's treatment and after their discharge. Sometimes, providers do not know when a patient will improve. Thus, by repeating measurement at regular intervals, the team can begin to see patterns appear in how patients as a group are improving (e.g., reduction in PHQ-9 scores). Benefits of periodic testing include
            - tracking patient progress to see if their improvement plateaus, which may suggest that treatment has reached its maximum beneficial level, and
            - providing guidance for deciding the length of treatment that yields the most benefit for the patient, which, given waitlist time for some services, may increase a program's ability to treat more patients.
    - **STUDY** the progressively richer data as the team collects it.
        - Compare findings with the baseline data and data from later collection points.
        - Review the data to ensure that patients are improving from baseline scores.
        - Summarize the knowledge gained.
        - Decide whether to promote improvement of patient outcomes or attainment of programmatic goals, based on the overall findings.
        - Make changes as a team to improve services, based on outcomes or other indicators (e.g., patient or staff feedback, emergence of new evidence-based practices).
        - Redesign elements within the service or program, if warranted by the findings.
    - **ACT** on the new service or program design, noting the changes that the team has made.
        - Continue to compile data and otherwise document the revised implementation and the data collection process.
        - Examine the new data received, comparing it with baseline data and with the earlier cycles' performance at comparable points in time.

Figure 7: Model for Improvement

As illustrated in Figure 8, the PDSA cycle is a continuous quality improvement process that generally occurs at least once per year or more often (e.g., when there is a drop in scores, a new service is added, or a program is changed).

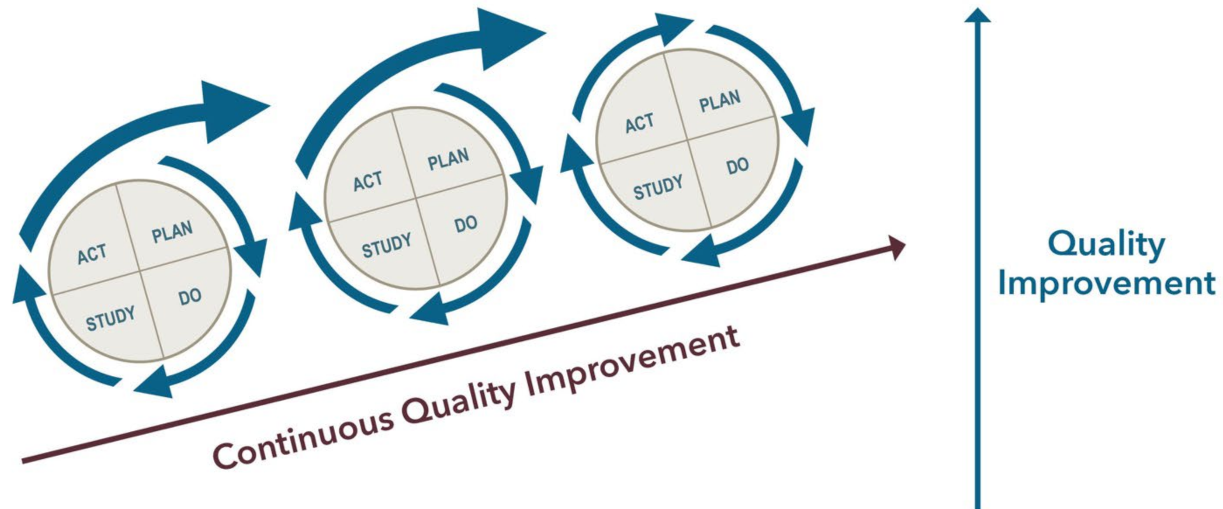

Figure 8: PDSA cycle

Metrics

Data collection is an essential process for many reasons. It supports quality improvement and increases program sustainability. Often, leadership's interest in favorable patient outcomes encourages them to engage with patient data, and this attention to the data can translate into enhanced interest in the program, which keeps the program visible and thus advocates for its continued operation.

