The Academy
Integrating Behavioral Health and Primary Care

A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration

Observations From Exemplary Sites

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A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration

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Executive Summary

This AHRQ-funded guidebook was developed to assist the field of primary care and behavioral health in identifying professional practices for developing a workforce for integrated care. The guidebook was developed as part of a project that included an expert panel, a literature review, and identification of key professional practices through observation and interviews at exemplary primary care organizations.

Methodology

Eight high-performing primary care organizations with integrated behavioral health and primary care participated in the study. All were multispecialty groups, five in urban locations and three in rural areas. The organizations included four federally qualified health centers (two of which were private and not for profit), two hospital systems, a government-operated facility, and a private practice. The annual number of patient visits at each organization ranged from 10,400 to 159,096, and the total number of full-time-equivalent clinicians in primary care, behavioral health, and psychiatry ranged from 6 to 80.

During site visits, the guidebook study team used rigorous qualitative methods—observation, interviews, and document collection—to learn how care can be integrated in primary care organizations. The team shadowed clinicians and other health care professionals involved in care delivery to observe the patient care process, and followed patients through their visits. (Excerpts from interviews and field notes are distributed throughout the main body of the report.) The resulting data enabled the research team to identify many commonalities across the sites and gain insight into the professional practices that members of exemplary integrated primary care organizations engage in when integrating care.

Findings

The study team organized findings into **organization-level professional practices** and **interpersonal and individual professional practices** that supported integrated care at exemplary primary care organizations.

Organization-Level Professional Practices

Organization members **paid attention to organization mission and vision**, with a clear focus on a mission to serve patients by providing population care. The vision to accomplish the mission was optimal integrated care, which involved applying a team approach, working to improve the integrated care model, and adapting to the community's needs.

Organizations recognized the importance of continually improving how integrated care is delivered. They **built quality improvement practices into their organizational cultures**, including:

- Opportunities for innovation, including risk tolerance and mistake tolerance.
- Ongoing evaluation and revision of initiatives.
- Gathering feedback.
- Accountability based on performance goals.

Organizations **showed a commitment to ongoing quality improvement** by:

- Investing in quality improvement personnel and processes.
- Assessing and realigning quality improvement efforts.
- Developing process improvement documents for use in training.
- Following a data-driven approach.

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As part of advocacy work, organization leadership **marketed the model and vision for integrated care**, creating buy-in and support outside the organization and encouraging staff at all levels to participate in advocacy. Leadership **advocated for State- and community-level changes** that support integration, and **engaged in advocacy efforts aimed at eliminating barriers to care** for patients.

Organization leadership also **managed finances to support the organization's mission and vision for integrated care**, including negotiating with external financial stakeholders and managing internal finances. Organizations take calculated risks, dedicate resources to enroll patients in insurance programs, and provide care regardless of the patient's ability to pay.

Organization leaders **determined the level of expertise and depth of staffing needed** to deliver integrated care, and **emphasized the value of hiring, training, and developing staff** to deliver integrated care. Among the skills observed were:

- Addressing staffing gaps.
- Defining required expertise.
- Staffing to fulfill mission and vision.
- Creating strong teams.
- Collecting information about patient care.
- Making adjustments in staffing to enhance patient experience.

Organizations also **addressed behavioral health clinician (BHC) staffing issues**, including BHC accessibility to other clinicians and patients, connection with a primary care team, coverage for other BHCs, and staff recruitment. **Psychiatrist staffing and access issues** were addressed as well, including availability for consults and brief encounters, and for sharing knowledge with primary care clinicians. Organizations were **selective in hiring** and looked for people who would fit with the culture of the organization and with the pace and purpose of the integrated clinic. People in a variety of roles participated in the hiring process.

Staff training was critical, and organizations dedicated many resources to ensuring that employees were prepared to deliver integrated care that was aligned with the organization's model and vision. Orientation-related practices for new hires included training about culture and about policies and procedures; subsequent training involved interprofessional shadowing, electronic health record training, close supervision, strategic scheduling, refining clinical skills, and familiarization with clinic resources. **Training and learning were ongoing** for employees, and organizations offered a range of formal opportunities, such as mentoring, supervision, and presentation of information through a range of modalities. Leaders **assessed training efforts** on an ongoing basis.

Organizations **created a structure to support the delivery of integrated care**. This involved **outlining clear roles and responsibilities** while remaining open to the idea that these roles and responsibilities might evolve over time. Organizations **used a team approach** to integrating care for patients; the approach included, among other characteristics:

- Clear roles and responsibilities.
- Manager and supervisor involvement in clinical practice.
- Determination of the right level of care.

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Organizations **structured clinical workflow** to accommodate the degree of interdependence required among individuals performing integrated care tasks. Workflow structuring included developing:

- Protocols to support sequential tasks (tasks that need to be highly routinized, i.e., carefully scheduled and coordinated).
- Meeting structures where sequential tasks and reciprocal tasks (tasks that require back-and-forth communication and adjustment) can be proactively identified and discussed.
- Rules for engagement and interruption to facilitate discussion of unanticipated reciprocal tasks.

Organizations created **shared physical work spaces** for integrated care teams to support coordination of sequential tasks and collaboration on reciprocal tasks. This allowed BHCs and primary care clinicians to work in close proximity with each other and collaborate in providing patient care. Exam rooms and other spaces facilitated protection of patient privacy, efficient workflow, interaction with patients, and telemedicine encounters in organizations using that technology. Some organizations allowed community and public health organizations to use facility spaces to provide patient services and host meetings.

All of the primary care organizations had **an information infrastructure** to support integrated care tasks and workflow. Each organization used a single electronic health record (EHR) system in which all clinicians and other practice staff could document and share patient information. Organizations developed EHR structures that supported behavioral health documentation, information sharing, communication, decision support, and data reporting for integrated care.

Interpersonal and Individual Professional Practices

Professionals in these organizations sought to **ensure that all patients received the level of integrated care they needed, from the right clinicians, when that care was needed.** Recognizing that managing staff and workflows for integrated care teams requires **collaboration**, the organizations **developed clinical workflows** that:

- Facilitated patient access to BHCs and other clinicians as needed.
- Included pre-visit planning to improve coordination of services.
- Supported timely responses to unanticipated patient needs.
- Created clear pathways for care, including establishing roles and boundaries between different areas of the organization.
- Enabled interdisciplinary communication about patient care.

The workflows for BHCs:

- Helped them balance consults and appointments.
- Provided strategic scheduling of appointments.
- Allowed for unscheduled time for collaboration on unanticipated behavioral health issues with the primary care team.
- Kept visits brief to keep workflow on track.

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Clinicians engaged in **professional practices when documenting and sharing information using the EHR system.** Clinicians wrote concise notes, followed documentation protocols, communicated with the team via EHR, and used the EHR for patient education. They maintained structured care plans and used registries and data tracking tools to manage patient care.

Clinician supervision was considered a key aspect of integrated care. In addition to administrative and organizational functions, supervisors played an important role in hiring appropriate staff, helped with problem-solving, and provided ongoing education and training for staff by identifying staff learning needs and modeling exemplary clinical behavior.

Collaborative practices among clinicians, regardless of discipline, were important to integrating care. These included pooling expertise, situational awareness (remaining accessible to other members of the team), articulation of roles, and acting on the organization's shared values.

Communication practices for general coordination of care, included, as mentioned above, facilitating access to clinicians and practice resources and writing clear and concise summaries of patient visits. Other practices involved:

- Communicating during collaborations and consults.
- Interdisciplinary collaboration and communication of patient needs to clinicians.
- Communication about comfort level in treating patients.
- Communication to de-escalate conflicts.
- Encouraging consistent messaging to patients.
- Debriefing as needed about patient encounters.
- Offering peer support.

Communication with patients was equally significant. Such practices included:

- Using multiple communication modes, such as phone, secure email, and Web-based portals.
- Explaining each clinician's role on the care team.
- Celebrating patients' successes.
- Encouraging positive behaviors.
- Communicating in a culturally appropriate manner.
- Acknowledging patient concerns about clinical operations.
- Offering guidance about community resources.

Clinicians of all disciplines **managed shared patient visits.** When a clinician from another discipline participated in a patient visit, the lead clinician described that person's expertise and expressed trust in the person's skills. During a patient visit, collaborating clinicians knew who had the lead and would manage the encounter, and worked together to meet the patient's needs. Clinicians also knew how to manage the discussion when family members, friends, or other caregivers were present.

Clinicians shared a set of **professional practices related to how to engage with patients.** These included practices related to developing individual clinical relationships and group visits, as well as practices specific to BHCs.

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Professional practices that dealt with engaging patients included:

- Destigmatization of care.
- Rapid assessment.
- Agenda setting.
- Considering contextual factors.
- Using teachable moments.
- Patient education.

Professional practices related to group visits included:

- Broad expertise.
- Communicating about group visit availability.
- Use of evidence-based strategies such as motivational interviewing.
- Skillful management of group dynamics.
- Connecting patients to resources.
- Communicating with the patient's care team.

Professional practices specific to BHCs included:

- Negotiating treatment for patients among different providers and resources.
- Helping patients get access to specialty mental health services.
- Ongoing communication with patients.
- Clarification of role within the care team.
- Adjusting treatment quickly in response to new or acute issues.
- Helping patients identify problems and set goals.
- Teaching patients how to reframe their thinking about key life events.

Conclusion

This project aimed to identify a set of professional practices for primary care organizations to follow and thereby to succeed at integration of behavioral health and primary care. This guidebook demonstrates the breadth of organizational and individual professional practices that are needed for high-quality integrated care delivery. Organizations can use this guidebook to work toward achieving a level of integrated care seen in some of the best primary care organizations in the country. Moreover, policymakers may find this guidebook useful to identify benchmarks for assessing integrated care in primary care organizations.

With such rich data, many interesting research questions emerge from this work. Areas for exploration could include examining how communication among professionals and patients differs in integrated settings and non-integrated settings, how the professional practices identified here are connected to clinical outcomes, and how these practices can be best implemented and disseminated to primary care organizations motivated to integrate care for the patients they serve.

1 Background

Empirical evidence suggests that the U.S. health care system continues to provide inadequate coverage to consumers and falls short in preventive and chronic disease care, among other indicators.[1] Rapid changes in the health care system, particularly the implementation of the Affordable Care Act of 2010, have initiated a surge of redesign efforts.[2, 3] Central to much of this redesign is the need to reduce fragmentation of care through integration, a goal that is particularly relevant to efforts to strengthen the ties between behavioral health and primary care.

Delivery of effective primary care services has received a great deal of attention in the literature as a way to improve population-based care. Empirical evidence suggests that behavioral health integration—often referred to as collaborative care, integrated primary care, or integrated care—leads to improved care and reduced costs.[4-6]

The goal of this AHRQ-funded contract was to assist the field of primary care and behavioral health in identifying core professional practices for successful integration of care. The project team developed a targeted effort focusing on issues related to primary care, behavioral health care, and the integration of the two. The project plan included:

- **An expert panel** that guided the development and commission of the project. The panel (Appendix A) was composed of experts in primary care and behavioral health.
- **A review of the literature** to determine what issues must be addressed to improve delivery of integrated care. The findings of the literature review are presented in a companion report developed under this contract.
- **Identification of key professional practices** through observation and semistructured interviews with people providing integrated care in primary care organizations.

The purpose of this project was to identify the key professional practices that are prominent among exemplary integrated primary care organizations, with the aim of helping other sites achieve the goal of integrating care more effectively.

1.1 Guiding Definitions

This project focused on a group of primary care organizations that can be considered exemplary, as defined below. Our work was guided by an understanding of primary care, behavioral health, integrated behavioral health and primary care, and by a definition of what it means to be competent in providing integrated care. Two additional terms—professional practices and competencies—clarify the domain addressed by this project. The organizing framework of this document is to outline professional practices of integrated care based on observed data from exemplary primary care organizations. An individual, team, or organization expresses the professional practices we identify as "whole" patterns of behavior that integrate competencies into competent professional behavior. Each section will have a professional practice listed and examples of what this looks like in practice.

Behavioral health. Behavioral health care includes mental health care, substance abuse care, health behavior change, and attention to family and other psychosocial factors.

Behavioral health clinician (BHC). A provider who has been trained to provide mental health and substance use services. Often behavioral health providers are psychologists, social workers, licensed professional counselors, and psychiatrists.

1 Background

Competencies (what it takes to do practices well). This refers to the knowledge and know-how that are required for people to participate in the professional practices of integrated behavioral health. Competencies are *deconstructed* ingredients of excellent professional practices.

Exemplary sites. For the purposes of this project, exemplary sites represent examples of primary care organizations that have integrated behavioral health services. In this Guidebook, we identify high-functioning professional practices from each organization.

Integrated behavioral health and primary care. "The care that results from a practice team of primary care and BHCs, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."[8]

Primary care. "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[7]

Primary care clinician. A medical provider who has been trained to deliver primary care in a primary care setting. This may include family physicians, internists, pediatricians, nurse practitioners, and physician assistants.

Professional practices (what people do together at work). This refers to identifiable patterns of behavior that people do together when they are working. We focus specifically on patterns of behavior that accomplish integrated behavioral health, and demonstrate a *synthesis* of the competencies required to perform these behaviors well.

2 Methodology

2.1 Study Team

Deborah J. Cohen, Ph.D., Oregon Health & Science University, was the Project Lead for this team. Melinda M. Davis, Ph.D., Oregon Health & Science University, and Benjamin F. Miller, Psy.D., University of Colorado, Denver, were co-leads. Three research associates worked closely with us: Jennifer D. Hall, M.P.H., Oregon Health & Science University; Emma C. Gilchrist, M.P.H., University of Colorado, Denver; and Sara Keller, M.P.H., M.S.W., Oregon Health & Science University. In addition, a primary care clinician, Leah Baruch, M.D., Oregon Health & Science University, assisted with data collection and analysis. This effort was accomplished as a partnership between Oregon Health & Science University and the University of Colorado, Denver.

The Expert Panel that supported our team helped us refine our site selection strategy, provided feedback on our data collection tools, and contributed in other ways (see Appendix A).

2.2 Site Selection

Eight primary care organizations with integrated behavioral health and primary care participated in this study. To identify functions critical to providing optimal integrated care, we sought a sample composed of high-performing integrated primary care organizations in the United States, and with variation on key characteristics (e.g., geographic location, size, ownership, patient mix). With the assistance of our Expert Panel, we generated a list of primary care organizations to approach about the study. We contacted a practice leader at each site, and described the study. If the practice leader was interested in participating in the study, we started the process with a phone call with our team, asking preliminary questions about the penetration of behavioral health into primary care, the integration model they used, the financial stability of the integrated program, and their ability to collect data and use it to monitor quality of care (see Appendix B for our Exemplary Practice Screening Sheet). Practice leaders' responses were recorded and shared with the Expert Panel, who helped us decide whether or not to proceed with data collection. Once we agreed to move forward with a site, we started observation visit planning (described in more detail below).

Early in the process, we learned that this selection procedure was not sufficiently rigorous, and we needed to gather more information before planning additional observation visits. To address this, we developed a multi-step selection process that asked practices to provide evidence of the penetration of behavioral health in primary care, describe the quality of the collaboration among providers in greater detail, and establish the practice's ability to assess the quality of care provided to patients. While this process did allow us to identify higher performing practices, we learned that it was very difficult to find practices that met study criteria.

The initial AHRQ contract was for the project team to visit five exemplary practices; however, after the project was initially funded, the project team received additional support from the CalMHSA Integrated Behavioral Health Project in California and Maine Health Access Foundation to visit one and two additional sites, respectively. Because of the geographic limitations placed on the project team to identify sites within Maine and California, it was difficult to find sites that met all the study criteria. Therefore, some relaxing of the inclusion criteria was done and sites were selected based on our original approach of using the screening questions and recommendations from the local foundations.

Using this approach, we contacted 18 primary care organizations by email. Of those, 12 agreed to speak with us. Four self-identified as excluded based on email communications and two did not respond to the email invitation. Practice leaders from 12 primary care organizations, usually the practice manager and lead behavioral health provider, participated in a screening call to further explain the project and complete the

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Exemplary Practice Selection Sheet questions. From those, we selected the practices that participated in this study (Figure 1a). The first five practices were selected from a national sample, and those that were selected agreed to participate. Three additional practices were selected to participate, two from Maine and one from California (Figure1b). The characteristics of the practices participating in this study can be found in Table 1 below.

Figure 1a Selection of Integrated Primary Care Clinics From a National Sample

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Figure 1b Selection of Integrated Primary Care Clinics in California and Maine

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Table 1 Characteristics of Integrated Practices

Practice Characteristics								Patient Panel Characteristics, %											
				FTE[1], n (%)					Age (years)				Race/Ethnicity				Insurance/Payer Mix			
ID	Practice Type	Ownership	Location	Primary Care Clinicians[2]	Behavioral Health Clinicians[3]	Psychiatrists	Annual Patient Visits (n)	Female	≤18	19–44	45–64	≥65	White	Black	Hispanic	Other	Medicare	Medicaid	Commercial	Uninsured
1	Multi-specialty Group	FQHC[4], private, not for profit	Urban	37 (22.5)	8 (7.4)	4 (2.5)	90,480	62.4	13.3	48.9	29.9	7.9	n/a[5]	n/a[5]	29.0	71.0[5]	7.0	35.0	39.0	19.0
2	Multi-specialty Group	FQHC[4], private, not for profit	Urban	8 (6.5)	14 (12.2)	3 (3.0)	10,972	55.9	28.1	32.4	36.6	2.9	62.4	21.6	15.2	0.8	10.0	38.0	8.2	43.8
3	Multi-specialty Group	Gov't	Urban	71 (70)	6 (5.6)	3 (1.25)	159,096	17.0	0	10.0	25.0	65.0	62.0	11.0	25.0	2.0	54.0	0.2	14.8	31.0
4	Multi-specialty Group	Private	Urban	56 (48.2)	18 (17.4)	2 (2.0)	104,520	52.2	35.4	41.6	17.9	5.1	0.45	0.02	3.47	96.06	8.0	22.0	24.0	46.0
5	Multi-specialty Group	Hospital System	Urban	7 (5.8)	2 (1.6)	2 (0.2)	10,400	42	0	52.0	44.0	4.0	59.7	20.3	1.5	18.5	15.0	26.0	59.0	0
6	Multi-specialty Group	FQHC	Rural	2 (1.2)	4 (3.8)	2 (1.8)	10,693	28.6	1.7	50.3	43.8	4.2	83.7	4.5	0.3	11.5	41.0	43.0	2.0	14.0
7	Family Practice w/OB	Hospital System	Rural	5 (5.0)	1 (1.0)	n/a	27,000	64.0	30.0	36.0	24.0	10.0	75.0	10.0	10.0	5.0	5.0	40.0	30.0	25.0
8	Multi-specialty Group	FQHC[4], private, not for profit	Rural	12 (9.9)	4 (2.9)	1 (0.2)	102,960	58.0	31.0	44.0	18.0	7.0	30.0	3.0	53.0	14.0	4.0	49.0	11.0	36.0

1 Full-time equivalent

2 Primary care clinicians include: medical doctor (MD) or doctor of osteopathy (DO) practicing family medicine, internal medicine, or pediatrics; physician assistant (PA); nurse practitioner (NP).

3 Behavioral health clinicians include: clinical psychologist (PhD), doctor of psychology (PsyD), licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), and licensed clinical professional counselor (LCPC)

4 Federally qualified health center

5 Only collects Hispanic and non-Hispanic; "Other" includes non-Hispanic, declined, and not collected/unknown

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2.3 Data Collection and Analysis

Dr. Cohen, who is experienced in qualitative research methods, developed the data collection tools for this study. This included a practice survey, a pre-site visit interview guide, an extensive observation guide, and a semistructured interview guide. She and her team conducted the site visits. Dr. Cohen's team has experience in studying primary care and integrated primary care organizations. They knew how to observe in this setting, and they had experience conducting semistructured interviews with primary care organization informants. Between two and five researchers, depending on the size of the organization, participated in each visit.

