Standard 3: Behavioral Health Integration

This Standard identifies key components of an effective Behavioral Health Integration strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

Your network has a **clear, detailed, documented policy** for identifying individuals with behavioral health needs, connecting those individuals with appropriate care, and tracking outcomes.

85% of the practices in your network have fully implemented the policy.

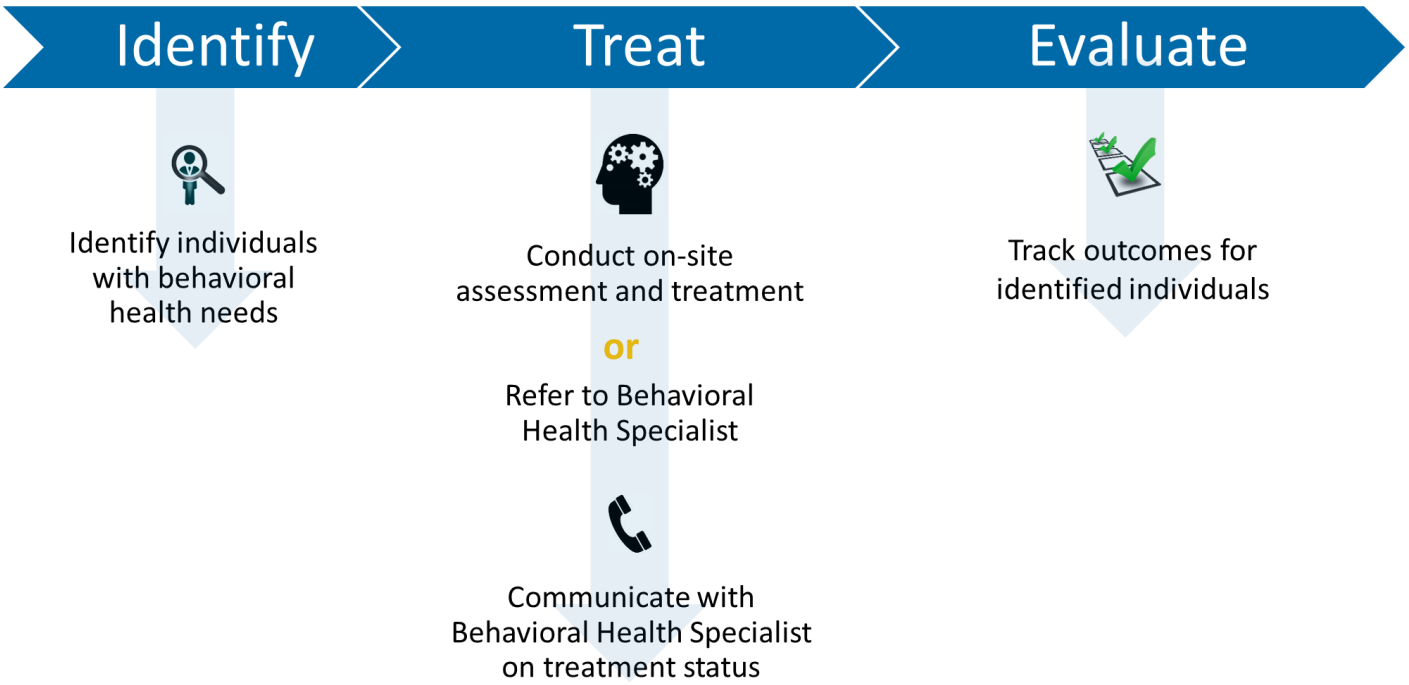
Process Measures:

1. Improved rate of depression screening
2. Improved rate of substance use screening
3. Improved rate of primary care follow-up for depression
4. Improved rate of primary care follow-up for substance use
5. Improved rate of Behavioral Health Specialist follow-up for depression
6. Improved rate of substance use specialist follow-up for substance use

Outcome Measure:

1. Increased rate of depression remission

Key Elements of Behavioral Health Integration



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Identify individuals with behavioral health needs

1. Screen all patients for **depression** and **substance use** in the primary care setting
    a. Develop or use a screening tool that can be self-administered or administered by an individual who does not have a mental health degree. At a minimum, include the PHQ-9 for depression (may use PHQ-2 for initial screen) and a standardized and validated tool for substance abuse.
    b. Ensure there are support services to administer the tool for individuals with barriers to completing the screening tool on their own
    c. Utilize a trained behavioral health specialist on site or through referral (at least with masters level training) who conducts a more targeted follow-up assessment when necessary
    d. Conduct the behavioral health screening no less often than every two years
    e. Develop a process for identifying a re-screening at each routine visit
    f. Capture screening results in the EHR and make accessible to all relevant care team members

Address behavioral health needs

1. Conduct an assessment of needed behavioral health resources to support your practices
2. Establish the necessary relationships with behavioral health providers to meet your needs
3. If sufficient behavioral health services are not in network, execute an MOU with at least one behavioral health clinic and/or practice and develop processes and protocols for other behavioral health providers
4. Use a standardized set of criteria to determine whether or not the behavioral health condition can be addressed in the primary care setting by a primary care provider. Consider:
    a. Diagnosis/behavioral health condition
    b. Level of impairment/Severity of need
    c. Comfort level of the primary care team to manage the individual's needs
    d. Complexity of the required medication management
    e. Age of the individual
    f. Individual preference
    g. If the provider doing medication management for the individual has psychiatric medication management training
5. Educate individuals that screen positive for a behavioral health condition using available behavioral health resources regardless of the need for a referral
6. Ensure that primary care team members that provide behavioral healthcare have training that covers:
    a. Behavioral health promotion, detection, diagnosis, and referral for treatment
    b. How information will be exchanged and within what timeframe
    c. Defining a timeframe within which a referral should be completed
    d. Appropriate coding and billing
7. Ensure that all referrals are tracked and linkage to follow-up care is confirmed.

Communicate with Behavioral Health Specialist on treatment status

1. Develop process, protocol, and technology solutions for behavioral health provider to make the assessment and care plan available to the primary care team with appropriate consent
2. Ensure behavioral healthcare plan outlines treatment goals, including **when** follow up is required and **who** is responsible for follow up
3. Ensure behavioral health provider is available for consultation as needed by the primary care physician (process for this should be outlined by MOU) if individual is transferred back to the primary care setting

Track behavioral health outcomes/improvement for identified individuals

1. Utilize individual tracking tool to assess and document individual progress at one year and other intervals as determined by the provider
2. Develop processes and protocols for updating tracking tool that include:
    a. **Who** is responsible for updating
    b. **When** updates are to be made
    c. **How** treatment should be adjusted if not effective