The selection of metrics to incorporate into the integrated care model should be a team decision. It may be helpful to start with basic quality metrics, such as the percentage of patients screened for a certain condition, the percentage of patients with a warm handoff by the provider, and reasons for the warm handoffs. These measures can be helpful starter metrics in a new integrated care program (Raney, 2021). See the appendix for a list of process, outcome, staffing, and cost metrics that are often useful in integrated care settings.

Screening

An integral part of the quality improvement process is the use of patient-level assessment or screening tools that fit a certain service or program. For example, as discussed in Section II of this document, some organizations engage in universal screening at set intervals. They screen patients for a behavioral health disorder before the provider sees them. This screening presents an opportunity to find people who may have a behavioral health need even though that need is not the reason for their appointment.

The volume of patient assessments completed is high with universal screening. Thus, some programs choose to administer a modified, brief assessment instead of the full assessment tool to initially screen for behavioral health disorders. The care team gives the full version of the tool if the patient scores positive on the brief assessment.

Outcomes

While depression, for example, is one sign that a patient may need services, the integrated care model uses a biopsychosocial method, which assumes the presence of more than one health concern that would benefit from a collaborative treatment approach.

In the context of quality improvement, a patient with depression who also has diabetes with high hemoglobin A1c (HbA1c) has two immediate needs—reduction in depression concurrent with controlling their diabetes. An interplay exists between these two health risks, and reduction in one may lead to a reduction in the other. To understand the relationship between the two health risks, the care team logs the HbA1c values and PHQ-9 scores in the program's practice management system or registry at each assessment and matches up the two scores for patients who have both conditions. Under this example, the data describes the relationship between depression scores and HbA1c values. The care team explores the association between the two; as one changes, so does the other. The care team can apply this approach to many other clinical and behavioral metrics commonly seen in primary care.

It is important to note that not all patients with depression, diabetes, or other health concerns are the same. For example, if an examination of data on patients with depression across all patients screened over time shows a reduction in PHQ-9 scores, this reduction, although favorable, may provide an incomplete picture. Including all patients in the dataset may mask subgroups of patients who either respond better or worse than the average for all patients. Therefore, it is sometimes helpful to analyze the data by subgroups of patients, such as by health status (e.g., patients with hypertension or obesity), behavioral health diagnoses (e.g., depression, anxiety, PTSD, substance use disorder), or demographic or other characteristics of interest (e.g., age, gender, race/ethnicity). Later analyses may show that rates of reduced depression vary based on health diagnoses or age, or that older adults show improvement in HbA1c levels at rates higher than young adults. This level of analysis requires matching patient scores over time so that when the care team analyzes the data, they can select and analyze subgroups (e.g., patients with diabetes and depression).

While data extracted from diagnoses is a cornerstone of quality improvement, tracking other data, such as patient retention in treatment, is also important in assessing program success. Analyzing retention in conjunction with patient outcomes can reveal whether a relationship exists between treatment outcomes and the number and type of appointments a patient keeps.

Staff Metrics

Another metric for assessing quality improvement involves changes in staff attitudes, beliefs, and practices as the program matures. The care team can further analyze this program growth to decide if it is associated with positive patient outcomes.

Level of Integration

Level of integration is another insightful metric that the team can assess through one of several models, including using the Standards Framework to find where a program falls on the continuum of preliminary to advanced levels of integration. As with the other metrics, the care team can analyze findings to see whether advancement along the continuum is associated with positive patient outcomes.

Feasibility Considerations

Familiarity with the program's contract, billing codes, and reimbursement criteria will help the team decide if and how they can bill for assessment activities that support the program's continuation. Additionally, understanding how to use the data collected can be part of program impact evaluations. Reviewing how other programs bill for these activities and use the data for evaluation can also be insightful.