2.3.1 Tool Development and Pilot Testing

Dr. Cohen, with the assistance of Sara Keller, developed the data collection tools for this study. They developed preliminary tools, shared these tools with the larger team and the Expert Panel for feedback, and refined the tools. Using the refined tools, Dr. Cohen and Ms. Keller tested the data collection tools at an OHSU clinic. We learned during pilot testing what types of assistance practices needed when completing the practice survey, that the observation tool was effective and provided a loose structure for field researchers to provide rich data on observed practices in the clinic, and that the semistructured interviews needed some revisions. We revised the semistructured interviews and implemented careful versioning for the different types of clinic members we interviewed. Tools continued to be refined, as needed, throughout the duration of the data collection process to ensure that we collected the richest and most robust data possible.

All of the revised data collection tools and the study protocol were submitted and approved by the Institutional Review Board at OHSU and University of Colorado, Denver.

2.3.2 Pre-Visit Planning

Prior to visiting the primary care organization, we conducted a pre-site visit interview with primary care and behavioral health leaders, and hosted a webinar in which an information technology expert from the organization demonstrated their electronic health record (EHR) system. These conversations lasted approximate 60-90 minutes each, and helped our team prepare for the visit. Following these conversations, we began a complicated process of planning the site visit. This included identifying the right number of team members to attend the visit, identifying who would observe in what areas of the organization and for approximately what length of time to determine, roughly, the start and end time for each observation day, including who would meet and greet us on the first day of the visit and show us around, and identify and schedule interviews. Visits typically were 3 days, and, depending on the size of the practice, 2-5 people attended each site visit. Participating practices also completed a Practice Information Form (PIF) with general information of the practice including provider and staff characteristics, patient panel characteristics, and revenue and billing information.

Visit components. On site, the team was given a brief primary care organization tour. We then separated to shadow the different types of clinicians and health care professionals involved in care delivery. We wanted to observe the patient care process from multiple vantage points. This included primary care and BHCs, as well as pharmacists, social workers, care coordinators, care and case managers, enrollment specialists, medical assistants, and front desk staff. We also wanted to understand the integrated care process from the vantage point of patients,

and we followed patients through their visits, often with several different clinicians and health care professionals. During the observation process we would get to talk informally with clinic members about their experiences and practices related to integrated care.

Additionally, we conducted 8 to 12 semistructured interviews at each site with a wide range of practice members, including but not limited to, the organization's leaders, primary care providers, BHCs, psychiatrists, social workers, care managers and coordinators, pharmacists, clinical and nonclinical support staff, and key operations personnel, such as quality improvement and information technology specialists.

We also collected relevant documents (e.g., workflows, protocols, training documents) and took pictures of the facility.

During the visit, team members would take notes about what he/she observed. Each night, team members would take the notes and write a full set of field notes. Field notes were very in-depth and detailed accounts of each day's observation, and often were many pages in length.

Expert Panel review. To ensure the rigor of our process, we shared field notes from the first day's observation with at least two members of our Expert Panel during each visit. The expert panel members read our notes and then debriefed with us the following evening. The purpose of our debriefing session was to identify areas that needed more investigation and to begin identifying lessons learned.

2.3.3 Data Management

All notes were written up as field notes within 24 hours of observing. Interviews were audio recorded, professionally transcribed, reviewed for accuracy, and de-identified. Field notes, interview transcripts, documents, and photographs were put in Atlas.ti™, a qualitative data management and analysis program.

2.3.4 Data Analysis

We used a grounded theory approach to analyze the data, which means that we did not approach the data with predetermined codes. Rather, the qualitative team read data aloud as a group, discussed it, and decided on how to tag and name important segments of text. For instance, we might read field notes that describe how the primary care providers and BHCs managed clinic workflow during a patient care session. We believed that how this was done was important to integrating care for patients. We would select (highlight) the relevant text and then name it, for instance with the name "workflow." Thus, workflow became a preliminary "code" that we could use again and again to tag other relevant data sources (e.g., field notes, interview data). We continued this process of reading, tagging, and naming text together until we were no longer creating new codes. At that point, we divided the remaining data and analyzed it individually, using the code list we had developed. In addition, our coding process was informed by a number of analysis sessions with Expert Panel members who read and discussed data with us.

Once the data were analyzed and coded in this preliminary fashion, we conducted a second analytic cycle in which we read all of the data within a single code. We divided the codes among the team members, and each team member was responsible for analyzing tagged text from a single code (e.g., workflow) and identifying the most interesting or important "findings" related

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to how care was integrated across practices. Each person on the team prepared a document to describe and organize these findings. We reviewed and refined findings with Expert Panel members. In addition, during the process of organizing our findings, we made connections to the literature. It was during this phase of our work that the work of Edmonson on teams, teamwork, and teaming influenced how we viewed the organization-level professionals practices that we were identifying across the exemplary integrated primary care organizations.[9-11] Edmondson's work informed how we present the organizational professional practices portion of the guide.

While there are many different definitions of competence in the literature and many excellent reviews stand out on the topic,[12] we draw on Norris's[13] research and approach to the "generic competence," which focuses on identifying and assessing "common abilities that explain variations in performance." In Norris's framework, those individuals who are the most effective performers at their task have their distinguishing characteristics identified and then compared with other individuals (or practices) to better understand the importance of this "competency" or behavior in delivering integrated care. In essence, this is what we have done with this project. The data we collected gave us excellent insight into the behaviors and professional practices members of exemplary integrated primary care organizations engaged in when integrating care, and we were able to identify many commonalities across the exemplary sites.

3 Findings

We observed that high-quality integrated care required a high-functioning, well-organized primary care practice, as well as key behaviors at the organizational, practice, interpersonal, and individual clinician levels. Our findings are organized into two main categories:

- **Organization-level professional practices.** In the first section, we identify the organization-level professional practices that exemplary primary care organizations implement to create a community of professionals who can work together to deliver integrated care.
- **Interpersonal and individual professional practices.** In the second section, we identify the professional practices that people in the primary care organizations engage in to deliver integrated care to patients. We describe how people in the exemplary practices organize their behaviors to deliver population-based integrated care to patients.

Our work expresses whole patterns of behavior that *integrate competencies* into competent professional behavior by an individual, team, and organization. We include examples, in the form of excerpts from our field notes or from interviews we conducted, to illustrate these professional practices.

We focus specifically on professional practices and behaviors related to integrated care. While we observed that many professional practices and behaviors are critical to delivering exceptional primary care, these are not described in detail in this report. Readers should recognize that exceptional primary care is a necessary foundation for exceptional integrated care.

3.1 Synopsis of Findings

This section summarizes all of the organization-level professional practices and interpersonal and individual professional practices that supported integrated care at the primary care organizations. Each of the professional practices is linked to the portion of the guidebook that describes the findings and offers excerpts from the project team's field notes and interviews that illustrate the practices.

3.2 Organization-Level Professional Practices That Support Integrated Care

3.2.1 Advocating for a Mission and Vision Focused on Integrated Care

3.2.1.1 Shared Mission and Vision

Organizational mission. Clinic members, at all levels, are able to articulate a clear organizational mission.

- **Service as mission.** The organization's mission is to serve patients by providing population-based care in an integrated care model.
- **Focusing on team approach.** Leaders are clear that providing integrated care is the way to achieve the organization's mission.

Clear vision. Leaders define a clear vision for integrated care as a model of care for the clinic.

- **Ongoing improvement.** The vision for integration is a clear guiding framework, and over time, practice members at all levels help to clarify and improve the integrated care model in practice.

- **Adaptation based on community needs.** The organization's vision for integrated care evolves within the local environment, and the organization adapts as needed to meet the evolving needs of the community.

Commitment to mission and vision. Leaders show their commitment to integrated care by modeling integration-related behavior in their own professional practices.

3.2.1.2 Health System Functions as a Learning Organization

3.2.1.2.1 Characteristics of Learning Organizations

Opportunities for innovation. Leadership provides opportunities for innovation and encourages staff to share new ideas and pilot-test new programs.

- **Risk tolerance.** Leadership is willing to take on risks and challenges and try new things.
- **Mistake tolerance.** Leadership encourages a culture in which people are not afraid to make a mistake.

Evaluation and revision. Leadership regularly evaluates and revises programs and initiatives.

Obtaining feedback. Leadership regularly solicits employees' feedback, input, and perspective on areas of improvement.

Accountability based on performance goals. Leadership holds staff and the organization responsible for achieving identified performance goals, and has the capacity to discuss these standards. This includes creating volume targets for BHCs so there are benchmarks and data available to gauge activity and engagement.

3.2.1.2.2 Commitment to Ongoing Quality Improvement

Investment in continuous quality improvement. The organization invests in continuous quality improvement, including management-level personnel who help identify quality issues and staff to lead quality initiatives. Quality improvement leaders engage an interdisciplinary group of clinic members in quality improvement processes.

- **Assessment of quality improvement efforts.** The organization has systems in place (e.g., team meetings) to review quality measures and assess and realign quality improvement efforts.
- **Documents for training.** Quality improvement efforts lead to the development of process improvement documents, such as workflows, protocol, and procedures documents, which are used to train others (e.g., new employees) in these professional practices.

Data-driven approach to quality improvement. Organization members take an active and data-driven approach to identifying quality initiatives related to integrated care. For instance, the organization tracks data to assess the frequency and penetration of BHCs by primary care provider, and follow-through on warm handoff of referral to BHCs or specialty mental health, and all aspire to look at how these patterns of care affect outcomes.

- **Consistent documentation.** The organization uses data to inform the quality improvement targets and monitor the quality improvement process for integrated care. Health IT systems, such as the EHR system, are developed and customized to support documentation of clinically relevant information, particularly for behavioral health, if good documentation templates were not part of the basic EHR package. Clinic members are trained to consistently document care using these systems. Analysts can extract the data, and the organization uses the data to monitor and continually improve the quality of integrated care.
- **Sharing data with external organizations.** The organization uses health IT data to make a case for integrated care to payers and other external organizations.

Data transparency. Quality measurement is transparent and built into an incentive package; data to assess how a team is doing are accessible and easy to use by clinical teams.

3.2.1.3 Advocacy

Advocacy work. Leadership markets the model and vision for integrated care to others, creating buy-in and support for this vision outside of the organization. Leadership encourages all staff, at all levels, to participate in advocacy work.

State and community changes. Leadership advocates for changes at the State and community level that support integration.

Awareness of barriers. Leadership is aware of barriers to care for patients; advocacy efforts aim to eliminate those barriers.

3.2.1.4 Financing Integrated Care

3.2.1.4.1 Negotiating With External Financial Stakeholders

Health plans and other payers. The organization develops strong relationships with health plans and other payers and shows a persistent willingness to push back (as needed) and negotiate contracts that meet the needs of the organization and make integration possible.

State and local governance. The organization develops strong relationships with the State and local governance and can leverage these relationships to create a better funding and financial environment for integration.

Using data. The organization collects and uses data to show how the quality of the integrated care that it provides exceeds the quality of the care that competitors provide, thereby saving money for the payer. This results in negotiated contracts that pay for integrated services.

3.2.1.4.2 Managing Internal Finances

Offsetting of costs. When integrated care provided by practices represents a cost center within a larger organization, those costs are offset by others parts of the system that are profit centers, or through savings that integration creates in other parts of the system.

Capitated payments. Capitated payments give the integrated organization more flexibility to manage its finances and support integrated care.

Managing existing payment structure. Fee-for-service billing for behavioral health using CPT codes are carefully managed to keep BHCs' schedules open so that they are available for consults.

Finding money-saving opportunities. The organization looks for money-saving opportunities, such as handling as much care as possible outside of the exam room (particularly in capitated, integrated care systems), and putting an emphasis on appointments with providers who deal with the most complicated cases.

Developing supplemental income. The organization develops supplemental sources of income, such as developing integrated care training programs and marketing these services to outside organizations.

Using supplemental funding sources. The organization supplements its finances with grants; its long-term projects or initiatives often begin as small grants and pilot programs.

Taking calculated risks. The organization takes risks on new projects that are considered important and necessary, and works out the financing later.

Dedicating resources to enroll patients in insurance programs. The organization assigns staff to help patients enroll in insurance programs, thereby making it possible to bill for integrated services and minimize the cost of providing care to uninsured patients.

Providing care regardless of patient's ability to pay. The organization does not share financing details about individual patients with service providers in order to prevent payment consideration from dictating how care is delivered.

3.2.2 Building a Sustainable Staffing Structure for Integrated Care

3.2.2.1 Expertise and Staffing for Integrated Care Teams

Expertise needed for integrated care delivery. The organization is able to determine the types of expertise needed to deliver integrated care. Typically this means relying on primary care clinicians (physicians, nurse practitioners, and physician assistants) and behavioral health clinicians (psychologists [Ph.D. or Psy.D.], licensed clinical social workers, licensed clinical professional counselors, psychiatric nurse practitioners, and psychiatrists) as well as nurses, pharmacists, and ancillary support staff (case managers, care managers) to support complex patients and to facilitate access to more traditional mental health services.

- **Addressing gaps.** The organization is able to identify when there is a gap in expertise on the integrated care team, and takes steps to fill that gap.
- **Defining required expertise.** Primary care organizations were clear regarding the professional expertise needed to fill a particular role or function; sometimes this was learned through trial and error.

Staffing to fulfill mission and vision. The organization's staff is able to fulfill its mission and vision of providing all patients with access to integrated care.

Strong teams. The organization is able to create strong clinical teams with sufficient experience and knowledge. The working behaviors of teams should not be idiosyncratic, but should abide by protocols and work processes such that people in the same roles (e.g., medical assistants) but on different teams are interchangeable when a need arises (e.g., vacation).

Collecting information to enhance patient experience. The organization has the ability to gather and use information about patient cycle times, workflow, and staff feedback to make adjustments in staffing to enhance the patient experience of care.

3.2.2.2 BHC Staffing and Access Issues

Accessibility to clinicians and patients. The organization has enough BHCs so there is real-time availability to primary care clinicians and patients. (A common mistake is to get BHCs fully scheduled so they are unavailable for collaboration and warm handoffs in a more specialty behavioral health role.) The organization also must address any concern that BHCs will not be adequately utilized.

- **Adequate access to BHCs.** Full-time BHC staff presence is often required in order to make routine access to BHCs easy, foster necessary relationships, and make services available.

Connection with primary care team. The organization creates an environment where the BHC is connected to a primary care team, but where covering for another BHC is the norm.

Staff recruitment. The organization is committed to staff recruitment and a rigorous hiring process.

3.2.2.3 Psychiatrist Staffing and Access Issues

Access to psychiatrists. Psychiatrists are available for consults and brief encounters, and adequate staffing and open scheduling of psychiatrists support patient access to these services.

Knowledge sharing. Psychiatrists focus on medication management and care of the most complex patients, and play a role in educating, training, and supporting primary care clinicians to manage the more moderate and routine needs of patients.

3.2.2.4 Hiring

Clear description of culture and vision. During the hiring process, organization members provide an explicit description of the clinic culture and vision for integration. As their integrated programs evolve, clinic members get better at clearly articulating expectations for integrated care to potential hires.

Participation in hiring process. Multiple clinic members at different levels and from different roles in the organization are involved in hiring new staff, helping applicants get a full and realistic view of the organization, and helping the organization get multiple perspectives on the applicant's potential.

Training programs. The organization develops training programs (e.g., offering postdoctoral fellowships, or serving as a clinical training site for academic programs that train clinicians), because these provide the opportunity to shape and assess trainees' skills and provide a stream of highly qualified future applicants.

3.2.2.5 Training and Development

3.2.2.5.1 Orientation-Related Practices

Training about culture. Resources were allocated to orienting new hires to the organization's culture. This included developing written materials on the history, culture, mission, and vision of the organization, as well as providing face time with organization leaders who could communicate organizational values to new hires.

- **Sharing of stories.** Organization leaders and others informally share stories during meetings and at other times to solidify and communicate the practice mission and culture to new hires.

Policies and procedures. Written materials are prepared to communicate key policies and procedures, and shared and reviewed with new hires during orientation.

3.2.2.5.2 Training New Hires

Interprofessional shadowing. New hires are taught about their roles and responsibilities, as well as the roles and responsibilities of others in the clinic. Although reviewing written protocols could do this, the organization often accomplishes this through an extensive shadowing process, whereby new hires observe more experienced professionals in the practice. Shadowing may involve the same position as well as other positions that interface closely with the new staff member's role.

EHR training. A critical aspect of training is learning how to use the EHR system. This is accomplished both in computer classrooms (formal training) and during the shadowing process.

Supervision. New hires are closely supervised. Supervisors ensure that trainees have sufficient opportunities to shadow other people, answer questions, and monitor progress, to know when the person is ready for the next step in training.

- **Assistance during patient visits.** Following shadowing, when clinical staff start seeing patients, they often do so with the assistance of another experienced clinician.

Strategic scheduling for new clinicians. When clinical staff are ready to start seeing patients alone, they are given a light schedule for several days, allowing the new employee the extra time needed to apply new skills and asks questions as needed.

Refining clinical skills. Experienced BHCs help new BHCs refine their therapeutic skills for working in an integrated clinic.

Familiarization with clinic resources. Experienced practice members help new BHCs understand the range of resources available in the clinic, and help PCPs learn strategies for engaging BHCs in patient care.

3.2.2.6 Ongoing Training

Mentoring. A formal, ongoing mentoring infrastructure allows peers to learn from each other and from more experienced professionals. Formal within-specialty mentoring meetings are held for BHCs, and there are learning opportunities for PCPs. For new BHCs, there is a structure for advancing to mentorship and supervisory roles.

- **Transition after initial training.** After initial training is complete, new hires transition to a mentoring/supervising structure.

Supervision. Supervisors are available to talk with staff, provide feedback, and take advantage of key moments for learning. Formal time is allocated for feedback, particularly for new hires.

Training opportunities. Meetings are structured so ongoing training needs can be addressed through a range of modalities (written, video, interactive tutorial, face-to-face). Trainings are used to introduce new workflows, correct existing workflows, and identify when new positions may be necessary to implement optimal workflows.

Assessment of training efforts. Organization leaders continually seek feedback and evaluate the effectiveness of their training efforts.

3.2.3 Structuring the Organization for Delivering Integrated Care

3.2.3.1 Defining Roles and Responsibilities for Integrated Care

Clear roles and responsibilities. The organization works to identify clear roles and responsibilities among clinic members. This is a high priority and, in some cases, a work in progress, particularly as new types of professionals are added to the staff.

- **Staff flexibility.** Clear definitions of roles and responsibilities help professionals work fluidly and with flexibility. This is most noticeable when a practice is short-staffed and a person works outside his/her defined role to temporarily fill a care gap for patients.
- **Adaptation to local setting.** Definitions of roles and responsibilities are adapted across settings within the same system to align with the characteristics of a local clinic (e.g., physical space, funding streams, staffing arrangements).

Managers and supervisors involved in clinical practice. Managers and supervisors of BHC, psychiatrists, and PC clinicians are practicing clinicians and have experience in integrated care and in the role they are supervising. Because they are still in clinical practice, they can model how to manage and adapt roles and responsibilities.

Determining right level of care. It is critical to define what "patient in crisis" means, and how differing types of patient behavioral health illness and severity should be handled. This determines who is responsible for patient care (e.g., an embedded BHC or a referral for more long-term therapy) and clinical workflows.

- **Selecting level of care.** BHCs play a critical role in getting the right level of care to patients. They identify and address the behavioral health needs that can be managed in the clinic and identify those patients who need more intensive services.

3.2.3.2 Structuring Clinical Workflow for Integration

3.2.3.2.1 Development of Protocols

Multiple ways for patients to access BHCs. The organization can create and consistently use multiple pathways or workflows to facilitate patient access to BHCs, including warm handoffs, consultations, and proactive referrals.

Routinized clinical processes. The organization places a value on certain routinized clinical processes (e.g., screening and assessment) by setting clear goals and providing feedback on goal attainment, and assistance in achieving goals, if needed.

Decision support tools. The organization develops decision support tools to alert health care professionals when a routinized clinical task (e.g., screening) is needed, and builds systems to ensure that when this task is accomplished, it is documented in discrete fields for monitoring and learning purposes.

Awareness of patient flow. The organization develops systems that help integrated teams coordinate their activities and have a level of awareness (situational awareness) of where others on the team are with regard to patient flow.

Creating efficient protocols. The organization creates protocols that avoid unnecessary repetition, and that balance clinic information needs with patients' tolerance for, for instance, completing behavioral health screening questionnaires.

Data collection for panel management. In addition to creating the structures needed for collecting these data, the organization uses these data to facilitate panel management, and address access for integrated care.

3.2.3.2.2 Development of Meeting Structures

Planning meetings or huddles. Workflows accommodate planning meetings, such as huddles, so primary care and behavioral health providers can identify, ahead of the visit, scheduled patients who need both primary care and behavioral health services, and coordinate those services efficiently.

Ability to interrupt clinicians. Workflows accommodate unanticipated primary care and behavioral health needs during a patient visit. Providers are interruptible for consults and warm handoffs when there is an emergent issue.

- **Unscheduled time.** Develop daily schedules, particularly for BHCs, so they have sufficient unscheduled time to collaborate on unanticipated behavioral health issues with the primary care team.

Peer-to-peer problem solving. Meeting structures accommodate peer-to-peer problem solving.

Team meetings. Interdisciplinary team meetings create awareness among clinicians from different backgrounds that helps them develop and understand each other's work and services.

- **Care planning for complex patients.** Interdisciplinary team meetings and conversations afford opportunities for more in-depth dialogue to develop care plans for very complex patients.

3.2.3.2.3 *Development of Rules for Interruption and Collaboration*

Interruption. When visiting with patients, the protocol is that clinicians can be interrupted by a knock on the door, as well via other means (cell phone, walkie-talkie, pager, etc.).

Collaboration. The organization develops daily schedules, particularly for BHCs, so they have sufficient unscheduled time to collaborate on unanticipated behavioral health issues with the primary care team.

3.2.4 Maximizing Physical Work Space for Integrated Care

3.2.4.1 Creating Team Work Spaces for Integrated Care

Shared work space. Physical space is designed so clinicians share a work space on the primary care floor and in a communal workspace, if available. Clinicians literally work shoulder-to-shoulder.

- **Embedded BHCs.** Clinicians often did not have individual offices. BHCs are embedded in the primary care clinic, and often share work space with primary care clinicians and clinical support team members. These teams work shoulder to shoulder, creating a very high social presence among team members and facilitating conversation and coordination.
- **Proximity. BHCs may or may not have their own office.** If they have their own office, they have a strong organizational norm to be accessible and visible to primary care. If BHCs do not have their own offices, there are quiet, private spaces where they can see patients, in close proximity to medical examination rooms.

Facilitation of communication. The physical space allows for communication among team members, particularly primary care providers, BHCs, and clinical support staff, at times such as before and after a handoff between clinicians.

Facilitation of coordination and collaboration. The physical space allows professionals of different backgrounds to cross paths regularly, which is critical for coordination and collaboration.

Support for collaboration and patient privacy. Work spaces are designed for integrated care, with particular attention to having a space where behavioral health, primary care clinicians, and others work together, as well as a private space where clinicians can work privately with patients.

- **White noise.** In small spaces, the organization uses white noise machines to maintain patient privacy.

3.2.4.2 Designing Examination Rooms for Integration

Identifying which team member is with patient. At some organizations, exam rooms have a colored flag system outside of the door to designate which clinician is with the patient. Other organizations use the EHR system to fulfill this function.

Workflow efficiency. Strategic design of exam rooms in a "pod" allows primary care and behavioral health clinicians to move from patient to patient in an efficient manner and continue to be in close proximity to clinical support staff.

Patient interaction. Examination rooms, rooms for meeting with patients (if not meeting in examination rooms), and workspaces are designed intentionally for the use of computers such that eye contact and screen sharing can be easily managed.

Telemedicine support. Organizations that had telemedicine had spaces for these visits (and the necessary equipment) at both the delivering and receiving end of the telemedicine encounter.

3.2.4.3 Integrating Services Under a Single Roof

Access to other services. To the extent that space allows, clinic leaders rent space to other community and public health organizations (e.g., specialty mental health services, WIC, pharmacy, public health department) to create a single place where patients can access the services they need.

Community spaces. Organizations often design spaces for group meetings and community meetings into their structures. These rooms provide space for larger team meetings, group therapy, and educational sessions (e.g., cooking classes) and community meetings.

3.2.5 Organizing Health Information Technology to Support Integrated Care

Shared EHR system. The organization has one EHR system that is used by all clinicians and staff.

Shared EHR access. Clinicians have access to medical, behavioral, and mental health information and records.

3.2.5.1 Supportive Functions Within the EHR System

Supportive functions for integrated care delivery. The EHR system has certain features that are important to supporting the delivery of population-based integrated care, and that are accessible to all clinicians. These include the following:

- Easy-to-use templates for common behavioral health screening tools used in the practice (e.g., PHQ-2, PHQ-9, GAD-7). These tools collect screening data in numeric form/fields that is then usable by the clinic as data and for decision support (e.g., alerts);
- Decision support tools to alert health care professionals when screening is needed;
- Support for developing an EHR-based shared care treatment plan;
- Ability to write group notes; and
- Scheduling templates tailored to different clinicians' visit types.

Ability to track patients through workflow. The EHR system has a tracking system that allows clinicians and clinical support staff to identify where a patient is in the integrated workflow (patient is with primary care clinician, BHC, etc.)

3.2.5.2 Customizing the EHR System for Integrated Care

Customization for behavioral health. The EHR system is customized for behavioral health, because basic systems do not have the required documentation templates. Interdisciplinary teams develop these customizations; these teams require people with content expertise (e.g., BHC) and information technology expertise.

- **Templates.** Considerable effort is put into customizing behavioral health templates (similar to those that already exist for physical health.) These allow for efficient documentation: BHCs document patient notes into structured or discrete numeric fields rather than traditional free-text narrative notes.
- **Structured data.** As a result of customization, there is a structure in the EHR system to document BHC visits, consults, warm handoff in a numeric field or form that can be accessed as data and used to guide operational decisions and quality improvement efforts.

Data reporting. As a result of customization, the organization can extract data from the EHR system and create the reports needed for population management and quality improvement as it relates to integrated care.

3.3 Interpersonal and Individual Professional Practices for Delivering Integrated Care

3.3.1 Managing the Structure and Timing of Integrated Care Delivery

3.3.1.1 Managing Staff and Workflows

3.3.1.1.1 Workflows for Integrated Care Teams

Collaboration. Professionals work with other members of the practice team (e.g., medical providers, BHC colleagues, medical assistants) to keep clinical work running smoothly.

Workflows to access BHCs. The organization creates and consistently uses multiple pathways or workflows to facilitate patient access to BHCs, including warm handoffs, and consultations with or without the patient present.

Integration-based workflows. Professionals follow workflows defined by the integration model adopted by the clinic, so patients are navigated to appropriate clinicians. This can include both internal and external referrals for behavioral health, primary care, enabling services, etc.

Access to BHCs. BHCs are either physically present and accessible on the primary care floor (when not with a patient) or can be reached via pager or phone.

3.3.1.1.2 *Workflows for Integrated Care Delivery*

Pre-visit planning. Workflows accommodate pre-visit planning, such that primary care and behavioral health clinicians identify scheduled patients who need both primary care and behavioral Unanticipated needs. Workflows accommodate unanticipated primary care and behavioral health needs during a patient visit. There are bidirectional interactions, and primary care providers and BHCs are interruptible for consults and warm handoffs.

Clear pathways for care. Workflows enable model-appropriate care, creating clear pathways for care that can be addressed in the clinic as well as clear pathways for coordinating treatment for the more severe needs that may need to be addressed by another area in the clinic (e.g., specialty mental health services) or by outside services.

- **Roles and boundaries.** Workflows enable appropriate roles and boundaries between different levels or areas of the organization, such as specialty mental health services and chemical dependency programs.

Interdisciplinary communication. Workflows allow for communication among professionals from different disciplines (e.g., primary care, behavioral health, psychiatry) before and after a handoff between clinicians. Before a handoff, professionals discuss concerns and problems for their colleague to focus on. After a handoff, professionals summarize their visit, offer their assessment, and decide on next steps.

3.3.1.1.3 *Workflows for Behavioral Health Clinicians*

Balancing consults and appointments. BHCs gracefully step out of current appointments for brief consults, as needed. They determine whether the consult takes precedence, and are able to execute this decision by either ending the visit with the current patient, identifying a time frame when they can engage the new patient, or strategizing with the provider on care and returning to the current patient to pick up where they left off.

Strategic scheduling. BHCs construct their appointment templates to match the primary care clinic flow—more follow-up appointments at quiet times in the clinic and more open slots during busy times.

- **Unscheduled time.** BHCs arrange their daily schedules with sufficient unscheduled time to collaborate on unanticipated behavioral health issues with the primary care team.

Brief visits. BHCs conduct brief visits, keeping appointments and primary care workflow on track.

3.3.1.2 Documentation and Information Sharing

Concise notes. Clinicians write concise notes that contain all information relevant to the shared care or clinical handoff. Notes typically include a brief description of the problem and symptoms, the diagnosis, and the treatment plan.

- **Documentation protocols.** Clinicians follow the documentation "rules" defined by the organization, using the templates, mineable data fields, or other features that the organization has developed for this purpose. This makes information accessible, easy to use, and easy to find. It also supports data tracking, data reporting, and quality improvement efforts.
- **Notes in style of medical charts.** BHCs write notes that fit not only the "rules" but the style and substance familiar in medical charts, e.g., clear structure, easy-to-find facts and plans, and limits on long or rambling discourses or hypotheses that aren't solid information.

Team communication via EHR. Clinicians use EHRs to communicate with others on the team and to document throughout the patient visit, and as a patient education tool.

- **EHR communication features.** Clinicians use EHR features, such as in-baskets and messaging tools, to communicate with others on the team. They may task encounter notes to others on the integrated care team as a request for action or for review. Clinicians know when to use and when not to use these features.
- **Choice of communication mode.** The complexity of the patient's situation and the urgency of the situation are two factors that drive decisions about whether thin communication (email, instant message) or rich communication (phone call, face-to-face discussion) approaches are needed.
- **Documentation during patient visits.** Clinicians document in the EHR while simultaneously engaging and interacting with patients. Clinicians know how to manage and modulate documentation during patient visits, including when to stop typing, make eye contact, and listen intently to patients.
- **EHR as patient education tool.** Clinicians use the EHR as a patient education tool, such as by sharing the screen with patients to show trends in relevant clinical measures (e.g., BMI) and sharing educational information (e.g., self-management activities) in a visit summary.

Structured care plans. Clinicians create and maintain a care plan that outlines treatment, describes plans for follow-up, and ensures that the patient and all involved clinicians are on the same page. The plan provides access to patient information and identifies who's responsible for addressing specific health care needs and goals. Care plans are often used for complex patients and pain management patients.

Population management using registries. Clinicians use registries and data tracking tools to manage the care of patients with chronic diseases, and to monitor screening and health maintenance activities.

3.3.1.3 Supervision

Recruitment. Supervisors interview, select, and hire staff and clinicians with appropriate skills and qualities that fit the culture of the integrated clinic.

Feedback and coaching. Supervisors listen to behavioral health and primary care clinicians and help assist with problem-solving. When this relates to patient care, supervisors help without taking over patient care.

Operational management. Supervisors manage a clinical practice in addition to having supervisory responsibilities; maintaining a clinical practice is important as a way to stay relevant and engaged in patient care.

- **Modeling behavior.** Supervisors model exemplary clinical behavior and are highly collaborative with other clinicians on the team.

Ongoing learning. Supervisors identify, execute, and implement learning opportunities to help integrated team members (e.g., primary care clinicians, BHCs, psychiatrists) and improve the clinic's integrated care model.

3.3.1.4 Inter-Professional Collaboration

Pooling of expertise. Clinicians acknowledge and integrate into patient care the priorities of other providers, using the contributions, skills, and knowledge of others who have different roles and expertise.

- **Using input.** Clinicians incorporate and act on input from other team members.
- **Sharing decisions.** Clinicians share decision-making with other members of the team by identifying points where team member perspectives need to be combined and an explicit decision needs to be negotiated.
- **Respecting different work styles.** Clinicians adapt to others' working styles and preferences, within the limits of the basic roles and processes established by the organization.

Situational awareness. Clinicians anticipate when they might be needed by other members of the team and remain accessible.

Articulation of role. Clinicians early and clearly articulate their role to others, explaining "who I am and what I do."

Acting on shared values. Clinicians routinely act on the shared values for communication and collaboration articulated by the organization.

3.3.2 Communication Practices That Facilitate Integrated Care

3.3.2.1 Communication Among Clinicians and Staff

3.3.2.1.1 Communication Practices for General Coordination of Care

Access to clinicians. Clinic members communicate to manage and adjust clinicians' schedules (behavioral health and primary care) and clinical workflow in order to provide patients with the best possible access to clinicians, even for patients who are not on the visit schedule.

Access to practice resources. Clinic members communicate to ensure patient access to other practice resources (e.g., social workers, community health workers, insurance assistants) on the day of the visit or soon after, if necessary.

Patient visit summaries. Clinicians produce clear and concise summaries of a patient's situation so that another person in the practice can use the information in a subsequent visit or step of the clinical care process. Each summary includes enough information to allow other providers to rapidly assess the acuity of patient need.

3.3.2.1.2 Communicating During Collaborations and Consults

Interdisciplinary collaboration. Professionals from the same and different professional backgrounds engage in dialogue about patients and work together to understand what's going on, and to help patients through a range of problems and treatment modalities.

- **Assessment of patients.** Clinical staff (e.g., medical assistant) and non-clinical staff (e.g., front desk staff) identify and communicate observations of patient needs to clinicians.

Communication about comfort level. Clinicians consult with each other regularly, either in person or over the telephone and email. Clinicians are aware of and/or explicitly communicate about one's comfort level with addressing certain problems and treatment modalities (e.g., managing medications).

De-escalation of conflicts. Clinicians and staff members communicate in order to de-escalate conflicts with patients. This is especially important when working with patients where substance misuse is a concern; this is not left to the BHC to manage.

Consistent messaging. Clinical staff support each other in reinforcing messages to patients; this is especially important when working with patients for whom substance misuse is a concern.

Debriefing about patient encounters. All clinical and non-clinical staff members can debrief as needed after challenging patient encounters, and explore ways to make practice-level changes to prevent problems from happening again. Clinicians can ask colleagues for a "gut check" or opinion about a patient when unsure of the patient's story, feeling manipulated, or simply uncertain about the best approach to working with the patient. This is especially important for patients for whom there is concern about illicit or prescription substance misuse.

Peer support. Clinic members communicate to support colleagues who might be frustrated by a patient and need to discuss this in order to continue to provide the care the patient needs.

3.3.2.2 Communication With Patients

3.3.2.2.1 General Communication Practices

Multiple communication modes. Clinicians communicate with patients via multiple modes, including the phone, secure email, and Web-based portals.

- **Avoiding unnecessary visits**. Clinicians use phone conversations and email correspondence to reduce unnecessary visits to the practice.

Team role clarity. Clinicians offer clear and succinct self-introductions that clarify each clinician's role on the care team and relationship to other care providers.

Celebration of successes. Clinicians communicate appreciation for patients and celebrate patients' successes.

Encouraging positive behaviors. Clinicians use patient data (accessed in the EHR or obtained during the clinical encounter) to encourage patients toward positive behaviors.

Culturally appropriate communication. Clinicians communicate in a culturally appropriate manner, and are careful when discussing sensitive or stigmatized issues, particularly those related to behavioral health and substance use.

Acknowledging patient concerns. Clinicians make a point of being aware of and communicating about clinical operations in order to address patients' concerns (e.g., long waits) and to mediate and manage difficult patient situations, as needed.

Guidance about community resources. Clinicians communicate knowledgeably with patients about community resources, programs, and other relevant services for patients. Clinicians provide insider guidance to help patients navigate what are often multiple and complex systems.

3.3.2.2.2 Managing Shared Patient Visits

Care team introductions. Clinicians may bring clinicians from other disciplines into a patient visit. When this happens, the clinician introduces the other member of the care team by describing this person's expertise and reinforcing his/her trust in this person's skills.

- **Rationale for care team approach.** Clinicians explain to patients why meeting with another type of clinician on the care team is valuable, and communicate his/her trust of this other care team member.

Leading the appointment. When a visit includes two clinicians from differing disciplines, the clinicians know who has the lead and will manage the encounter, and they are able to work together to discuss the patient's needs and identify how they will work on these together. This is done without overwhelming or overpowering the patient.

Communication with other parties. When family members, friends, or other caregivers are present, clinicians know how to manage the discussion with patients and other parties.

3.3.3 Clinical Practices of Integrated Care Teams

3.3.3.1 Professional Practices Related to Engaging Individuals, Couples, and Families in Care

Destigmatization of care. Clinicians normalize and de-stigmatize care (e.g., behavioral health care) when necessary, and present integrated services as part of routine whole-person care.

Rapid assessment. Clinicians focus on rapid and accurate assessment; they ask probing questions in a way that invites honest responses, they present problems quickly with or without a screening tool, and they get a good understanding of the patient's needs even if some are not spelled out. This is especially important for patients on controlled medications for chronic pain.

- **Readiness for change.** Clinicians assess each patient's readiness for behavioral change and knew when to intervene.

Agenda setting. Clinicians work with patients to determine priorities for care when patients present with multiple, complex needs.

Contextual factors. Clinicians consider contextual factors in the context of screening, management, and treatment of pain, chemical dependency, and substance use.

Teachable moments. Clinicians use teachable moments to reinforce or heighten motivation for change and engagement in health care behaviors or services.

Patient education. Clinicians address educational issues and support self-care activities by patients.

3.3.3.2 Professional Practices Related to Group Visits

Broad expertise. Group facilitators/leaders have the expertise to cover a variety of physical and behavioral health issues.

Knowledge of group visit availability. Group facilitators/leaders communicate with integrated care teams about the availability of group visits.

Use of evidence-based strategies. Group facilitators/leaders use evidence-based strategies, such as motivational interviewing, during group visits.

Management of group. Group facilitators/leaders manage the dynamics of the group visit and are able to balance individual and group needs.

Connecting patients to resources. Group facilitators/leaders identify patients' needs and connect patients to appropriate resources.

Updating the care team. Group facilitators/leaders communicate with the patient's care team regarding actions/outcomes of group participation. This updating can be done in a variety of ways, including communicating through the EHR.

3.3.3.3 Professional Practices of Behavioral Health Clinicians

Building rapport. After introducing himself or herself, the BHC builds rapport and connection to the patient and the primary care team.

Connecting patients to resources. The BHC negotiates treatment for patients among different providers and resources within the health system and the community. The BHC has professional connections to people in the community, including substance use counselors, traditional therapists, and psychiatrists.

Helping patients get access to specialty care. The BHC supports patients who are waiting for access to specialty mental health services (outside the primary care clinic/service area). The BHC does this in a way that reinforces the patient's understanding that specialty mental health care is the appropriate path, while noting that the BHC is providing interim support.