IX. Sustainability

Sustaining integrated care is important for long-term feasibility. One tool for sustainability is billing for services using the current procedural terminology (CPT) codes. The clinic's billing specialist needs to keep up to date with the changes in the CPT codes at the state and federal (CMS) levels to comply with the billing for integrated care services. It is possible to apply traditional CPT codes for these activities while still following time-keeping rules. Additionally, CMS and some states are creating avenues to bill for integrated behavioral health services for individual encounters and monthly care management, including the psychiatric collaborative care model. Please check with CMS on the CPT codes currently in use.

Some codes do not have a time requirement but require specific elements instead. In integrated care settings, a brief diagnostic evaluation that meets the requirement for a 90791 diagnostic evaluation without medical services and captures the key features of the code may not need to meet a time requirement.

Some examples of services that meet these criteria include the following.

- Interventions that are too brief to be billable
- Hallway conversations/consultations
- Curbside consultations with psychiatric consultants
- Phone calls to patients
- Repetition of rating scales
- Interdisciplinary team meetings
- Registry management
- Some services provided by unlicensed paraprofessionals or peers (in some states)

Other services that may be billable in some areas are as follows.

- Providers can bill for the use of measurement tools to code 96127 in allowable settings.
- In allowable settings, SBIRT codes can be used and billed.
- Health and behavior assessment and intervention codes, when allowed, can be used and billed for support of a physical health diagnosis.
- Many state Medicaid plans include peer support as a billable service, though the types of peer support covered vary by state. Billing codes used by the provider include the following (Open Minds, 2018).

- H0038 (general self-help/peer services, per 15 minutes)
- H0039 (assertive community treatment, face-to-face, per 15 minutes)
- H0040 (assertive community treatment program, per diem)
- H0025 (behavioral health prevention education service)

An important first step in the billing process is credentialing and paneling behavioral health providers with insurance payers. The payer and the clinic credential the providers and approve their involvement on the provider panel. Until these processes are complete, the program must be prepared to cover 3 to 6 months of non-billable services.

Tracking services, reimbursements, and denials from the outset of the program is a recommended practice to improve the bottom line. The integrated care model's proven links to PCP satisfaction and clinic attainment of quality improvement goals are key concepts to emphasize in advocating for an integrated care program.

Furthermore, this model promotes patient retention by reducing behavioral health care stigma and associated health disparities because the BHP provides services within the privacy of the primary care appointment.

X. Telehealth

To keep patients and clinic staff safe during the COVID-19 pandemic, medical and behavioral health providers implemented telehealth services more quickly than they may have otherwise done. Audio-only and video visits have become commonplace and acceptable for both patients and providers and have led to quantifiable improvements in access to care for a variety of services and practices. For many patients, telehealth services are preferable, as they create less impact on work schedules and typically do not require them to arrange childcare or transportation.

Considerations for Implementing Telehealth Services

When choosing a telehealth platform, it is important to select a HIPAA-compliant vendor. Many HIPAA-compliant options are available to choose from, including the following (Office of Civil Rights, 2021).

- Skype for Business/Microsoft Teams
- Updox
- VSee
- Zoom for Telehealth
- Doxy.me
- Google G Suite Hangouts Meet
- Cisco Webex Meetings/Webex Teams
- GoToMeeting
- Spruce Care Messenger

Other key considerations for selecting a vendor and setting up secure telehealth services include the following items.

- Patient access to technology, such as broadband or Wi-Fi connectivity or a cell phone with reliable service
- Adequate hardware to conduct virtual visits without interruptions or delays
- Payer guidelines, which vary by state and change often
- Provider training on telehealth use and prior patient-provider engagement
- Confidentiality issues
- Scheduling
- System coordination

The Office for the Advancement of Telehealth (OAT), “built by the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services” assists with setting up telehealth programs (HRSA, n.d., para. 1). The mission of OAT is “to improve access to quality health care through integrated telehealth services” (HRSA, n.d., para. 2). Information at telehealth.hhs.gov can help with setting up a telehealth program. The website “provides information for health care providers and patients about the latest federal efforts to support and promote virtual health care” (HRSA, n.d., para. 1). More than likely, telehealth will become an essential element of future integrated care programs.

Patient Preparation for Telehealth Visits

According to HHS, patients should take some steps to prepare for telehealth visits to ensure the visits proceed smoothly. The care team can share the information below with patients through a handout before a telehealth appointment and then call the patient to see if they need help (HRSA, n.d.).

Patients should be encouraged to prepare for a telehealth visit by doing the following.

- Find a quiet, private place from which to join the appointment. Try to select a place that is well-lit so the provider can see you well. Avoid having bright lights behind you, which will make you appear in shadows to the viewers.
- Write down lists of current medications and any symptoms or concerns that you want to mention.
- Have paper accessible to take notes.
- Request an interpreter several days in advance, if needed.
- Read any instructions sent by the provider on how to join the session.
- Close other apps on your phone or computer to ensure they do not affect the internet speed or your ability to connect to the session.
- Wear comfortable clothing in case you need to show the provider an area of your body.

Provider Preparation for the Telehealth Visit

Because of the COVID-19 pandemic, a variety of telehealth practices became commonplace. Many BH2I Cohort 1 grantees found that audio-only telehealth visits were the best choice to continue collaborating with their patients, primarily because of issues around internet access or bandwidth strength, as well as lack of equipment.

Providers should prepare for a successful telehealth visit by doing the following.

- Figure out the provider and patient technological capabilities and select a platform that fits those capabilities. Remember, some patients may not have access to computers or the internet. Further, patients with neurodevelopmental disorders or other health conditions may have sensory issues that make using telehealth platforms difficult. Consider if any visual or auditory accommodations can be made, such as conducting an audio-only visit for someone with visual impairments or sensitivities.
- Engage in planning and preparation with the patient to understand telehealth treatment needs for small children, such as parent-child interaction therapy, and for people with disabilities.
- Prepare any screening tools that will be used during the visit. If the screening tools can be completed in advance either through the mail or via a virtual portal, ensure that the patient has the capacity to complete them before their visit (e.g., time to fill out and bring the papers, understanding of the virtual portal, internet connectivity, computer access).

Observations and Conclusions

Based on observations from BH2I Cohort 1, the BH2I T/TA Center team compiled the following implementation checklist for integrated care teams.

Implementation Checklist

- Find team members, including a PCP champion who can elicit PCP buy-in.
- Develop a shared vision and draft a strategic plan around that vision.
- Draft policies and procedures and revise them over time as integration progresses.
- Train and educate staff.
- Define the population served.
- Conduct regular evaluations of the program through data collection and analysis and identify gaps and areas for improvement.
- Define workflows and create examples to share with the team.