Ongoing communication with patients. The BHC maintains communication with patients regarding the potential use of behavioral health services (e.g., by phone or by dropping by during primary care appointments), including communication with patients who may not be ready yet to engage in BHC treatment.

Clarification of role. Through action and communication, the BHC differentiates between the work done by the BHC and the primary care physician or other team members, while reinforcing how members of the care team work together to integrate the patient's care.

Adjustment of care. The BHC adjusts treatment quickly in response to new or acute issues (e.g., suicidal ideation, sudden loss or grief, extreme situational distress), develops a safety plan if needed, and connects patients with additional resources when needed.

Agenda setting. During time-limited patient visits, the BHC rapidly develops treatment plans that help patients identify problems and set goals, and concisely brings the relevant information into the picture.

- **Communicating the agenda.** The BHC negotiates and communicates a visit agenda that meets the patient's needs for behavioral health care in the context of the patient's overall care.
- **Concluding visits.** The BHC communicates the closing of brief counseling visits by offering a summary of the visit and next steps (e.g., reviewing and reinforcing the patient's care plan).

Reframing life events. The BHC teaches patients the skills to reframe how they think about key life events (e.g., ability to turn negative thoughts into positive achievements).

3 Findings

3.2 Organization-Level Professional Practices That Support Integrated Care

At the exemplary sites, we observed seamless and flexible teamwork among people from different disciplines to address patients' health care needs. This included teamwork among primary care clinicians, psychiatrists, BHCs, and social workers, as well as clinical and non-clinical support staff.

We learned that organization leaders played a critical role in creating a system and environment that supported seamless and flexible teamwork. In this section, we identify the organization-level professional practices and behaviors that we observed and that key informants identified as central to creating a strong integrated care system. Importantly, the way we structure our findings is directly informed by Edmondson's work on teams, teamwork, and teaming.[9-11] As Edmondson's work shows, at the foundation of effective teams are leadership and organizational structures that create an environment that has the right balance between structure and flexibility. This balance allows teamwork and collaboration to flourish. We observed this to be the case among the exemplary sites.

3.2.1 Advocating for a Mission and Vision Focused on Integrated Care

Organization leaders play a role in formulating the mission and vision for an organization. The **mission** statement of an organization defines the present state or purpose of the organization and explains what the organization does, for whom, and how it does what it does. The **vision** of an organization defines an optimal, desired future state; it provides inspiration and guidance as to what the organization is working to achieve.

Among the exemplary primary care organizations we observed, organization members paid attention to organization mission and vision, with a clear focus on a mission to provide population care. The vision to accomplish this was optimal integrated care. As part of achieving this vision for integrated care, organization leaders as well as staff at all levels of the organization reported advocating for changes that help deliver more robust integrated care to the population they serve.

Additionally, the organizations recognized that it was necessary to continually improve how the clinic delivers integrated care. We observed how the organizations built quality improvement practices into their organizational cultures, and how this helped them function as learning organizations.

3.2.1.1 Shared Mission and Vision

ORGANIZATIONAL MISSION

Clinic members, at all levels, are able to articulate a clear organizational mission.

Interview with chief executive officer

Q Can you tell me a little bit about how you've created this organization and the culture?

A It's all about mission. I think that's the driving force here. People believe in our mission of outreach to populations that don't have other opportunities for care, and that is the driving force. I tell visitors sometimes, it's really more about that than it is about integration. I think with a mission-central organization, staff comes here, and they identify with the mission, and many people come because of that. I don't even like anybody to say they work for me … if they come here and they have a similar mission, then we're in agreement.

3 Findings

SERVICE AS MISSION

The organization's mission is to serve patients by providing population-based care in an integrated care model.

Field notes

A patient comes wandering by—this is actually the second or third time I've seen this particular patient wander by the desk. This time he stops. He asks the person at the desk, "Where is doctor [name]? I need refills on all of my medications because they're all out." The person at the desk asks him if he's checked in at the front, because that's what he really needs to do to have an appointment with the doctor. The patient says yes, he checked in at the front. They told him he needed to wait, but he can't wait because he has another appointment. He needs to see the doctor right now for the medication refills. The person at the desk calmly tells him that she's with other patients. The patient isn't having it. The person at the desk stands up at this point and says, "Here, follow me. I'll take you where you need to go." He does this gently and in a non-confrontational way, with a "helping" tone in his voice. The patient follows him, and then in the hallway on our way to the front we run into the doctor, who says, "I've been looking for you," and takes the patient into her office.

FOCUSING ON TEAM APPROACH

Leaders are clear that providing integrated care is the way to achieve the organization's mission.

Interview with quality improvement coordinator

"There are so many people with high blood pressure, diabetes, and so many other conditions that you need a team approach to medicine. I think that's what we are going to do. It's not going to be just little silos everywhere. It's going to actually be a web. I believe that's the future of medicine. I think we shouldn't be looking at things just as isolated units. I think we have to look at the body and disease as just interconnected."

CLEAR VISION

Leaders define a clear vision for integrated care as a model of care for the clinic.

Interview with behavioral health clinician

"I think there's been a pretty remarkable shift to it being much more of a team that's working together. And the provider is part of that team to help facilitate better health care, better outcomes for patients. It has really changed from this kind of top-down, 'I'm the doctor, do what I say' to 'We're a team that's working in collaboration.' I think it's easier for newer folks coming in, because we've got this really robust system and model in place now."

3 Findings

ONGOING IMPROVEMENT

The vision for integration is a clear guiding framework, and over time, practice members at all levels help to clarify and improve the integrated care model in practice.

Interview with behavioral health clinician

"I think there are always areas for improvement. I've been here 5 ½ – 6 years, and one thing I've noticed is we are always changing. I think in some ways that's probably the definition of a good integrated care clinic, because you have to change to continue to adapt to the population you're serving. We are providing population-based care, and we need to address the needs of the population."

ADAPTATION BASED ON COMMUNITY NEEDS

The organization's vision for integrated care evolves within the local environment, and the organization adapts as needed to meet the evolving needs of the community.

Interview with integrated care director

"We recognized that we had lots of patients that were cycling in and out of the hospital for medical reasons. Our providers are not attending physicians at the hospital. They don't do rounds at hospitals. So there is a lack of coordination with hospitals. So for a lot of our patients, very physically and mentally ill patients, they were being left to schedule their own hospital discharge appointment with us. So for a variety of reasons that just wasn't happening, and that wasn't good enough. So we created our hospital discharge clinic as a way to more proactively seek those patients once they've been discharged from the hospital, for us to target them. And then to create a system where they could access that hospital discharge very quickly and be seen by a multidisciplinary team of providers."

COMMITMENT TO MISSION AND VISION

Leaders show their commitment to integrated care by modeling integration-related behavior in their own professional practices.

Interview with chief executive officer

"I think it's the buy-in to the mission, frankly. I don't think there's institutional resistance to this. I think that it's a model that they own, starting with buy-in. I think buy-in is getting people to agree to something. Ownership is getting people to believe that this is part of what they should be doing and part of the process of development, so that they've developed it and want to see it implemented. I think that is, one, providing them with enough resources to do this and, two, by owning the process."

Interview with medical services administrator

"That leads me to another thought, which is really selling stakeholders in the value of this. A lot of the bean counters, if you will, are not going to see that there's value in having integrated folks at first. But we have done some things over the years where we've looked at reduction in overprescribing pain medications, antidepressants, overutilization of emergency services. And we've been able to make some comparisons that integrated care has drawn those down a little bit. So I think there are huge benefits, obviously. But it's being able to establish them to some of the bean counters. That could be hard [chuckles] with the payers at all different levels, to really help them learn that this integrated care model can be a cost-savings model."

3.2.1.2 Health System Functions as a Learning Organization

A practice is a learning organization, as defined by Edmondson, if it is able to use data to make improvements to its operations and create a culture in which people in the organization are not afraid to innovate and experiment, make mistakes, and learn from those mistakes, because this is the way that health care organizations improve.[10, 11, 14]

3.2.1.2.1 Characteristics of Learning Organizations

We observed professional practices and behaviors characteristic of learning organizations, including the following:

OPPORTUNITIES FOR INNOVATION

Leadership provides opportunities for innovation and encourages staff to share new ideas and pilot-test new programs.

Interview with senior vice president

"We have an acupuncture program because we have people who are really interested. We have homeopathy because we have people who do that, and we have behavioral health because I built it and grew it. We have the autonomy to do that. What happens is you wind up with arms of things. We have a medical person who is very interested in adolescent health. Well, next thing you know, we've got adolescent health centers, right? That's because somebody did that."

Interview with vice president of medical services

"These are concrete examples of how we make decisions. For instance, clinical staff in the back complain all the time about front desk people. 'They screw up my schedule. My life sucks because they screw up my schedule all the time. If I had them sitting right beside me, then I could control them and make things work how I wanted.' So I said, 'Okay, let's try it.' So we took a front desk person, put them back with the clinical team, and all the phone traffic for that team goes straight to the team, and they managed the schedule. It worked pretty well."

Field notes

If it is a service that is really needed, they try to get it going and figure out how to code for it later.

Interview with vice president of behavioral services

"This organization was one of the three hospitals in the State that raised their hand and said, 'We'll give it a try.' Literally, I think we had like 6 weeks. … It was like this was a budget crisis, and this needed to happen. And 6 weeks, we're going to do it."

RISK TOLERANCE

Leadership is willing to take on risks and challenges and try new things.

Interview with director of integration

"I think it's kind of what makes our model work so well is something that others have said many times. It's the ready, fire, aim approach. Seeing what works and will not work. We'll try something and reevaluate it in a week or two. If it's not working, we'll do a team huddle and change the workflow. It's always kind of a work in progress until we get it perfected. So there's not a hard and fast written rule as to how it came about."

MISTAKE TOLERANCE

Leadership encourages a culture in which people are not afraid to make a mistake.

Interview with chief of operations

"Another big part of it is, don't be afraid to make a mistake and take risks. I think at [Organization] you can get into bigger trouble by not taking a risk than by taking a risk and failing. It's a very failure-tolerant environment. [Chuckles] So people are kind of freed up to say, 'Let's try that,' Maybe it will work, maybe it won't."

EVALUATION AND REVISION

Leadership regularly evaluates and revises programs and initiatives.

Interview with behavioral health clinician

"So I asked some primary care providers, I said, 'What did you tell the patient before you sent me to talk with him?' And they were telling me things like, 'Well, I told him if he didn't stop smoking crack it was going to kill him and that you are going to come in and basically take the patient's crack away.' If a primary care provider's job was to close the sale for the BHC model, they were not doing a good job of that. So we had to go back to the drawing board because we are creating something that we did not intend. We were doing a good job of identifying people that needed intervention, but we were not doing a good job of setting that intervention up for success. So we went back, and I did a series on motivational interviewing trainings with the primary care providers, which they really enjoyed and found very useful."

OBTAINING FEEDBACK

Leadership regularly solicits employees' feedback, input, and perspective on areas of improvement.

Interview with vice president of medical services

"Mostly I'm here to support all the people that are doing the work, help them to remove barriers, and help them figure out how to do this stuff better and better and better. Because people doing the work know best how they're going to connect to people. The great ideas about how to change and do things differently come from the people doing the work, for the most part."

Interview with chief operating officer

"We start off by saying, 'What's good? What's working well?' That warms up the group, and I'm writing things down or scribbling on my computer. Then, 'Okay, what's not working so well? What's bad?' And they'll say whatever needs to be improved. Usually, that's longer than what's good. People seem to be able to articulate, 'We need this or we need that.' And then I say, 'Okay, tell me what's really ugly? What's really messed up?' A couple years ago it was the computer system. Physician shortages are what we're hearing now. Then what happens is I take all that and distribute it among our executive staff, and we go through it, comment by comment by comment. We also use it in our strategic planning, and we'll say, 'Here's what the employees are saying.' So we kind of prioritize that because, again, we need to know what's going on out in the field. We'll say, 'Out of all these comments, here are five priorities for 2013–2015, or whatever it might be.'"

ACCOUNTABILITY BASED ON PERFORMANCE GOALS

Leadership holds staff and the organization responsible for achieving identified performance goals, and has the capacity to discuss these standards. This includes creating volume targets for BHCs so there are benchmarks and data available to gauge activity and engagement.

Field notes

Someone asks if there are productivity standards for the BHCs. Ideally they want the BHCs to see 8 to 12 patients per day. Before they introduced the EHR they only got to count the patients on their schedules. Now there are better ways to track productivity (e.g., brief consults) with the EHR. One of the ways administrators can tell if there's a problem with a BHC is if they're not being utilized. The BHCs can always find work to do. If they're not being used, it may be that they're not looking for work or they're not valued by the providers.

Interview with director of integration

"From a systemic level, if there's an office that really is struggling behind on Pap smears or mammograms or hypertension or PHQ screens, that gets flagged, and we can take a look at it. Then we have a team of regional vice presidents. They'll work with the clinical leadership at that site to address, 'What is it? Is there a chink in the data entry? Is it that we're not doing the right things that we should be doing? Is it training?'"

3.2.1.2.2 *Commitment to Ongoing Quality Improvement*

We observed that the organizations create a strong foundation and commitment to ongoing quality improvement. This included the following:

INVESTMENT IN CONTINUOUS QUALITY IMPROVEMENT
The organization invests in continuous quality improvement, including management-level personnel who help identify quality issues and staff to lead quality initiatives. Quality improvement leaders engage an interdisciplinary group of clinic members in quality improvement processes.

Interview with quality improvement coordinator

"My role in the QI team is to assemble and aggregate data, and submit it to the corporate QI committee for review. I basically gather the information for it to be analyzed.

We have several layers within our QI program. Ultimately, the first layer is the board of directors. All information within our QI program is fed into the governing body, which is the board of directors. Underneath that we have a corporate QI committee, and within the committee we have representation from all disciplines of care. We have representation from pharmacy, IT, the medical services, behavioral. All division heads within each sector make up this corporate QI committee.

We did a lot with the QI committee, making sure that the resources are in the primary care organizations, and that the information that they're needing, that we're documenting that properly in the EHR, that all the information is there for them to be able to mine that data. Also they have to report it up the ladder in the QI committee. So we're on the ground helping support them to make sure that we implement the policies and procedures they need for the QI committee, and also make sure the information gets back up to them."

Interview with physician

"We really do have some pretty high-level thinkers. I've been very impressed with the staff. We have a clinical directors group who gets together from all the sites, and we have about 28 sites. We discuss clinical issues; something like post-exposure prophylaxis—if that changes, then we'll come up with a policy. We look at clinical issues, and we'll determine what else needs to be done, where we're having problems, and that's great.

There's a clinical management group, and those people also meet, and we'll go over some clinical problems. The clinical managers will determine what needs to be done. That includes the regional medical directors, as well as other people who have clinical positions, and also mental health people are always at those meetings, too. So that's very good."

ASSESSMENT OF QUALITY IMPROVEMENT EFFORTS

The organization has systems in place (e.g., team meetings) to review quality measures and assess and realign quality improvement efforts.

Interview with quality improvement coordinator

"We'll choose a weakness or a QI measure that we need to work on. We set goals, and then at our QI committee meetings we look at those goals. We look at the data and determine where we are. We celebrate successes, or we create a corrective action plan if needed, and monitor that, trend it. We do the 'plan, do, study, act model' in quality improvement where you look at it, reevaluate it, tweak it if you need to, and then go back. We're constantly monitoring. It's a fluid process."

DOCUMENTS FOR TRAINING

Quality improvement efforts lead to the development of process improvement documents, such as workflows, protocol, and procedures documents, which are used to train others (e.g., new employees) in these professional practices. (For more on this, see *Training and Development*.)

Interview with behavioral health clinician

"We had to develop the well-child checkup protocol. A nurse developed the medical/physical stuff, and I developed the behavioral/developmental stuff and did the first 750 well-child checkups with our pediatricians. We identified 14.9 percent of kids needed something developmental or behavioral, which is right in line with the Surgeon General's prediction that at any one snapshot point you should hit 15 percent. So we still have our behavioral health team doing those parts of the well-child checkup. Not all of our clinics use that model, but most of them do. Someone with a developmental background helps with all well-child checkups, and we've been doing that for about 10 years.

We've refined the protocol, and we're actually right now in the process of reconsidering whether we're using good screening tools. Every so often we review the research and see is there anything new going on. We're right now considering if we need to revise the tools again."

DATA-DRIVEN APPROACH TO QUALITY IMPROVEMENT

Organization members take an active and data-driven approach to identifying quality initiatives related to integrated care. For instance, the organization tracks data to assess the frequency and penetration of BHCs by primary care provider, and follow-through on warm handoff of referral to BHCs or specialty mental health, and all aspire to look at how these patterns of care affect outcomes.

Interview with quality improvement coordinator

"We'd tell them, 'You need to do a CQI [continuous quality improvement] project for this year. Pick something that the site has battled with, then track it and let us know how it's going.' It was a very passive approach to CQI. And a lot of the times we would realize that a lot of the sites would pick the same things over and over again, or pick things that they were doing really good at. We're in the process of changing that. Right now we are selecting global CQI topics to give them a little more direction. Because in the past, everyone would just do their own thing. There would be no sharing of information, even though Site A is doing diabetes and Site B is doing diabetes, they would never talk."

Interview with analyst

"Reporting Workbench is much more user friendly, end-user friendly. We have the ability to create templates where they literally have to click, 'Run,' and that's it. It gives them all the information that they need about a case list, when their treatment plans are due, who has an overdue PHQ-9, what referrals they might have open, how many appointments they've had for the month, are they meeting their productivity, things like that. There's a lot more control over their patients and over their administrative needs."

Field notes

Administrators can look at providers' performance on the Data Mall. This has information about diabetes, annual exams, using the BHCs and dieticians. If there's a provider who is not using the BHC [he or she can be contacted].

CONSISTENT DOCUMENTATION

The organization uses data to inform the quality improvement targets and monitor the quality improvement process for integrated care. Health IT systems, such as the EHR system, are developed and customized to support documentation of clinically relevant information, particularly for behavioral health, if good documentation templates were not part of the basic EHR package. Clinic members are trained to consistently document care using these systems. Analysts can extract the data, and the organization uses the data to monitor and continually improve the quality of integrated care. (For more on this, see *Organizing Health Information Technology to Support Integrated Care*.)

Interview with analyst

"I usually assist people with reporting for their quality improvement projects. We also can design the system. If somebody has a particular piece of information they need to record, we can build that into a recordable item and then are able to extract that information.

More specifically, the clinic was working on improving PHQ-9 assessments. Depression assessments are supposed to be done at least every 30 days for patients who are diagnosed with depression. What they wanted to do was build a decision support tool for the PHQ-9, so if it had been over 30 days since it had been done, and the patient is diagnosed with depression, then the end user would be reminded to complete the PHQ-9. So that's something that we built with them."

SHARING DATA WITH EXTERNAL ORGANIZATIONS

The organization uses health IT data to make a case for integrated care to payers and other external organizations. (For more on this, see *Advocacy*, and *Financing Integrated Care*.)

Interview with chief executive officer

"We have to absolutely be committed to making it work. Because it's gotten easier, but we have constantly bucked bureaucracies and payers. It requires just a single-mindedness to make it work. Even if the reimbursement isn't what you want it to be, you do it, and you prove it.

You give them data. We've got data from Blue Cross that showed that our patients were 24 percent less costly than other primary care providers. That's their data. Emergency utilization was way down, hospital days were way down, specialty referrals were down. The only thing that was up was primary care visits, which they thought was a positive thing. So, yeah, we believe in it. So we have to negotiate with providers to gather data to prove that it works.

It's gotten a lot easier than it used to be. Now everybody knows about it. Everybody subscribes to it. It still doesn't mean they're going to be very generous with their contracts, but we've negotiated some neat things to get payment streams that help support the model."

DATA TRANSPARENCY

Quality measurement is transparent and built into an incentive package; data to assess how a team is doing are accessible and easy to use by clinical teams.

Interview with quality improvement coordinator

"We have a portal where the employees can go in and view some of the quality measures. It's actually just tied to the incentive program now, but we want to move that into all quality measures so that there's transparency within the organization that you can view to see how you compare to someone else, or how the other sites compare to someone else.

The portal's great. At the end of the quarter we will post those results on that portal. And the staff, since it's tied to an incentive plan, really buy into that, and they'll go and look at that at the end of the quarter to see where their measures are.

And it's self-policing in that if they're below goal on something, then they want to make sure that they get up to that goal. I think it's a good tool to have, to help them reach that. If it's something that may be a goal that we hadn't reached, then we'll make sure that front-line staff have that training and know what the corrective action steps are to be able to make that goal again. So, I think it's great teamwork from top to bottom that we communicate that back down."

Field notes

Data Mall is set up to be transparent and encourage a little healthy competition among providers. It allows providers to see how well others are meeting their screeners and metrics.

3.2.1.3 Advocacy

ADVOCACY WORK

Leadership markets the model and vision for integrated care to others, creating buy-in and support for this vision outside of the organization. Leadership encourages all staff, at all levels, to participate in advocacy work.

Field notes

They all do advocacy work. The CEO had thought about hiring someone, but it seems to be really important to have someone testifying who has been in the trenches. She describes another time they had success changing policy—supervision of psychologists required on-site presence. However, they have rural psychologists located 1.5 hours away. That travel time means a lot of patients weren't seen. They went and petitioned so trainees could be supervised at a distance.

STATE AND COMMUNITY CHANGES
Leadership advocates for changes at the State and community level that support integration.

Interview with senior vice president

"One of things I fight for, State-wide, nationally, is really building the behavioral health services, particularly in the community health centers. In [State] recently, we just got an integrated license. We're actually the only organization who could apply for it. [Chuckles] And so that's brand new. And so I worked with the State on that. I worked with the office of mental health and the department of health and integrated settings."

AWARENESS OF BARRIERS
Leadership is aware of barriers to care for patients; advocacy efforts aim to eliminate those barriers.

Field notes

They point out that the bus stops right out in front of the clinic. It wasn't always this way. The bus used to drop people off across the street, but they have a number of patients who are in wheelchairs, and the office manager went to city council meetings and made the effort to get the bus route changed. These kinds of stories come up relatively frequently.

3.2.1.4 Financing Integrated Care

We observed that leadership managed finances to support the organization's mission and vision for integrated care, including the following:

3.2.1.4.1 Negotiating With External Financial Stakeholders

HEALTH PLANS AND OTHER PAYERS
The organization develops strong relationships with health plans and other payers and shows a persistent willingness to push back (as needed) and negotiate contracts that meet the needs of the organization and make integration possible.

Interview with clinic administrator

"[Organization] has relationships with payers. We're in what we call shared savings arrangements. So if we can save money, we split that with the payers. It's more technical than that, but basically, that's the bottom line. It's in everybody's best interests, but you don't do that without making sure that the quality is really good, the experience is really good."

Interview with chief financial officer

"We never schmooze them. [Both chuckle] I think it's a respect. We recognize they've got the money, so we have to be fairly nice, but we don't have to take everything they say, because we're all kind of trying to work together to meet the needs of the patients. We know more what the patients need than they do, and they just take the money and pay people. We actually see them face to face. A long time ago we set in our strategic plan that we wanted to be big enough to be noticed, or to be able to negotiate."

Interview with chief financial officer

"With the Blue Cross/Blue Shield side, and then a couple of other payers, we've been able to work out a care coordination fee. It's similar to a case rate, but it's an add-on to fee for service. So we bill as fee for service, the CPT codes, just whatever we do. But then if we're seeing them on the behavioral side of the house, then we get this additional care coordination fee to help offset some of the costs for that infrastructure."

STATE AND LOCAL GOVERNANCE

The organization develops strong relationships with the State and local governance and can leverage these relationships to create a better funding and financial environment for integration.

Interview with director of integration

"It's a fairly large brick building. We're really blessed because it normally would have been a very expensive building. But the State issued some tax-deferred bonds, and so we were able to buy them very reasonably, and so it all came together."

Field notes

Part of the way this program developed was that their CEO was on the government-appointed team. [Organization] is used to responding to things like this. They recently shut the inpatient hospital, and [Organization] was asked to set up a crisis stabilization unit. [Organization] did this in 6 months. They were able to expand a building that now has primary care and recovery groups in addition to other services. They were able to fund the new facility with half State monies and half their monies. It's similar to how they fund the school based programs, half and half.

USING DATA

The organization collects and uses data to show how the quality of the integrated care that it provides exceeds the quality of the care that competitors provide, thereby saving money for the payer. This results in negotiated contracts that pay for integrated services.

Interview with chief executive officer

"We have to absolutely be committed to making it work. Because it's gotten easier, but we have constantly bucked bureaucracies and payers. It requires just a single-mindedness to make it work. Even if the reimbursement isn't what you want it to be, you do it, and you prove it.

You give them data. We've got data from Blue Cross that showed that our patients were 24 percent less costly than other primary care providers. That's their data. Emergency utilization was way down, hospital days were way down, specialty referrals were down. The only thing that was up was primary care visits, which they thought was a positive thing. So, yeah, we believe in it. So we have to negotiate with providers to gather data to prove that it works."

3.2.1.4.2 *Managing Internal Finances*

OFFSETTING OF COSTS

When integrated care provided by practices represents a cost center within a larger organization, those costs are offset by others parts of the system that are profit centers, or through savings that integration creates in other parts of the system.

Interview with chief executive officer

"What happens in individual pieces of the program don't really matter that much. So you can do things that lose money. You can do things that make money."

Interview with medical director

"The business model, right now really is that we … don't make money. It's very few of our 44 primary care clinics that are in the black if you look up their net operating margin. There's many reasons behind that. Some of it is accounting. Some of it is services that you would bill for differently if we were free-standing clinics, versus part of an integrated system. Part of it is we have clinics like this one that take a predominance of Medicaid. With that kind of a discount factor, there's just no way we could ever make it as a freestanding practice."

Interview with chief financial officer

"That's another issue with this integrated model. We may have fewer visits because of this model, but they're long visits, and they're very detailed visits. It's good for the patient, it's good for the system, but it's not great for reimbursement. So we could be slightly penalized because of that, but we try to make up for it in our other types of contract."

CAPITATED PAYMENTS

Capitated payments give the integrated organization more flexibility to manage its finances and support integrated care.

Interview with chief financial officer

"We've been able to structure contracts in more flexible ways. So if we can get a capitation arrangement where you pay us X dollars for this care on the primary care or the behavioral health side, we can use those dollars to support this integrated side. If we can get capitation to incorporate both, that's ideal, because there's recognition that you're providing this care regardless of where it's coming from. If it's coming from mental health or if it's coming from medical, it's all in the same pool."

MANAGING EXISTING PAYMENT STRUCTURE

Fee-for-service billing for behavioral health using CPT codes are carefully managed to keep BHCs' schedules open so that they are available for consults. (For more on this, see *Expertise and Staffing for Integrated Care Teams*.)

Interview with director of integration

"It's always a bit of a struggle because this is a billable provider. But this is not a transplanted outpatient mental health provider. They can't be behind a closed door all day. So, we've now converted those into RVUs [relative value units], and are looking at that as the BHC needs to see about six to seven patients a day, from a RVU point of view."

FINDING MONEY-SAVING OPPORTUNITIES

The organization looks for money-saving opportunities, such as handling as much care as possible outside of the exam room (particularly in capitated, integrated care systems), and putting an emphasis on appointments with providers who deal with the most complicated cases.

Interview with vice president of medical services

"If you figure out how to reduce your total cost, you actually make more money, even if you lose a whole lot of revenue in the process. That's heresy. So every time we don't have a visit to this building, we need less parking spaces, less parking garage. We need a smaller lobby. We need less waiting rooms. We need less medical assistants to take them back and weigh them and process them and everything. A lot of doctors say, 'I'm not going to do telemedicine and phone medicine until I get paid for it.' Well, that's just stupid because if you save ten simple visits a day by doing them on the phone, then you have room in your schedule for ten more, or at least seven or eight more complicated visits for which you get paid more. Your schedule all day long should be nothing but complicated visits. Anything simple should be done by a home worker or the phone or e-mail or mail out or something like that. You should have only complicated visits, with very few exceptions, in person. Even if you can avoid a lot of complicated visits by phone or e-mail or whatever, you're still money ahead because cost isn't just provider cost, which is all providers think about. The majority of the cost of the visit is the parking lot and the waiting area and the lobby and the lights and the heat and all the things it takes to sustain a big, physical operation."

DEVELOPING SUPPLEMENTAL INCOME

The organization develops supplemental sources of income, such as developing integrated care training programs and marketing these services to outside organizations.

Interview with physician

"We take a lot of psychosocial, social work students, and we try to embed them into the clinics. That's another way we try to offer the same services equally across all of our centers."

Field notes

They tell us about the training academy that we see on the way in. They hold sessions four times a year for executives who want to learn their model. It's for CHCs and FQHCs.

USING SUPPLEMENTAL FUNDING SOURCES

The organization supplements its finances with grants; its long-term projects or initiatives often begin as small grants and pilot programs.

Interview with vice president of medical services

"We also chase grants and contracts and research and philanthropy, and all that kind of stuff. Something like 11, 12 percent of our budget comes from those places. And that's often just enough margin to allow you to do nicer things."

Interview with vice president of quality improvement

"Actually, improving depression screening, improving management started off as a small grant. That was actually right in the beginning of our EHR implementation."

TAKING CALCULATED RISKS

The organization takes risks on new projects that are considered important and necessary, and works out the financing later. (For more on this, see *Characteristics of Learning Organizations*.)

Interview with chief operating officer

"Another expression that we have around here is, 'Do the right thing, and the money will follow.' They were doing the right thing, and then we got a grant later. I think it was a $100,000 grant from the State because they saw the problem, too, and they would love to do this and replicate it in other places."

Interview with senior vice president

"Our model is, figure out what you want to do. So we say, 'This is how we want to deliver care to people.' And you do that, right? And then the dollars come, because you're doing it first. You're figuring out some of these things, and so that's really how we do it. We often lose money on new projects, because we feel like we have to try to figure it out. Then it's much easier to write a grant for something that you're already doing."

DEDICATING RESOURCES TO ENROLL PATIENTS IN INSURANCE PROGRAMS

The organization assigns staff to help patients enroll in insurance programs, thereby making it possible to bill for integrated services and minimize the cost of providing care to uninsured patients.

Field notes

She's checking for patients that might qualify for Medicaid or if they have coverage that's ending. If it's ending, she's making sure they've done the recertification. She says she's already talked to a few patients this morning. A woman she just talked with wasn't eligible. She shows me on her sheet how she tracks this in shorthand—she's asking questions about monthly salary, if there are any kids, etc. Medicaid patients have to apply/renew every 6 months and SCHIP is every year. She's making sure people are covered so they can bill.

PROVIDING CARE REGARDLESS OF PATIENT'S ABILITY TO PAY

The organization does not share financing details about individual patients with service providers in order to prevent payment consideration from dictating how care is delivered.

Interview with chief executive officer

"It's dangerous when people start seeing patients with what they get paid for and what they don't get paid for in mind. So everybody's salaried. There are no incentives. You just come here because you want to do what the work is that we do, and you do it. I'm not saying we don't have productivity standards. We don't have doctors who are seeing four people a day. But for the most part, people take the time they need to do what they need to do, and we usually break even."

3.2.2 Building a Sustainable Staffing Structure for Integrated Care

Scoping behaviors are those leadership practices that focus on identifying the types of expertise needed to achieve integrated care. Among the exemplary organizations that we observed, leaders at all levels determined the level of expertise and depth of staffing needed to deliver integrated care, and emphasized the value of hiring, training, and developing staff to deliver integrated care that is aligned with the organization's purpose, mission, values, and integration model.

Population-based care was the goal among these organizations. This means making behavioral health services available to the full population of patients the practice serves, not just a subset of patients who may meet specific diagnostic criteria.

3.2.2.1 Expertise and Staffing for Integrated Care Teams

EXPERTISE NEEDED FOR INTEGRATED CARE DELIVERY

The organization is able to determine the types of expertise needed to deliver integrated care. Typically this means relying on primary care clinicians (physicians, nurse practitioners, and physician assistants) and behavioral health clinicians (psychologists [Ph.D. or Psy.D.], licensed clinical social workers, licensed clinical professional counselors, psychiatric nurse practitioners, and psychiatrists) as well as nurses, pharmacists, and ancillary support staff (case managers, care managers) to support complex patients and to facilitate access to more traditional mental health services.

Interview with pharmacist

"I'm a medication therapy management pharmacist. My role here is to meet with patients directly, either in conjunction with their providers or separately, and go through their medications and make sure they're taking them for a reason, that they're working for them to get to their goals, they're safe, and they're able to take them as prescribed. So trying to find opportunities to improve their medication regimen. ... And then throughout the day I might get questions about different medications or different things come up. The triage nurses will kind of bounce stuff off me as well."

ADDRESSING GAPS

The organization is able to identify when there is a gap in expertise on the integrated care team, and takes steps to fill that gap.

3 Findings

DEFINING REQUIRED EXPERTISE

Primary care organizations were clear regarding the professional expertise needed to fill a particular role or function; sometimes this was learned through trial and error.

Interview with psychiatrist

"To me it's critical for telemedicine that you've got to have a good person on the other end. They've got to be good with people. They've got to be comfortable with psychiatric diagnosis. They have to understand the medications you're using so they can be looking over your shoulder, in a way, so that they can talk to the patient about how to take the medicine, all those kinds of things. When the patient brings in a plastic bag filled with pill bottles, they know what they're dealing with. Then they can go through them and not make mistakes in pronouncing the names. So, we have tried case managers. We've tried LPNs. We've tried practically people off the street. We've tried to train a whole host of folks. But we really have found that the RN level really is that expertise that we need for the most part."

STAFFING TO FULFILL MISSION AND VISION

The organization's staff is able to fulfill its mission and vision of providing all patients with access to integrated care.

Interview with chief operating officer

"When we were small, I was pretty much able to handle things on my own. But then we grew and grew and grew. At some point, I'd say probably 13, 14 years ago, we decided to put another layer in there of regional vice presidents. And that has helped a lot. As we've grown it's allowed someone to focus on a particular region, because we have four regions. A big part of my job is to work with those regional vice presidents to focus on those offices that they have. Those folks are just tremendous to work with in making sure that operations are running smoothly, that our staffing is in place, that we've got policies and procedures in place, and that they're applied—training, recruiting, that sort of thing."

STRONG TEAMS

The organization is able to create strong clinical teams with sufficient experience and knowledge. The working behaviors of teams should not be idiosyncratic, but should abide by protocols and work processes such that people in the same roles (e.g., medical assistants) but on different teams are interchangeable when a need arises (e.g., vacation).

Interview with pediatrician

"If the BHC's in a consult, I'll pull somebody else. If she's backed up, she has a couple of kids she needs to see, I'll pull somebody else. I don't like to have families have to sit and wait, personally, because I don't like to sit and wait. So I feel badly for them. So I'm probably more apt than other folks to say, 'Hey, [my BHC] is tied up. Can you?' If it's not something that I think [my BHC] is going to have to meet with for an ongoing basis, that it's more of a, 'Hey, I've got a 6-monther here with an ASQ [Ages and Stages Questionnaire]. Can you go in?' I happily pull in somebody else very quickly. And they're happy to do it, too."

COLLECTING INFORMATION TO ENHANCE PATIENT EXPERIENCE
The organization has the ability to gather and use information about patient cycle times, workflow, and staff feedback to make adjustments in staffing to enhance the patient experience of care.

3.2.2.2 BHC Staffing and Access Issues

ACCESSIBILITY TO CLINICIANS AND PATIENTS
The organization has enough BHCs so there is real-time availability to primary care clinicians and patients. (A common mistake is to get BHCs fully scheduled so they are unavailable for collaboration and warm handoffs in a more specialty behavioral health role.) The organization also must address any concern that BHCs will not be adequately utilized.

Interview with director of integration

"We want the BHC to have at least half of their time as unscheduled time, because they need to be available for those critical activities of day-to-day consultation, the curbside consultation. They're pulled in frequently to joint meetings with the primary care providers; they get warm handoffs throughout the day and do schedule scrubs. All these things come up to fill their schedule. It's critically important that they're available for that. So having three BHCs in this clinic is really a high intensity of BHCs to primary care providers."

Interview with clinical administrator

"I have three new behavioral providers. They're all full-time. My concern is making sure that the medical providers really get the role of the BHC, and really embrace it and adopt it so that they utilize it to their advantage and the patient's advantage, and also keep them busy.

I have practical issues I have to deal with. When I'm paying for staff, it's to make sure that they not only are doing what's right, but they're also staying busy at the same time."

ADEQUATE ACCESS TO BHCS
Full-time BHC staff presence is often required in order to make routine access to BHCs easy, foster necessary relationships, and make services available.

Interview with vice president of medical services

"We require our providers to work full time, or close to full time if they're going to be on a team. Because you can't work one day a week and provide that kind of access and relationship over time."

Interview with physician

"Maybe the psychiatrist was there ... twice a week. What do you do in the rest of the hours when you need somebody? That can be kind of tough. Especially for a medical provider who may not be as familiar with some of these medications, the psychotropic medications that you're prescribing, or even how to deal with somebody who is schizophrenic or somebody who is having a lot of emotional problems.

But here there's always somebody you can go to. So this is a real model program as far as I'm concerned. And it's great for the medical staff, because they have the mental health staff right there, and they're always there to help you and help the patient. So that's great. There are no gaps. And we have a thing now if a patient needs to be seen on that same day, they'll be seen on that same day."

CONNECTION WITH PRIMARY CARE TEAM

The organization creates an environment where the BHC is connected to a primary care team, but where covering for another BHC is the norm.

Interview with behavioral health clinician

"Because we have roughly 10 FTE providers at this clinic, we have multiple BHCs. So a lot of what we'll do when we're getting behind, you know we've got someone in your office, two in the lobby, and I've got two providers asking me to see patients. First thing I'm going to do is call one of the other BHCs. And sometimes we'll just say, 'I've got this one, whoever gets done first touch base with this provider.' And that way it's really a coordinated effort."

Field notes

I ask, "What happens if you're in with another patient when a provider needs a consult?" The BHC says, "They wear a pager and the doctors or CMAs just page another BHC."

STAFF RECRUITMENT

The organization is committed to staff recruitment and a rigorous hiring process. (For more on this, see *Training and Development*, and *Hiring*.)

Interview with chief executive officer

"Selection is really the key. We take the hiring process pretty seriously. We talk about mission. … We look at resumes, and we look for values. … As you probably heard, we do a lot of training. A lot of our hires come out of that. So we know people pretty well, and they know us pretty well. We do talk about mission a lot in our employee orientation. So we talk about hiring missionaries rather than mercenaries. Every time we hire a mercenary, we seem to regret it. So we're looking for people who have those kinds of core values."

Interview with behavioral health clinician

"The behavioral health providers, the nurses, the pharmacists, primary care providers are all selected by the whole team. The whole team has to agree before the offer is put out. So I think that we've got a good team, a team that is really passionate about their work, really willing to work in a patient-centered way."

3.2.2.3 Psychiatrist Staffing and Access Issues

ACCESS TO PSYCHIATRISTS

Psychiatrists are available for consults and brief encounters, and adequate staffing and open scheduling of psychiatrists support patient access to these services.

Interview with psychiatrist

"My job can be, one, to provide consultation. 'Here's what I think is really going on. Here's what I would recommend you try.' And the PCP tries that for so many weeks, re-evaluates, things like that. So it's a consultation combined with a lot of education.