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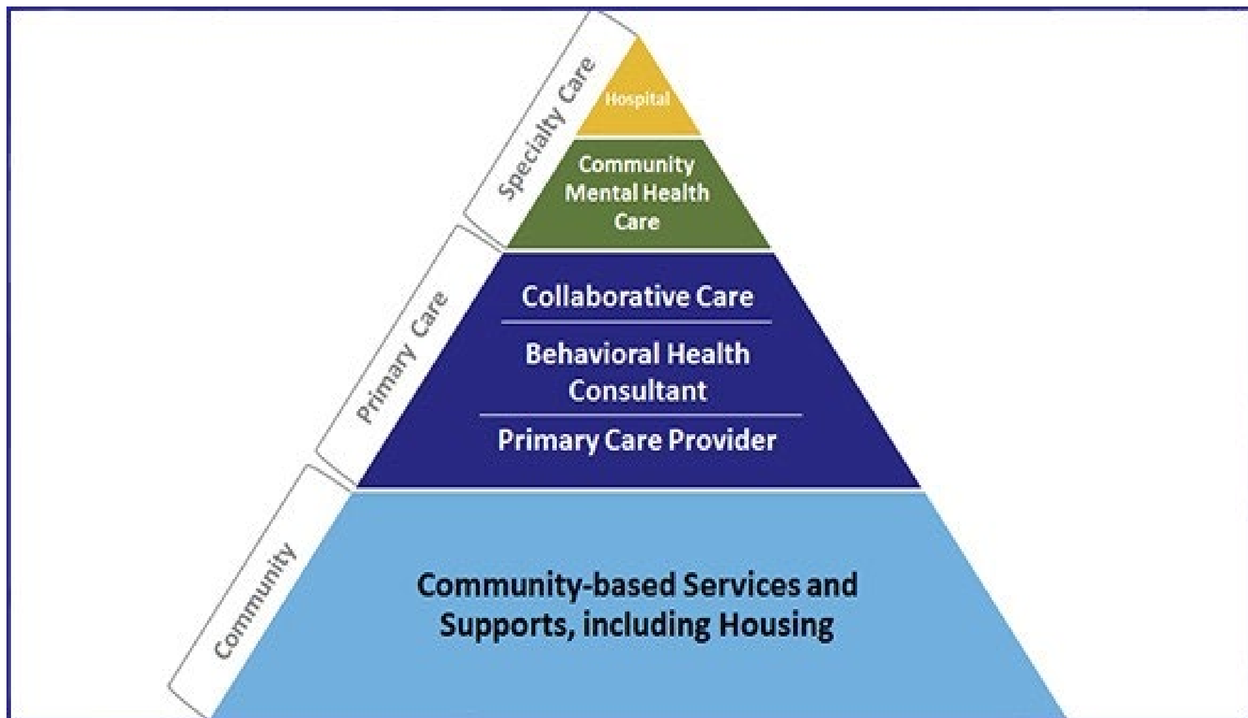
Appendix

AIMS Center Model



CHI Framework

Role	Key Elements of Integrated Care		Integration Continuum			
	Domains	Components	Preliminary	Intermediate		Advanced
Clinical Workflow	**1. Case finding, screening, referral to care**	Screening, initial assessment, follow-up for BH conditions	Patient/clinician identification of those with BH symptoms—not systematic	Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment	Systematic BH screening of all patients, with follow-up for assessment and engagement	Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement
		Facilitation of referrals, feedback	Referral only to external BH provider(s)/ psychiatrist	Referral to external BH provider(s)/psychiatrist through a formal agreement detailing engagement, with feedback strategies	Enhanced referral to internal/ co-located BH provider(s)/ psychiatrist, with assurance of warm handoffs, when needed	Enhanced referral facilitation with feedback via EHR system or alternate data-sharing mechanism; accountability for engagement
	2. Decision support for measurement-based stepped care	Evidence-based guidelines/treatment protocols	None, with limited training on BH disorders and treatment	PCP training on evidence-based guidelines for common behavioral health diagnoses and treatments	Standardized use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms	Systematic tracking of symptom severity; protocols for intensification of treatment when proper
		Use of psychiatric medications	PCP-initiated, limited ability to refer or receive guidance	PCP-initiated, with referral when necessary to prescribing BH provider(s)/psychiatrist for medication follow-up	PCP-managed, with support of prescribing BH provider(s)/psychiatrist as necessary	PCP-managed, with care management (CM) supporting adherence between visits and BH prescriber(s)/psychiatrist support

Clinical Workflow (cont.)		Access to evidence-based psychotherapy with BH provider(s)	Supportive guidance provided by PCP, with limited ability to refer	Referral to external resources for counseling interventions	Brief psychotherapy interventions provided by co-located BH provider(s)	Range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information
	3. Information exchange among providers	Sharing of treatment information	Minimal sharing of treatment information within care team	Informal phone or hallway exchange of treatment information without regular chart documentation	Exchange of treatment information through in-person or telephonic contact, with chart documentation	Routine sharing of information through electronic means (registry, shared EHR, shared care plans)
	4. Ongoing care management	Longitudinal clinical monitoring and engagement	Limited follow-up with patients by office staff	Proactive follow-up (no less than monthly) to ensure engagement or prompt response to care	Use of tracking tool to check symptoms over time and proactive follow-up with reminders for outreach	Tracking integrated into EHR system, including severity measurement, visits, CM interventions (e.g., relapse prevention techniques, behavioral activation), and proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when proper
	5. Self-management support that is culturally adapted	Use of tools to promote patient activation and recovery with adaptations for literacy, language, and local community norms	Brief patient education on BH condition by PCP	Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal setting	Patient education and participation in self-management goal setting (e.g., sleep hygiene, medication adherence, exercise)	Systematic education and self-management goal setting, with relapse prevention and CM support between visits

Workforce	**6. Multidisciplinary team (including patients) used to provide care**	Care team	PCP, patient	PCP, patient, ancillary staff member	PCP, patient, ancillary staff member, CM, BH provider(s)	PCP, patient, ancillary staff member, CM, BH provider(s), psychiatrist (contributing to shared care plans)
		Systematic multidisciplinary team-based patient care review processes	Limited written communication and interpersonal interaction between PCP and BHP(s), driven by necessity or urgency, or patient as conduit	Regular written communication (notes/consult reports) between PCP and BHP(s), occasional information exchange via ancillary staff or labs on complex patients	Regular in-person, phone, or email meetings between PCP and BHP(s) to discuss complex cases	Weekly team-based case reviews to inform care planning and focus on patients who are not improving behaviorally or medically, with capability of informal interaction between PCP and BHP(s)
Management Support	**7. Systematic quality improvement**	Use of quality metrics for program improvement	Informal or limited use of BH quality metrics (e.g., limited use of data, anecdotes, case series)	Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance	Use of identified metrics, some ability to respond to findings using formal improvement strategies	Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics and implementation of improvement projects by QI team/champion
	8. Linkages with community/ social services	Linkages to housing, entitlement, other social support services	Few linkages to social services, no formal arrangements	Referrals made to agencies, some formal arrangements, but little ability for follow-up	Screening for SDOH, patients linked to community organizations/ resources, with follow-up	Developing, sharing, and implementing a unified care plan between agencies, with SDOH referrals tracked

Management Support (cont.)	**9. Sustainability**	Build process for billing and outcome reporting to support sustainability of integration efforts	Limited ability to bill for screening and treatment, or services supported primarily by grants	Billing for screening and treatment services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under FFS, with process in place for tracking reimbursements	FFS billing, and revenue from quality incentives related to BHI	Receipt of global payments that reference achievement of behavioral health and general health outcomes

Psychiatric Provider Consultation Process

The consultation process follows the mnemonic *Nicely DONE* to help remind the provider about the key aspects of a good consultation. If done adequately, consultations can lead to the PCP and BHP providing effective care for common, less complex conditions in a way that reduces emergency room and inpatient admissions.

Nicely Build mutual trust and rapport	○ Communicate in a welcoming tone. ○ Be readily accessible. ○ Offer praise for things done well. ○ Avoid critical statements.
Diagnosis—provisional or confirm	○ Define the chief complaint quickly. ○ Assess provider comfort level and abilities and identify expectations. ○ Gather more pertinent information. ○ Discuss the differential diagnosis and make a "best guess" to move forward.
Offer concise feedback and suggestions	○ Respect time constraints. ○ Provide evidence-based pharmacologic and nonpharmacologic suggestions. ○ Offer a titration schedule. ○ Avoid excessive psychiatric jargon. ○ Recommend measurement tools.
Next steps and "if-then" scenarios	○ Present alternative strategies in case the primary plan does not work. ○ Summarize the plan before you end the call. ○ Encourage the provider to call back if needed.
Educational component	○ Tactfully embed education in the consultation. ○ Build provider confidence and ability. ○ Keep it brief—ideally less than a minute.