The second thing I can do is I can say, 'Well, this case is a little further down the road. Let me take them on, and let's see if I can stabilize them over a series of visits. And if I can, then I'm going to turn them back to primary care, and you follow the medicines. If they ever decompensate, you put them back on my schedule.'

But the big thing I'm trying to do is to never just build up a caseload like a traditional psychiatrist, because then I'll be 3 and 4 months out just to get a new appointment. The last thing I can do is to say, this is a really sick person. They need hard core traditional mental health care. I've got them started. We've got them ready. Let's get some appointments. Let's make sure they keep their appointments in traditional mental health and again open up my schedule."

KNOWLEDGE SHARING

Psychiatrists focus on medication management and care of the most complex patients, and play a role in educating, training, and supporting primary care clinicians to manage the more moderate and routine needs of patients.

Field notes

The patient is a middle-aged man who is profoundly obese, >450 pounds, and has a history of abscesses for which he's been frequently hospitalized, as well as depression for which he's prescribed Prozac, an SSRI. He also has some chronic pain issues. The PCP is the prescriber of the Prozac. Today, the patient told him that he was feeling more depressed, and the PCP called the director of psychiatric services for a curbside consult to talk about the dosing of Prozac in a patient of this size. The psychiatrist recommended increasing the dose, because for larger patients a larger dose is often needed. The PCP will continue to be the prescriber, and he's glad he had that kind of access to the psychiatrist because he would have been nervous to increase the dose otherwise.

3.2.2.4 Hiring

We also observed that primary care organizations were selective about the personnel that they hired, and looked for people who would fit with the culture of the organization and with the pace and purpose of the integrated clinic. For some organizations, building a postdoctoral training program consolidated and strengthened training efforts and provided a pipeline for hiring professionals skilled at working in an integrated clinic.

CLEAR DESCRIPTION OF CULTURE AND VISION

During the hiring process, organization members provide an explicit description of the clinic culture and vision for integration. As their integrated programs evolve, clinic members get better at clearly articulating expectations for integrated care to potential hires.

Interview with pediatrician

"A provider who wants to dictate how things work and how things go, be in charge of making changes, and have a nice, plush office wouldn't work here. It's got to be somebody who's really wanting to be part of a team, to be part of change, to be okay with all these changing things, to really have a family involved in the roles. The old school, 'I'm the doctor and it goes this way,' that doesn't work. So it's different than a traditional private medical practice."

PARTICIPATION IN HIRING PROCESS

Multiple clinic members at different levels and from different roles in the organization are involved in hiring new staff, helping applicants get a full and realistic view of the organization, and helping the organization get multiple perspectives on the applicant's potential.

Interview with clinic administrator

"I think right now the challenge will be to make sure that the new providers embrace it. When we do our interviews … we have BHCs there. We have the RNs there. We have a PharmD there. We have different members of the team, because when we hire, we hire for fits."

Field notes

They also try to integrate case managers and BHCs into the interview process for new providers. People are exposed to integration early on.

Interview with chief operating officer

"We usually do a telephone interview first, especially if they're long distance, just to see if we're in the same ballpark financially, if we're in the same ballpark job-wise, and so on. And if we think, 'Yeah, this is a good feel,' then we'll bring them in. They'll usually interview with a number of people here, and then we'll just discuss the person and see what we think. We put a lot of emphasis on what we think their skill set is, of course, but also chemistry. If somebody seems to fit well chemistry-wise, that's really an important piece of this as well."

TRAINING PROGRAMS

The organization develops training programs (e.g., offering postdoctoral fellowships, or serving as a clinical training site for academic programs that train clinicians), because these provide the opportunity to shape and assess trainees' skills and provide a stream of highly qualified future applicants.

Interview with director of mental health services

"More and more we're seeing students coming out of graduate training with competencies in this area. But when we started out here we kind of trained our own."

Interview with behavioral health clinician

"I came here to [Organization] about six years ago through the APA-accredited internship program. I was here as an intern. I had primarily training and experience in more the traditional psychology realm. I really came here because I liked the model to the underserved population, and also the integrated care. Very early on in the internship, as I became more skilled in integrated care, I knew I was never going to accept a traditional psychology job. The fit was really just there. I loved the pace. I loved the expanded scope of practice that you have in a primary care clinic. Maybe halfway through my internship they offered the opportunity for me to stay on, so I've been here ever since."

Interview with chief executive officer

"As you probably heard we do a lot of training, and a lot of our hires come out of that. So we know people pretty well, and they know us pretty well."

3.2.2.5 Training and Development

Among the organizations, staff training was a critical task, and many resources were dedicated to ensuring that employees were prepared to deliver integrated care in a way that was aligned with the organization's model and vision. We observed a distinction between orientation and training, and practices related to both. Orientation includes the formal educational sessions that a new staff member attends to learn about the history, vision, mission, and culture of the organization, and to receive information about a range of procedural tasks. Training involves learning what is needed to do one's job in the most effective and efficient manner. For clinicians, training typically did not involve teaching about clinical material, but rather about clinical processes. For the experienced clinician, training focused on the practical aspects of how integrated care was rendered (e.g., roles and responsibilities, clinical protocols and workflow, and how to use the EHR). Training was an ongoing activity, with virtual and face-to-face opportunities to learn new techniques and clinical content, and to keep staff apprised of and engaged in organizational changes.

3.2.2.5.1 *Orientation-Related Practices*

TRAINING ABOUT CULTURE

Resources were allocated to orienting new hires to the organization's culture. This included developing written materials on the history, culture, mission, and vision of the organization, as well as providing face time with organization leaders who could communicate organizational values to new hires.

Interview with medical services administrator

"[Organization] is a fascinating place to work. We are a culture. ... We have this whole three-day training that every employee has to go through that's called Core Concepts, where it really drives home those relational principles, those relationship operating principles and relationship styles. So that I think has huge, huge value."

Interview with chief of operations

"We have an orientation where, when somebody first comes in on the first day of the job, they have a mini-orientation over at HR. And that's mostly to get people signed up for benefits, because if you wait too long you lose that opportunity to get people signed up for benefits.... And then I talk to people about [Organization] , welcome them to the company. It's usually about an hour and a half spiel, going through everything from our personnel policies to integrated care, to mission, board, organizational structure, those kinds of things. So people get a sort of flavor for it. And I don't know if that's really training or not. It's more orientation."

SHARING OF STORIES

Organization leaders and others informally share stories during meetings and at other times to solidify and communicate the practice mission and culture to new hires.

Interview with clinic administrator

"We have our provider meeting in the morning and the staff meeting. One of the things that we do when we bring on new providers, especially this many, is have the existing team explain to the new providers what does it mean to be an integrated primary care clinic. What does that mean? How is this clinic different from others?

So it's fun to hear especially different line staff, the MAs, and the front desk staff. There's just a different.... The only way I can really explain it is sort of just this love for these patients. Is that they know them. The front desk staff know them by name. They have relationships with them. This often becomes a second family where people really feel like maybe they've been pushed around or let down by other clinics in the system who aren't really set up to deal with it."

POLICIES AND PROCEDURES

Written materials are prepared to communicate key policies and procedures, and shared and reviewed with new hires during orientation.

Interview with behavioral health clinician

"For the BHCs, we've put together a manual. We have an orientation guide for them. Here's what you're going to be doing in terms of we are going to shadow, what you're going to learn as you're shadowing, what we want to make sure the core competencies are that you get in terms of visit types, and how to do documentation and billing. … We go over different interventions with them. They'll get twelve hours of MI [motivational interviewing] training. They'll shadow inpatient services and day treatment, so that they get to see the continuum of different services.… And we're going to have weekly check-in with the BHC for a set amount of time. So periodically, just see, how's it going? What kind of challenges are you facing?"

3.2.2.5.2 *Training New Hires*

New hires are taught about their roles and responsibilities, as well as the roles and responsibilities of others in the clinic. Although reviewing written protocols could do this, the organization often accomplishes this through an extensive shadowing process, whereby new hires observe more experienced professionals in the practice. Shadowing may involve the same position as well as other positions that interface closely with the new staff member's role.

INTERPROFESSIONAL SHADOWING

Written materials are prepared to communicate key policies and procedures, and shared and reviewed with new hires during orientation.

Field notes

The BHC arrives and introduces me to everyone, and we chat a little before her meeting. She's been here for 8 years, and she's been a BHC mentor for the last 2 years. She says they developed their structured month-long training process about 3-4 years ago when they realized that rigorous training was necessary to get BHCs ready for the job.

Interview with director of operations

"How do we train them? Well, they go through a week's worth of orientation at the beginning. And then depending on the discipline, so for instance all of our admin support go through a month-long training before they're handed off to one of the departments, and that's cut our turnover in admin support drastically.

And we bring in providers or case managers. They're hooked up with a mentor in the clinic. And it depends on the person's abilities. Typically, what we try to do is say to the RNs that we have them shadow for 2 to 3 weeks. The first week, they watch the person. The second week, they kind of do it in tandem. The third week the person watches them. Then we give them a mentor that will be there long-term for them."

3 Findings

EHR TRAINING

A critical aspect of training is learning how to use the EHR system. This is accomplished both in computer classrooms (formal training) and during the shadowing process.

Field notes

[Name 1]: People don't get good Epic training and then get into bad habits. We need to give consistent, good training right after hiring.

[Name 2]: It would be helpful to have double training – basic Epic training and psychosocial Epic training.

[Name 3]: Yes, and with the diversity of our providers, it seems like the centralized training is not enough. I think it could easily be 50 percent of a person's job to do training for the psychosocial team.

[Name 4] says she spends a lot of time correcting people's errors, so it would save time to be proactive. She thinks that every week for a while after hire, new providers and staff should receive some direct Epic supervision.

SUPERVISION

New hires are closely supervised. Supervisors ensure that trainees have sufficient opportunities to shadow other people, answer questions, and monitor progress, to know when the person is ready for the next step in training.

Interview with behavioral health clinician

"I think this is a year-long process of talking to [the interns I supervise] about [working in an integrated setting]. They have formal didactics. They have 3 hours of didactic a week, which is loaded very heavy by all of our internship faculty as well as other professionals within our integrated system in teaching them didactically about integrated care. Our medical providers, our psychiatrist, do didactics for them. So they're learning about that. They do lots of reading. But then it is in supervision, going case by case, talking about integration on a macro as well as a micro level.

We also believe heavily in the value of on-the-fly supervision. … We are always available to them, especially initially when they're new to us. There are times early on that we're consulting on the fly after every patient that they're seeing. And sometimes a couple of times before they let the patient go, because we need to know, what do I need to tell this primary care provider? What should my plan be? What do I need to do with this patient? So we're kind of modeling for them, we're teaching them didactically. We're teaching them in supervision, we're consulting with them during the day. They're observing us, oftentimes for the first couple of weeks when they're here to see what we're doing with patients."

Interview with registered nurse

"When new people start, we all shadow each other, to get an idea of what does [Name] do? What does [Name] do? What does the front desk do? And everyone, even MAs or providers, everyone who starts, they spend time at the front desk. They spend time shadowing the MAs, shadowing me, shadowing the BHCs. So, I think we do a good job of that here."

Field notes

New BHCs shadow the case manager, MA, and provider so they understand the different workflows. Then they are shadowed by a supervising BHC to provide feedback and make sure they're operating under their model. BHCs also meet with all new staff to describe and explain their role to new staff and providers.

ASSISTANCE DURING PATIENT VISITS

Following shadowing, when clinical staff start seeing patients, they often do so with the assistance of another experienced clinician.

STRATEGIC SCHEDULING FOR NEW CLINICIANS

When clinical staff are ready to start seeing patients alone, they are given a light schedule for several days, allowing the new employee the extra time needed to apply new skills and asks questions as needed.

Field notes

Part of why this model works is because you need to be really flexible with scheduling. The key is to start slow. All the nurses that do this are trained by an RN. You train them, then assess their level of comfort. If they're doing well you can give them more. One thing you notice in the psychiatrists is if they're going back to a more traditional MH model – that's the easy way.

Field notes

A new provider will be assigned a panel of patients. This is usually an existing panel with an existing case manager who knows the panel. They do a lot of shadowing in their own clinic. New providers then see patients on their own and get 60-minute appointments. This gives them time to learn the EHR and work with the BHCs and the nutritionists, get used to the flow, and stay on schedule while integrating other components of care. They also troubleshoot if anyone is struggling with any of these components.

REFINING CLINICAL SKILLS

Experienced BHCs help new BHCs refine their therapeutic skills for working in an integrated clinic. (For more on this, see *Professional Practices of Behavioral Health Clinicians*.)

FAMILIARIZATION WITH CLINIC RESOURCES

Experienced practice members help new BHCs understand the range of resources available in the clinic, and help PCPs learn strategies for engaging BHCs in patient care.

3.2.2.6 Ongoing Training

At the exemplary sites, training and learning were ongoing activities for employees, and the organizations offered a range of formal opportunities for continued learning.

MENTORING

A formal, ongoing mentoring infrastructure allows peers to learn from each other and from more experienced professionals. Formal within-specialty mentoring meetings are held for BHCs, and there are learning opportunities for PCPs. For new BHCs, there is a structure for advancing to mentorship and supervisory roles.

Interview with vice president of medical services

"We've got a 2-year investment, huge investment with people who have done professional mentoring in other industries that were in health care. And we're actually getting into people's business about how they practice medicine and how they think. But mentors don't have any line authority. They're separate from the management structure, so they're your friend and your adviser and supporter, not authority in any sort of way."

Interview with director of operations

"We bring in providers or case managers, and they're hooked up with a mentor in the clinic. The first week, they watch the person. The second week, they kind of do it in tandem. The third week the person watches them, and they kind of go through there. Then we give them a mentor that will be there long-term for them."

TRANSITION AFTER INITIAL TRAINING

After initial training is complete, new hires transition to a mentoring/supervising structure.

Interview with behavioral health clinician

"I train learners at other facilities on motivational interviewing. So that's telephone-based. The group that I have right now is largely I think in [State] and [State]. So I had an hour-long call with her. The hour-long calls are set up so that ... this pile here, they send me tapes that they do with patients. And there's a scoring system. I listen to the tapes and score for fidelity to the standard for motivational interviewing. And I give feedback to them. I love it. So fun."

SUPERVISION

Supervisors are available to talk with staff, provide feedback, and take advantage of key moments for learning. Formal time is allocated for feedback, particularly for new hires.

Field notes

One of [BHC's] admin responsibilities is coordinating the orientation training. New BHCs shadow inpatient workers and workers in day treatment so that they understand the total continuum of care and the other services available to their patients. They have two new staff starting next week. [BHC] is also responsible for providing motivational interviewing training for all 40 clinics. The training is three sessions that are 4 hours long and span 3 weeks. It's spread out so that people have a chance to practice in between sessions.

TRAINING OPPORTUNITIES

Meetings are structured so ongoing training needs can be addressed through a range of modalities (written, video, interactive tutorial, face-to-face). Trainings are used to introduce new workflows, correct existing workflows, and identify when new positions may be necessary to implement optimal workflows.

Interview with clinic administrator

"We have a committee that meets every Thursday. And that's where any issues go. So if a process isn't working or we need a process for something new, that's where that goes. It's multi-disciplinary. We have BHC, the PharmD, the RN, MA, front desk. We have everybody. And that's where we hash out any issues or processes that need to be fine-tuned."

Interview with case manager

"I like supervision for us. Every Thursday we get together as a group with [Doctor], and we discuss any cases that we have that we're finding difficult, like even trying to get resources for them."

Field notes

[BHC] notes that they are working on developing a video that they can use to provide training for new staff on their model as well as to show at conferences. He talks about meeting someone who can do the voice-over through another project that's willing to help if they pay for their time and then another group that's working on developing a video. He was able to mobilize these people and get permission to develop a work group to build this video.

Field notes

I ask if all employees have email. She says yes. She pulls up the email and says they actually do a lot over email. She shows me that they have an annual employee training that was just announced via email. They do it over email now versus during staff meetings/in-services. The training has information on it about child abuse, elder abuse, what to do in the clinic if there's a fire.

ASSESSMENT OF TRAINING EFFORTS

Organization leaders continually seek feedback and evaluate the effectiveness of their training efforts.

Interview with behavioral health clinician

"From our documentation to our orientation to workflows and processes, we've really looked at a lot of different angles to look at the fidelity of the work we do. So we can do a lot of checks and balances as we do our work to say, does the MA understand what their role is in this model? Does the front desk know what … their role is in this model? Does everybody know what the basic screenings are that we give all of our patients? Does everybody know how our psychiatry model works?"

3.2.3 Structuring the Organization for Delivering Integrated Care

We observed that the organizations created a structure or scaffolding that would support the delivery of integrated care. In some cases, this meant striking a balance between structure (clear roles and responsibilities, protocols) and the flexibility that was needed for integrated care teams to function effectively. Once leadership creates a vision for integration, the next task is to create a structure that allows clinicians to function in a way that is aligned with this vision. Structure was created by outlining clear roles and responsibilities, but remaining open to the idea that these roles and responsibilities might evolve or change over time. Developing information system structures was critical to structuring consistent ways of documenting and sharing information. Finally, allocation of physical space was critical to supporting individual and collaborative work.

3.1.3.1 Defining Roles and Responsibilities for Integrated Care

We observed a team approach to integrating care for patients. Teams included professionals of differing expertise and backgrounds (e.g., social workers, BHCs, psychiatrists, care coordinators, case managers, dieticians) working together to care for patients. It was critical to have clearly defined roles and responsibilities and knowing how roles and responsibilities fit together in the patient care process, so professionals could work together as seamlessly as possible.

CLEAR ROLES AND RESPONSIBILITIES

The organization works to identify clear roles and responsibilities among clinic members. This is a high priority and, in some cases, a work in progress, particularly as new types of professionals are added to the staff.

Field notes

The BHC director tells us that the care manager role is fairly new. RNs and MSWs work in this role. They're still working to flesh out what the BHCs do and what the care managers do. The BHCs have been here for 3 years, and they've done a lot of care management-type tasks (e.g., connecting patients with resources).

STAFF FLEXIBILITY

Clear definitions of roles and responsibilities help professionals work fluidly and with flexibility. This is most noticeable when a practice is short-staffed and a person works outside his/her defined role to temporarily fill a care gap for patients.

Interview with psychiatrist

Q Can you think about an experience where a patient, in your opinion, received suboptimal integrated care?

A When we don't have enough people to refer them to, they get suboptimal integrated care because I end up having to see them back. I'm just a shrink, you know. I will occasionally do things here that I won't do other places. Like I'll write for cholesterol drugs or stuff like that. I would never do that normally. But occasionally I'll do a little bit more medicine here. But it's not a lot. If we're understaffed, it's not as good.

3 Findings

ADAPTATION TO LOCAL SETTING

Definitions of roles and responsibilities are adapted across settings within the same system to align with the characteristics of a local clinic (e.g., physical space, funding streams, staffing arrangements).

Interview with social worker

"This location is unique because at all of the other practices the social workers on the second floor are doing both. They're doing case management and mental health. So this is the only site that's separate like that.

They don't have a grant for us to put more case managers in those practices, so we have LSWs and LCSWs, and half of their job is case management. So they do case management and mental health."

MANAGERS AND SUPERVISORS INVOLVED IN CLINICAL PRACTICE

Managers and supervisors of BHC, psychiatrists, and PC clinicians are practicing clinicians and have experience in integrated care and in the role they are supervising. Because they are still in clinical practice, they can model how to manage and adapt roles and responsibilities.

Interview director of mental health services

"All of our administrative folks, heads, who are licensed as clinicians still carry caseloads. ... I think that sets a tone, a recognition of ... if you're going to administer the work you've got to know what doing the work feels like and stay active with it."