Behavioral Health-Primary Care Integration Workflow for Enhanced Referral

Create a simple tool to check the completion of referrals for all patients/clients. Use this tool to track the performance of a specific referral relationship/organization, performance by provider, and any measures of success defined by the organizations.

Patient Identifier	Provider	Organization/ Provider Referred to	Date Referral Sent	Referral Received	Patient No-Showed Appointment	Return Communication Received	Medications and Care Plan Updated

Weekly totals:

Number of referrals [by organization, by provider] successfully completed: ____________________

Number of referrals [by organization, by provider] not successfully completed in expected timelines: ________________

Number of referrals [by organization] still outstanding: ________________________

Primary Care—Specialty Care Compact

This compact is available for general distribution with the support of the Colorado Center for Primary Care Innovation, the Westminster Medical Clinic, and Advancing Care Together. Please reference these organizations in any reprints or revisions. 9.14.12

<table>
<tr><th colspan="2">Transition of Care</th></tr>
<tr><td colspan="2">Mutual Agreement</td></tr>
<tr><td colspan="2">• Maintain exact and up-to-date clinical records.
• When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD].
• Ensure safe and prompt transfer of care of a prepared patient.*</td></tr>
<tr><td colspan="2">Expectations</td></tr>
<tr><td>Primary Care</td><td>Behavioral Health Care</td></tr>
<tr><td>• PCP keeps complete and up-to-date clinical records.
• Transfers information as outlined in Patient Transition Record in a prompt fashion.
• Orders proper studies that would ease the specialty visit.
• Provides patients with specialist contact information and expected time for appointments.
• Informs patient of need, purpose (specific question), expectations, and goals of the BHP visit.
• Obtains confidentiality release from patient to discuss care with BHP following federal and state privacy laws.*
• Ensures that patient/family are in agreement with referral, type of referral, and choice of specialist.</td><td>• Appropriate staff decides and/or confirms insurance eligibility.
• Finds a specific referral contact person to communicate with the PCMH/PCP.*
• When PCP is uncertain of proper laboratory testing, guides PCP prior to the BHP/CP appointment on proper pre-referral workup.
• Informs patients of needs, purpose, expectations, and goals of hospitalization or other transfers.
• Notifies referring provider of inappropriate referrals and explains rationale.</td></tr>
</table>

More agreements/edits: ____

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<table>
<tr><th colspan="2">Access</th></tr>
<tr><td colspan="2">Mutual Agreement</td></tr>
<tr><td colspan="2">
• Be readily available for urgent help to both the physician and patient.*
• Provide adequate visit availability.*
• Be prepared to respond to urgencies.
• Offer convenient office facilities and hours of operation.
• Provide alternate backup when unavailable for urgent matters.
• When available and clinically practical, offer a secure email choice for communication with established patients and providers.
</td></tr>
<tr><td colspan="2">Expectations</td></tr>
<tr><td>Primary Care</td><td>Behavioral Health Care</td></tr>
<tr><td>
• Communicates with patients who “no-show” to BHPs and address issues.
• Decides reasonable time for BHP appointment.*
• Establishes policy and protocol for direct communication by phone, by email, and in person with the BHP and patient.
</td><td>
• Notifies PCP of first visit no-shows or other actions that place patient in jeopardy.
• Schedules patient’s first routine appointment with requested provider.
• Provides PCP with a list of BHPs who agree to compact principles.
• Establishes policy and protocol for direct communication by phone, by email, and in person with the PCP.
</td></tr>
</table>