DETERMINING RIGHT LEVEL OF CARE

It is critical to define what "patient in crisis" means, and how differing types of patient behavioral health illness and severity should be handled. This determines who is responsible for patient care (e.g., an embedded BHC or a referral for more long-term therapy) and clinical workflows.

Interview with counselor

"Crying is not a crisis to me. I have a different level of what crisis is. I know that probably sounds desensitized. If somebody's in a crisis they're suicidal or homicidal or psychotic.... It's upsetting that you lose a loved one, but it's not a crisis every time. It's just upsetting. They've been dealing with it for weeks. So now we have [the BHC], and she can deal with it right then and there."

SELECTING LEVEL OF CARE

BHCs play a critical role in getting the right level of care to patients. They identify and address the behavioral health needs that can be managed in the clinic and identify those patients who need more intensive services.

Field notes

I chat with [BHC] for a bit after the patient leaves. She says that in a lot of ways they are the linkage to care. They make it happen for the patient. There were lots of phone calls that could have made navigating the system difficult, and the patient may have given up if she wasn't there. If she calls, MH intake has to see the patient in 2 weeks. It's best to solve the problem while the patient is there. After the patient leaves, she adds them to the spreadsheet, and then she'll follow up to ensure that they made it to the mental health intake. If they don't, she'll call the patient to find out what happened, and she'll help them reschedule if needed. Once they've made it to the intake appointment—she stops following them. She says they are the "gateway to the gateway for mental health services."

Field notes

[BHC] notes that it's their job to know the right level of care for the patients. They have multiple inpatient units, many have a specialty (e.g., mood disorders). They have 13 different programs for patients – including partial programs and day treatment. They also have counseling services, which they consider specialty BH. Then they have the integrated BHCs. They also have the same level of services for kids and adolescents, but at another location. In this building, on the floor above, they also have addictions services. One thing that's unique about this site is that they have one of the largest hospital and behavioral health systems in the country. They have the largest BH services in the five-county area. They've worked to build the right continuum of care for their patients

3.2.3.2 Structuring Clinical Workflow for Integration

At the organizational level, we observed that the organizations structured workflow to accommodate the degree of interdependence required among individuals. Edmondson, borrowing from the work of Thompson, identifies two types of tasks relevant to structuring the work of integrated care:

Sequential tasks. These need input from others to accomplish subsequent steps, as the tasks must be carefully scheduled and coordinated. An example of a sequential integrated care task is when front desk screening for the PHQ-9 triggers medical assistant review of the PHQ-9 and an alert of the physician when it is positive, leading to a warm handoff to the BHC during the patient's visit. We observed that all of these steps, particularly those that involve multiple clinicians or professionals seeing the patient during the visit, must be carefully coordinated.

Reciprocal tasks. These need input and materials from others in the clinic to be accomplished, and require back-and-forth communication and mutual adjustment. We observed reciprocal integrated care tasks when teams were caring for the most complex patients. An example is when multiple clinicians with different professional backgrounds needed to talk together to make a decision about the best course of treatment for a patient. In this case, what to do next for the patient (the next sequential step) requires some conversation.

At the organization level, structures help integrated teams efficiently manage sequential and reciprocal tasks. We observed important organization-level professional practices that helped support this: (1) developing protocols to support highly routinized sequential tasks, such as behavioral health screening; (2) developing meeting structures where sequential and reciprocal tasks can be proactively identified and discussed; (3) developing "rules for engagement and interruption" to facilitate discussion of unanticipated reciprocal tasks; (4) creating a shared physical work space for integrated care teams to support the coordination of sequential tasks and collaboration on reciprocal tasks; and (5) creating information infrastructure (i.e., an electronic medical record) to support integrated care tasks. Findings regarding practices in categories (4) and (5) are presented in subsequent sections of this guidebook.

3.2.3.2.1 *Development of Protocols*

The organizations developed protocols to support highly routinized sequential tasks, such as behavioral health screening.

MULTIPLE WAYS FOR PATIENTS TO ACCESS BHCS

The organization can create and consistently use multiple pathways or workflows to facilitate patient access to BHCs, including warm handoffs, consultations, and proactive referrals.

Interview with behavioral health clinician

"We don't just do mental health. We also do tobacco cessation. We do motivation for weight loss, non-adherence to medicine, medical concerns, that sort of thing. When one of those needs is identified, either the doctor will call me, or they'll come knock on my door, or the nurse will, whatever team member is available. Sometimes the patient will make it all the way to check out, and the doctor will have written on the router form that comes with them, 'needs to see the behavioral health provider.' And the clerk at checkout will always call me and make sure, 'Did you see this patient?' Just in case it didn't get to me already. So it sort of comes any number of ways. And generally, as long as I'm available and not with another patient, I go grab the patient, get a warm handoff from the provider or the nurse."

ROUTINIZED CLINICAL PROCESSES

The organization places a value on certain routinized clinical processes (e.g., screening and assessment) by setting clear goals and providing feedback on goal attainment, and assistance in achieving goals, if needed.

Interview with mental health operations director

"If there's not a clear understanding of who would benefit from briefer interventions in primary care.… Also, if everyone does not have a clear understanding of the model or a clear understanding of patient flow across mental health, you'll see places kind of trying to provide treatment that may not match the needs of the particular population. So for example, trying to do a specialty treatment within primary care may not be effective if you're trying to see someone for 16 sessions of PTSD treatment for 90-minute appointments. Again, that's going to back up your clinic. So try to make sure that everyone is communicated with, everyone has buy-in in the plan, and that there's an understanding of how the model is to work."

Interview with quality improvement coordinator

"For the Edinburgh Depression Screening ... our goal that we set was 81 percent. That 81 percent of our members would be screened. So each year I will go in and look at that and determine if we are on goal. If not, then we make a corrective action plan. Our 2011 was actually 93.7 percent."

DECISION SUPPORT TOOLS

The organization develops decision support tools to alert health care professionals when a routinized clinical task (e.g., screening) is needed, and builds systems to ensure that when this task is accomplished, it is documented in discrete fields for monitoring and learning purposes. (For more on this, see *Organizing Health Information Technology to Support Integrated Care*.)

Field notes

The LPN administers the PHQ-9. It is in the EHR with Likert scales and buttons. She turns her screen so the patient can see it. She reads the question (explaining the assessment is for the past 2 weeks). The patient answers each question, and she clicks the appropriate button.

AWARENESS OF PATIENT FLOW

The organization develops systems that help integrated teams coordinate their activities and have a level of awareness (situational awareness) of where others on the team are with regard to patient flow. (For more on this, see *Expertise and Staffing for Integrated Care Teams*.)

Interview with office manager

Q When somebody is moving through a medical appointment, how is it you know where they are?

A There's a tracking system that's on the computer system, when they leave the check-in and the nurse gets to them, the nurse has to log that the nurse has them. Then when the nurse has taken them into a room, they put in what room they're in. When the provider goes in with them, they put that they're in with the provider. When they go to check out, it's the thing to say that they're at checkout. So, that's how we know. We can pull up their chart and see exactly where they are.

Field notes

The MA gives the doctor a brief update about the patient that wants her to look at a lump on his chest in addition to his diabetes check-up. [Doctor] says to me, the nurse will notify me of important things before I even see the patient.

CREATING EFFICIENT PROTOCOLS

The organization creates protocols that avoid unnecessary repetition, and that balance clinic information needs with patients' tolerance for, for instance, completing behavioral health screening questionnaires.

Interview with quality improvement specialist

"I think just determining who's been screened and not wanting to over-screen and frustrate, I think that's a step that we're really needing to work on."

Interview with behavioral health clinician

"Sometimes I have screening instruments like PHQ-9, G-87's, PC-PTSD, so I've got all this information. So my job in going in to meet with a patient is not to rehash the stuff I already have. It's to fill in the blanks. To go in there with the clinical skill and be able to use the information I have to synthesize that with my conversation with the patient. As our primary care director trains our interns, when you come out I want three things: What's your diagnosis? What's your plan? What should I do? So really that's my goal in meeting with a patient. I need a diagnosis, I need a plan, and I need to be able to convey that to the primary care provider in a way that easily translates into action steps for them and helps us to coordinate our treatment plans together."

DATA COLLECTION FOR PANEL MANAGEMENT

In addition to creating the structures needed for collecting these data, the organization uses these data to facilitate panel management, and address access for integrated care.

Interview with vice president of quality improvement

"We were one of the very first adopters of putting in the PHQ-9 scores as a laboratory score in our electronic health record system. So we have a whole team that actually looks at that particular issue, the severe diabetics with severe depression."

3.2.3.2.2 *Development of Meeting Structures*

The organizations developed meeting structures where sequential and reciprocal tasks can be proactively identified and discussed.

PLANNING MEETINGS OR HUDDLES

Workflows accommodate planning meetings, such as huddles, so primary care and behavioral health providers can identify, ahead of the visit, scheduled patients who need both primary care and behavioral health services, and coordinate those services efficiently.

Interview with registered nurse

"They talk about who's coming in. What the visit schedule is for that day. What each particular visit may or may not need. Who may not show up.… I'm talking about the staff here. They know, more or less, who has a pretty high no-show rate. If they know that client Beta has a 77 percent no-show rate and is scheduled for 10 o'clock.… And if someone presents as a 9:45 as a walk-in, they know that 9:45 walk-in could probably go into the 10 o'clock no-show slot, so we don't turn people away."

Interview with pharmacist

"[Laughs] No typical day here. So typically, we do our huddle. The days I'm here, we actually huddle. So those are a good time to bring up any issues that have gone on. Either things we need to change with processes or whatever, and then do our schedules scrub to make sure everybody's on the same page for the patients that are coming in that day. Then I go back to my desk and make sure I've got everything in line, if I need any additional resources for the patients that I have coming in. If I haven't seen them before, I might try to talk to the provider and make sure I've got a background on what's going on with them, just because they are so complex."

ABILITY TO INTERRUPT CLINICIANS

Workflows accommodate unanticipated primary care and behavioral health needs during a patient visit. Providers are interruptible for consults and warm handoffs when there is an emergent issue.

Interview with behavioral health clinician

"The cell phone is a way of being available when I'm not in this office. Availability is a tricky thing. I think it's a way of learning the patterns of your clinic. I schedule the beginning of the day with follow-up patients. I usually schedule about 10, and I schedule them in 30-minute increments, even though I know I'm not going to spend more than 15 to 20 minutes with them. But that gives me some flexibility because then I know that every hour I can absorb at least one more patient if everybody shows up.

I also know the patterns of this clinic. It's somewhat unpredictable, but in general I know that the clinic has to get churning an hour and a half or so before I hit my peak volume times in terms of warm handoffs, or what we call "on demands." So I will also put an admin spot in my schedule at those high-volume times. That doesn't mean that I can only work a patient in during that time, that's a buffer. So when I get running 30 to 45 minutes late because I've continued to absorb patients throughout the morning, that's my catch-up time."

UNSCHEDULED TIME

Develop daily schedules, particularly for BHCs, so they have sufficient unscheduled time to collaborate on unanticipated behavioral health issues with the primary care team. (For more on this, see *BHC Staffing and Access Issues*.)

Interview with mental health operations director

"If folks come in and try to establish a specialty mental health clinic within primary care and are doing a traditional model of 60-minute appointments and things like that, then you begin to see a system breakdown. Because if you set up a specialty mental health clinic within primary care, quickly peoples' schedules get filled up, and they're no longer available for those 5-minute consultations in the hallway with the primary care physician. Then they're seen as less relevant because they're not available for those brief interventions."

PEER-TO-PEER PROBLEM SOLVING

Meeting structures accommodate peer-to-peer problem solving.

Field notes

[BHC 1] comes over and asks [BHC Mentor] for some help/advice. She accidentally shredded an ASQ on two patients before she'd entered it in the EHR. What should she do? They talk about this for a bit and decide that she should make a note in the chart that the documents were shredded before the data could be recorded. They can just do the screen the next time. [BHC Mentor] reminds [BHC 1] to remember to review and enter the screens before shredding. This is a very comfortable conversation, although it could have been very uncomfortable, an opportunity to reprimand someone in another setting.

TEAM MEETINGS

Interdisciplinary team meetings create awareness among clinicians from different backgrounds that helps them develop and understand each other's work and services.

Interview with director of integration and behavioral health clinician

Respondent 1: We attend the all-staff day that is put on by [Organization]. So all the BHCs do a meet and greet [with specialty mental health], and we do introductions at the all-staff day. So all staff get to know each other. And when you make a referral, you can say, oh, I know this person there.

Respondent 2: Staff do biweekly, 2-hour case consultation meetings here on campus. The staff here that meet for the 2-hour case consult meetings, well, when they have a patient that is also a patient of the primary care clinic, they've had [Doctor], the BHC, and the care coordinator join the case consultation meeting to discuss patients. We've had the psychiatrist join us as well. So we have a forum within our own service here that we can bring folks together and do a standing case consultation meeting for collaboration.

CARE PLANNING FOR COMPLEX PATIENTS

Interdisciplinary team meetings and conversations afford opportunities for more in-depth dialogue to develop care plans for very complex patients.

Field notes

They're done with their last patient of the morning. It was actually a lighter load than usual. The psychiatrist calls the pharmacy manager on her cell. The psychiatrist says he needs help. He had a patient this morning who was stable but struggled after a medication change. He's 44 with multiple medications. The psychiatrist consulted with the patient's PCP. The patient was doing well on Sertraline, but not good with Plavix. The patient would rather risk the medical symptoms than change the medication and start drugging/drinking again. The EHR says it's a Level 3 interaction – more study needed. It looks like the patient may need a higher dose of the Plavix based on how the Sertraline interacts with the blood serum. They make a plan to override the warning and flag the PCP to manage his Plavix more.

3.2.3.2.3 *Development of Rules for Interruption and Collaboration*

The organizations developed rules for engagement and interruption in order to create conversational space for addressing unanticipated reciprocal tasks.

INTERRUPTION

When visiting with patients, the protocol is that clinicians can be interrupted by a knock on the door, as well via other means (cell phone, walkie-talkie, pager, etc.).

Field notes

It's almost 10:00 am and the doctor comes up to the BHC and says, "Can I borrow you?" The BHC tells her that he was heading into his 10:00 am appointment. The other BHC is in with another patient. The doctor tells him that she has a patient who missed his methadone appointment this morning. They wouldn't dose him because his blood pressure was too high. He's upset. The BHC agrees and goes in to see the patient at the same time with the doctor.

Interview with behavioral health clinician

"I think the availability of a BHC is critical. We use the analogy in training a lot that, it's like a friend inviting you out for lunch. If you say no the first time, they may ask again. But if you repeatedly say no, they're going to stop asking. So that immediate availability of consultation, going into the exam room on demand, talking with a provider face to face immediately following, such that we're integrating the primary care and the behavioral health treatment plan into one in real time."

COLLABORATION

The organization develops daily schedules, particularly for BHCs, so they have sufficient unscheduled time to collaborate on unanticipated behavioral health issues with the primary care team.

3.2.4 Maximizing Physical Work Space for Integrated Care

The organizations we visited had a variety of physical layouts, and integrated care teams used work spaces in a range of ways that supported collaboration and coordination of care. Physical layout can promote or inhibit communication and relationship development among staff and clinicians, and can influence patient access and follow-through as a result of the need to travel from one place to another. Among the organizations we observed, leaders and others in the clinic were intentional about the design and use of physical space for integrated care. In some cases, the shared spaces that interdisciplinary teams used were designed de novo; in other cases, the spaces had been renovated and altered to support new patterns of collaboration in the care delivery process.

3.2.4.1 Creating Team Work Spaces for Integrated Care

The organizations created shared physical work spaces for integrated care teams to support coordination of sequential tasks and collaboration on reciprocal tasks.

SHARED WORK SPACE

Physical space is designed so clinicians share a work space on the primary care floor and in a communal workspace, if available. Clinicians literally work shoulder-to-shoulder.

Interview with chief operating officer

"On the second floor is where our integrated care offices are. It's mostly the exam rooms. We have a pod kind of arrangement where there are three exam rooms for the provider. Then there's a BHC embedded in between, and then another pod with three on the other side… That's, I think, a real key to making this work as far as just making sure the BHCs are very close."

EMBEDDED BHCS

Clinicians often did not have individual offices. BHCs are embedded in the primary care clinic, and often share work space with primary care clinicians and clinical support team members. These teams work shoulder to shoulder, creating a very high social presence among team members and facilitating conversation and coordination.

Interview with physician

"Just co-locating helps a lot, because you overhear conversations, you overhear a name and you think, 'Oh, her brother, I needed to....' So that helps a lot with visit planning and with avoiding unnecessary visits. That function, it looks chaotic, but I wouldn't give that up for anything. A nice lighted office with a window would take your productivity way down."

Field notes

In this hallway, in which there is triage happening, and into which the BHC office, two pods, and the bullpen all open up, I notice there is an intermittent stream of employees buzzing through, most of whose roles aren't immediately clear to me. They all greet each other with smiles. Everyone seems to know one another, and even though they all appear to be quite busy, I don't see anyone walk by the pods here without saying hi to anyone who happens to be in the area.

PROXIMITY

BHCs may or may not have their own office. If they have their own office, they have a strong organizational norm to be accessible and visible to primary care. If BHCs do not have their own offices, there are quiet, private spaces where they can see patients, in close proximity to medical examination rooms.

Field notes

There are a lot of folks standing around in this small area. Again, the talk amongst the providers is very collaborative. They are always asking each other stuff. Sometimes it is asking for information, sometimes it is asking someone to do something. Often it is checking where a patient is, who has seen the patient, and figuring out who needs to go in next. Sometimes it is for advice on using the EHR, advice on prescribing a medication, someone's take on the patient, particularly after the BHC has seen a patient. Their collaboration is very fluid.

FACILITATION OF COMMUNICATION

The physical space allows for communication among team members, particularly primary care providers, BHCs, and clinical support staff, at times such as before and after a handoff between clinicians.

Interview with behavioral health clinician

"We try to coordinate with primary care. I want to know where the primary care provider is in their flow. This is because I have two consumers of my services— the patients and the providers. I don't want to clog up their exam rooms. So a lot of times if they're done with the patient, we'll agree [to] put them in lab waiting, let them get their labs, the doctor will be with them within 15 minutes, so that we can put them in another location. The primary care provider can keep seeing patients, and pulling patients back from the lobby. But then I'll still find the primary care provider after I see the patient. Sometimes they may even alter the treatment plan or talk with the patient briefly again afterwards, but we're just kind of keeping the clinic churning, not slowing things down. So it's kind of a balancing act of working with providers, working with other behavioral health providers, and juggling a little bit."

FACILITATION OF COORDINATION AND COLLABORATION

The physical space allows professionals of different backgrounds to cross paths regularly, which is critical for coordination and collaboration.

SUPPORT FOR COLLABORATION AND PATIENT PRIVACY

Work spaces are designed for integrated care, with particular attention to having a space where behavioral health, primary care clinicians, and others work together, as well as a private space where clinicians can work privately with patients.

Field notes

In each clinic, the clinic managers sit in the open hallway so that they're available for clients and for consults. The clinic area is open. Each team sits together in a small open work area with desks. There are some dividers between teams that go up high enough that there is a slight sound barrier. It's minimal. You can hear and see across them, and within a team there are low dividers, if any. You can see and talk to folks easily because they're sitting right next to you, and you're looking right at them. In the team area the doctor, RN case manager, case manager support, scheduler, and MA are all sitting together. The BHC sits near the team. Since there are four teams and two BHCs, they sit really close to one team and just a few feet from the other team.

Field notes

Perpendicular to the main central hallway are three other hallways. Each provider has two exam rooms and two talking rooms. One of the talking rooms is tiled and is often used for blood draws. There isn't an examining bed in these rooms though. The second talking room is carpeted, smaller, and is most frequently used by BHCs for counseling sessions. They use a flag system here to specify for BHC, provider, and CMA.