Added agreements/edits: ____

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Collaborative Care Management	
Mutual Agreement	
• **Define responsibilities between PCP, BHP, and patient and find care team.*** • **Define PCP and BHP scopes of practice.*** • Clarify who handles specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up). • Maintain competency and skills within scope of work and standard of care. • Give and accept respectful feedback from the team or patients when expectations, guidelines, or standard of care are not met. • Openly discuss and agree on the type of care that best fits the patient's needs.	
Expectations	
Primary Care	**Behavioral Health Care**
• Follows the principles of the Patient-Centered Medical Home or Medical Home Index. • **Manages medical or behavioral problems to the extent of the PCP's scope of practice, abilities, and skills.*** • Provides designated care coordinator to work with the care team and designated care manager. • Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when proper, following evidence-based guidelines. • Resumes care of patient as outlined by the BHP, assumes responsibility, and incorporates care plan recommendations into the patient's overall care. • **Shares data with the BHP in prompt manner, including pertinent consultations or care plans from other care providers.***	• Reviews information sent by PCP and addresses provider and patient concerns. • Confers with PCP or sets up other protocol before ordering added services outside practice guidelines. Obtains proper prior authorization. • Confers with PCP before referring to secondary or tertiary specialists and, when proper, uses a preferred list to refer when problems are outside PCP scope of care. Obtains proper prior authorization. • **Sends periodic written, electronic, or verbal reports to PCP as outlined in the Transition of Care Record.*** • Notifies the PCP office or designated personnel of major interventions, emergency care, or hospitalizations. • Prescribes pharmaceutical therapy in line with scope of license and insurance formulary with preference to generics, if proper to patient needs. • Provides useful and necessary education/guidelines/protocols to PCP.

Added agreements/edits:

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Patient Communication	
Mutual Agreement	
• Consider patient/family choices in care management, diagnostic testing, and treatment plan. • Provide and obtain confidentiality release from patients according to community standards (see Transition of Care). • Explore patient issues on quality of life about their specific condition and share this information with the care team.	
Expectations	
Primary Care	**Behavioral Health Care**
• Explains, clarifies, and secures mutual agreement with patient on recommended care plan. • Aids patients in finding their treatment goals. • Engages patient in the Medical Home concept. The patient finds their care team and who takes part with the team. • **Is available to discuss patient questions or concerns about the consultation or their care management.***	• Informs patient of diagnosis, prognosis, and follow-up recommendations. • Provides educational material and resources to patients when proper. • Recommends proper follow-up with PCP. • Is available to discuss patient questions or concerns about the consultation or their care management. • **Participates with patient care team.***

Added agreements/edits: ____

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General Metrics Chart: Sample of Metrics

Process Measures

Integrated Health Care Issue	Sample Process Measure	Samples of Assessing Process
Patient Behavioral Health	Screening	% of patients with a positive PHQ-2 who completed the PHQ-9
	Diagnosis by PCP	% of patients with a positive PHQ-9 who received a diagnosis of major depression or dysthymia
Patient Flow	Tracking Patient Flow	• Number of patients referred to BHP (e.g., % with positive PHQ-9 and diagnosis of major depression or dysthymia) • Average length of treatment
Patient Capacity	Volume	• Numbers of patients by BHP • Number of patients with chronic health condition seen by PCP and BHP
Sustainability	Billing	• % of providers who reach minimum billing minutes and task targets per month • % of direct expenses covered by third-party billing

Outcomes Measures

Integrated Health Care Issue	Sample Outcome Measures
Impact on Patient Behavioral Health	Clinically significant reduction in behavioral health symptoms (e.g., % diagnosed with depression who had 50% reduction or more OR remission in PHQ-9 score at 6 months and 12 months)
Impact on General Medical Outcomes	Improvement in chronic health illness metrics (e.g., HbA1c, blood pressure, BMI)
Patient-Informed Metrics	• Patient satisfaction (e.g., model, cultural integration) • Overall patient wellness (e.g., quality of life)
Provider Satisfaction (Nurses, SUD Counselors, Doctors, etc.)	• Comfort with treating BH conditions • Overall satisfaction with integrated BH
Cost Metrics	• Total integrated BH health care costs and % recouped • Savings because of reductions in length and severity of readmissions to BH services after discharge • Shifts in line-item expenditures for a sample of integrated BH patients before and after engagement • Decrease in hospitalizations and emergency department visits