Interview with senior vice president

"The new sites that we've done, we've built them completely different. People are embedded in their sort of like point-of-care rooms. People go where the patient is, and everybody has work stations in the middle. So there's point-of-care rooms around the perimeter, and people go to the patient. They go register the patient. They do medical, social work, whatever they need. They go to that one room. And they're generic rooms. They're like the kind of care rooms that could be used for anything, and then in the middle are work stations. All of the disciplines sit at those work stations so that they're right there. There's a lot more ability for collaboration. Whereas here.… People go upstairs and downstairs all day long. Logistically, it's not ideal."

Interview with chief executive officer

"We thought about the fact that in family medicine, we use the exam tables infrequently, like probably a couple times a day. Most of the people are interviewed in a chair. Most of the exams we do, listening to somebody's heart and lungs, checking their legs to see if they're swollen, looking in their ears and in their throat and stuff don't really require an exam table. You can do that in a chair. We actually struggled with whether or not we should create interdisciplinary treatment rooms that didn't have exam tables. Because once you put the exam table in, it's like it becomes a totally different kind of thing. So we thought, well, maybe we could do that. We even looked at some exam tables that sort of turn into chairs. … But they were like $15,000 a piece or something. It was a little out of our price range. I think the exam table makes the room a medical room, and it's sort of hard to bring somebody in a room like that and do counseling. I mean you can, but the stuff is around and … it just feels different."

WHITE NOISE

In small spaces, the organization uses white noise machines to maintain patient privacy.

Field notes

The pod has a white noise machine because there is nowhere to go and talk. A lot of discussion happens in the hall, and the machine helps with confidentiality.

3.2.4.2 Designing Examination Rooms for Integration

IDENTIFYING WHICH TEAM MEMBER IS WITH PATIENT

At some organizations, exam rooms have a colored flag system outside of the door to designate which clinician is with the patient. Other organizations use the EHR system to fulfill this function. (For more on this, see *Organizing Health Information Technology to Support Integrated Care*.)

Field notes

Patients are starting to arrive for the day, and I notice that the care manager is acting as somewhat of a traffic director—asking who is in what room, which provider has gone in to see them, and she puts out the appropriate "door flag" to signify which provider is in with the patient.

Field notes

Each PCP with his/her own panel has two exam rooms. The doors of exam rooms have a flag system: blue = BHC or dietician, yellow and green = medical provider, and red = MA.

3 Findings

WORKFLOW EFFICIENCY

Strategic design of exam rooms in a "pod" allows primary care and behavioral health clinicians to move from patient to patient in an efficient manner and continue to be in close proximity to clinical support staff.

Interview with director of integration

"What really works well with our flow in this pod system is our pods are designed to have three exam rooms within about ten steps from each other. So we've got one provider that just kind of.… To use an example, he feels like … he can go from one exam room to the other and just go in a complete circle all day long in the most efficient manner. It allows him to just step right out. He can communicate with his nurse who is at a work station out there at the side of the three exam rooms. That provides efficiency in his workflow and communication with his nurse."

PATIENT INTERACTION

Examination rooms, rooms for meeting with patients (if not meeting in examination rooms), and workspaces are designed intentionally for the use of computers such that eye contact and screen sharing can be easily managed.

Field notes

These may be the best designed examination rooms I've seen. I admit, I am certainly taken in by the new, clean, and modern look of the rooms. However, the rooms are large. There is a desk located in each examination room where the doctor or LPN can work at the computer and look at the patient while talking to him or her. There is an examination table as well as work area with a sink. I ask about who designed the rooms, and the NP tells me that designers and architects worked on the design and color of the examination rooms. Some of these folks are staff and sometimes they contract out for designers. The designers make sure that the doors are wide enough for wheelchairs, that the rooms have enough room in which to navigate, etc. They also have a women's health examination room with a bathroom in it.

TELEMEDICINE SUPPORT

Organizations that had telemedicine had spaces for these visits (and the necessary equipment) at both the delivering and receiving end of the telemedicine encounter.

3.2.4.3 Integrating Services Under a Single Roof

ACCESS TO OTHER SERVICES

To the extent that space allows, clinic leaders rent space to other community and public health organizations (e.g., specialty mental health services, WIC, pharmacy, public health department) to create a single place where patients can access the services they need.

Interview with case managers

Respondent 1: I think it's beneficial that they have access to all these things in one area. Because sometimes they don't have transportation or gas to go back and forth to these different places. So the fact that we have an area down there where they can go has proved to be very beneficial for most of our patients.

Respondent 2: Yeah, I like having pharmacy on hand downstairs too. It's the same thing. We have a lot of patients who can't pay for their prescriptions. So trying to send them other places just isn't feasible for some of them, so we send them downstairs and say, 'Hey you can take advantage of this program to help you with the medication.'

Interview senior vice president

"We also have a 340B pharmacy on the first floor. And that's a real important piece of this puzzle, because before, patients really couldn't afford their medicines. So it was really important for us to be able to provide affordable meds. I don't know how much you know about 340B programs, but it's a program where if you're a federally qualified health center you can buy meds at a significantly discounted price, and then turn those savings over to patients."

Field notes

We see a space that is for the health department. They have a contract with the county's public health department. This is where people who receive social services can come and get those. The organization felt that providing this space to public health was of value to their patients who could come here and work with a public health representative to get their social services and also come here to receive their health care.

COMMUNITY SPACES

Organizations often design spaces for group meetings and community meetings into their structures. These rooms provide space for larger team meetings, group therapy, and educational sessions (e.g., cooking classes) and community meetings.

Field notes

When they built this building they wanted to make it a place that the community could use too. They created these community rooms and a really nice kitchen (to be used by community groups and also for health education). All local non-profit groups can contact the CEO's executive assistant and can schedule use of the room.

Interview with chief of operations

"And on the first floor, [there's] a very large community room, training room. There's a kitchen. We get focus groups in the community. And it's kind of a poor neighborhood. So we did those focus group meetings. We asked people what they wanted, because we didn't view this just to be a [Organization] building. We thought of it as a community resource. One of the things that they said that they really wanted was a community room that they could use for anything from tutoring kids, to community agencies participating in various things, to whatever the community might need. So we built a large room. It's with tables and chairs. I'd say it probably holds about 70 people comfortably."

Field notes

There are two meeting rooms that can join into a single large conference room or be split for smaller meetings. One of the rooms has a stage and theater lighting mounted on the system. They talk about some of the meetings that will be there tomorrow—the weekly PCP meeting will have the psychiatrist there. It's a Q&A that he likes to call "Stump the Chump."

3.2.5 Organizing Health Information Technology to Support Integrated Care

The organizations we observed put a great deal of emphasis on creating a single electronic health record (EHR) system in which clinicians and other practice staff could document patient information. The organizations were using a medical EHR system that was not designed with all of the structures (e.g., templates, decision support tools) required to support the delivery of integrated care. The organizations put a great deal of effort into developing the EHR structures needed to support documentation, information sharing, communication, and decision support for integrated care.

SHARED EHR SYSTEM

The organization has one EHR system that is used by all clinicians and staff.

Interview with chief operating officer

"I've heard of an organization trying to do it with two separate electronic health records. And they didn't … the records didn't talk to each other. And so, you just kind of scratch your head like, 'How can they do integrated care with a medical system and a behavioral system?' And I don't think it's very effective because you just can't see it."

Interview with clinic administrator

"I think it's good, because it gives you the sense that it's not just our BHCs that coordinate and collaborate. It's also, if someone is sent to specialty care, it still all goes in the electronic health record. They still are expected to collaborate and co-manage. It's just this person is in a more intensive kind of level of service right now."

SHARED EHR ACCESS

Clinicians have access to medical, behavioral, and mental health information and records.

Interview with behavioral health clinician

"I have a wealth of information sources available to me before I walk in to see that patient. I have a referral from a primary care provider that's going to identify a target, sleep, depression, diabetes. I have a primary care record, and then I have consultation with the primary care provider. So I have three sources of information before I walk into the room. Sometimes I have screening instruments like PHQ-9, G-87's, PC-PTSD, so I've got all this information. So my job in going in to meet with a patient is not to rehash the stuff I already have. It's to fill in the blanks."

3.2.5.1 Supportive Functions Within the EHR System

SUPPORTIVE FUNCTIONS FOR INTEGRATED CARE DELIVERY

The EHR system has certain features that are important to supporting the delivery of population-based integrated care, and that are accessible to all clinicians. These include the following:

- Easy-to-use templates for common behavioral health screening tools used in the practice (e.g., PHQ-2, PHQ-9, GAD-7). These tools collect screening data in numeric form/fields that is then usable by the clinic as data and for decision support (e.g., alerts);
- Decision support tools to alert health care professionals when screening is needed;
- Support for developing an EHR-based shared care treatment plan;
- Ability to write group notes; and
- Scheduling templates tailored to different clinicians' visit types.

Interview with social worker

"It's a lot quicker when you have templates set to click off certain things, than to be writing long detailed information."

Field notes

She populates the note using the intake template that another BHC created. She's able to select which template to use when she creates the encounter note in the EHR.

Field notes

She administers the PHQ-9. It is in the EHR with Likert scales and buttons. She turns her screen so the patient can see it. She reads the question (explaining the assessment is for the past 2 weeks). The patient answers each question, and she clicks the appropriate button.

Interview with behavioral health clinician

"We have care plans in [the EHR]. Well, they're individualized to the patient. And generally, probably the more complex the patient is the more likely there is to be a significant amount of substance in my section of that. Since they're in the chart, everybody can access them. Everybody sees them. And we will talk about the patient's care plan, one-on-one, as providers, and also when we do psychiatric consults, which we'll do generally twice a month. ... We'll take a look at what the different disciplines are doing to address the patient's medical and mental health issues."

Interview with social worker

"Our social worker is the social worker in the [weight loss] program. So she teaches classes there. And they have upwards of 100, 150 patients sometimes in those classes. So there's also a group note feature in there that's fantastic. I don't have to write 100 different notes or sign 100 different notes. I can write a standardized note and then, you have to do individual encounters for each patient. But then you just sign it once and it signs all of them. And it's a beautiful thing."

Pre-site visit interview with primary care organization

"All of our visits are based on 15-, 30-, and 45-minute appointments. The follow-up visits or same-day visits are 15 minutes. New patients, procedures, they're all 30 minutes. Well-child visits are 30 minutes. Physicals are 30 minutes. Our BHCs, they work on a 15-minute schedule for people that they schedule to come back in. Our traditional therapists work on 30- and 45-minute sessions. Our psychiatrists work on … kind of a modified schedule. They book three 15-minute appointments per hour, per diem. So they have a little different modified schedule."

ABILITY TO TRACK PATIENTS THROUGH WORKFLOW

The EHR system has a tracking system that allows clinicians and clinical support staff to identify where a patient is in the integrated workflow (patient is with primary care clinician, BHC, etc.) (For more on this, see *Structuring Clinical Workflow for Integration*.)

Interview with office manager

"There's a tracking system on the computer system. When they leave the check-in and the nurse gets to them, the nurse has to log that the nurse has them. Then when the nurse has taken them into a room, they put in what room they're in. When the provider goes in with them, that they're in with the provider. When they go to check out, it's the thing to say that they're at check out. So, that's how we know. We can pull up their chart and see exactly where they are."

3.2.5.2 Customizing the EHR System for Integrated Care

CUSTOMIZATION FOR BEHAVIORAL HEALTH

The EHR system is customized for behavioral health, because basic systems do not have the required documentation templates. Interdisciplinary teams develop these customizations; these teams require people with content expertise (e.g., BHC) and information technology expertise.

Field notes

We walk through another set of doors and we run into the Director of Psychiatry. She's introduced as part of the NexGen team. She supports the behavioral health and primary care folks on the EHR, and does new employee training. This leads [Name] to tell us about the templates that they've designed for their EHR. Someone from our research team says that she noticed that this organization has screens and tools that other NexGen users she's observed don't have. They mocked up the templates they would like to have in Word, and then someone on their internal NexGen team built the templates in the system.

TEMPLATES

Considerable effort is put into customizing behavioral health templates (similar to those that already exist for physical health.) These allow for efficient documentation: BHCs document patient notes into structured or discrete numeric fields rather than traditional free-text narrative notes.

Interview with director of mental health services

"Then the good news was that we could innovate … we could modify it and make it the way we need it. And the bad news was that we could modify it and make it the way we need it, because we have been constantly developing it. I mean, we've been working on it year after year after year."

Interview with physician

"They had to do some customization of the EHR to make it applicable to BHCs. They made it so it's more user friendly for the BHCs, so they don't have to go through all the task categories that are more applicable for medical providers."

STRUCTURED DATA

As a result of customization, there is a structure in the EHR system to document BHC visits, consults, warm handoff in a numeric field or form that can be accessed as data and used to guide operational decisions and quality improvement efforts.

Field notes

The BHC tells me that he has an open morning and three pre-scheduled visits in the afternoon. He had two "drive-bys."… He tells me that when you do a "drive-by," you put the patient in the schedule and document. He tells me that you could have the schedulers do that for him, but he takes care of it himself because he has observed it can take a scheduler up to 24 hours before it shows up in his schedule. Once it's on his schedule then he documents his notes. Until then, he writes notes on a folded face sheet. I also notice that there are stickers that get printed out for each patient with a bar code, the patient's name, and some other information on there (maybe chart number). When doing a drive-by, I see that the doctor hands the BHC one of the stickers and he sticks it on the face sheet where he is writing notes.

DATA REPORTING
As a result of customization, the organization can extract data from the EHR system and create the reports needed for population management and quality improvement as it relates to integrated care.

Interview with pharmacist

"It's nice because you have the IT infrastructure, like the Data Mall to help identify which diabetics aren't at goal. Which ones can you focus on? And the care teams come up to you with ones they need help or assistance with, overall. So it's not like you're only looking at diabetics. You're helping the case managers or the support staff that gets a phone call on a refill of meds, and they don't know what that medication is for. So, they turn around and ask you overall."

3.3 Interpersonal and Individual Professional Practices for Delivering Integrated Care

In the first part of this guide, we describe the professional practices that created a primary care organization that is prepared and positioned to deliver integrated care. We observed that these professional practices focused on delivering integrated care that was accessible to the full population of patients served by the organization, rather than to subsets of patients based on criteria or diagnosis. In this second part of the guide, we describe how the professionals in these organizations sought to ensure that all patients receive the level of integrated care they needed, from the right clinicians, when that care was needed.

3.3.1 Managing the Structure and Timing of Integrated Care Delivery

3.3.1.1 Managing Staff and Workflows

A tremendous amount of coordination and collaboration takes place among clinicians, clinical support staff, and non-clinical staff in integrated primary care organizations. With regard to workflow, we offer observations about professional practices relevant to managing workflow in integrated primary care organizations, features of clinical workflows (such as pre-visit planning) that were important to delivering integrated care, and BHC practices related to scheduling and managing patient visits that enabled efficient, integrated clinical workflow.

3.3.1.1.1 Workflows for Integrated Care Teams

COLLABORATION
Professionals work with other members of the practice team (e.g., medical providers, BHC colleagues, medical assistants) to keep clinical work running smoothly.

Interview with case manager

"We have the nurses to help with her medication management, and then I'm there for support and helping out with making sure she's communicating the right things to these people on the outside. Then we have primary care where we need her to be seen and checked out for these certain programs that will accept her for housing and behavioral health. We're having to get in contact with her therapist, and everybody knows her situation around here, so everybody's constantly chiming in to help, which I think has been great for her. I think that's a perfect example for integrated care all the way across the board, because the whole team has been involved in getting her what she needs."

WORKFLOWS TO ACCESS BHCS

The organization creates and consistently uses multiple pathways or workflows to facilitate patient access to BHCs, including warm handoffs, and consultations with or without the patient present.

Interview with behavioral health clinician

"So for my team, depending on who they saw, whether it be the nurse, the LPN, or the provider, when there's an identified need that somebody has any sort of mental health concern or a health behavior concern.… We don't just do mental health. We also do tobacco cessation. We do motivation for weight loss, non-adherence to medicine, medical concerns, that sort of thing. And so when one of those needs is identified, either the doctor will call me, or they'll come knock on my door, or the nurse will, whatever team member is available. Sometimes the patient will make it all the way to checkout, and the doctor will have written on the router form that comes with them, 'needs to see the behavioral health provider.' And the clerk at checkout will always call me and make sure, 'Did you see this patient?' Just in case it didn't get to me already. So it sort of comes any number of ways. And generally, as long as I'm available and not with another patient, I go grab the patient, get a warm handoff from the provider or the nurse."

INTEGRATION-BASED WORKFLOWS

Professionals follow workflows defined by the integration model adopted by the clinic, so patients are navigated to appropriate clinicians. This can include both internal and external referrals for behavioral health, primary care, enabling services, etc.

Interview with mental health operations director

"I think partially there can be failure when there's not an understanding of how primary care mental health integration works across the spectrum of care for mental health. If a facility has not really outlined a patient flow process from primary care to specialty mental health and when they're stable, if it's appropriate to send back to primary care. If there's not a clear understanding of who would benefit from briefer interventions in primary care. Also, if everyone does not have a clear understanding of the model or a clear understanding of patient flow across mental health, you'll see places trying to provide treatment that may not match the needs of the particular population. For example, trying to do a specialty treatment within primary care may not be effective if you're trying to see someone for 16 sessions of PTSD treatment for 90-minute appointments. Again, that's going to back up your clinic. So trying to make sure that everyone is communicated with, everyone has buy-in in the plan, and that there's an understanding of how the model is to work."

ACCESS TO BHCS

BHCs are either physically present and accessible on the primary care floor (when not with a patient) or can be reached via pager or phone.

Field notes

The BHCs have a mixed schedule. They have some patients that they see for therapy, but they try to keep their schedule open for referrals and warm-handoffs. They can get called on their cell phone by a team member (although these phones work very poorly in the building), on their desk phone, or someone may come and knock on the door.

3.3.1.1.2 *Workflows for Integrated Care Delivery*

PRE-VISIT PLANNING

Workflows accommodate pre-visit planning, such that primary care and behavioral health clinicians identify scheduled patients who need both primary care and behavioral health services and coordinate those services efficiently.

Field notes

The team huddles last anywhere between 5 and 30 minutes. During this time they do a schedule scrub. They look to see which patients need a BHC or an MTM [medication therapy management]. Often BHCs already have patients on their schedule. [Doctor 1] asks the BHCs if either of them have Patient 1 on their schedules. The two BHCs say no. [Doctor 1] says, "We need to get her on if no one has her."

UNANTICIPATED NEEDS

Workflows accommodate unanticipated primary care and behavioral health needs during a patient visit. There are bidirectional interactions, and primary care providers and BHCs are interruptible for consults and warm handoffs.

Field notes

It's almost 10:00 a.m. and the doctor comes up to the BHC and says, "Can I borrow you?" [BHC1] tells her that he was heading into his 10:00 a.m. appointment. He knows that [BHC2] is in with another patient. The doctor tells him that she has a patient who missed his methadone appointment this morning. They wouldn't dose him because his blood pressure was too high. The patient is very upset. [BHC1] agrees and goes in to see the patient at the same time with the doctor.

Interview with behavioral health clinician

"The cell phone is a way of being available when I'm not in this office. Availability is a tricky thing. I think it's a way of learning the patterns of your clinic. I schedule the beginning of the day with follow-up patients. I usually schedule about 10, and I schedule them in 30-minute increments, even though I know I'm not going to spend more than 15 to 20 minutes with them. But that gives me some flexibility because then I know that every hour I can absorb at least one more patient if everybody shows up.

I also know the patterns of this clinic. It's somewhat unpredictable, but in general I know that the clinic has to get churning an hour and a half or so before I hit my peak volume times in terms of warm handoffs, or what we call "on demands." So I will also put an admin spot in my schedule at those high-volume times. That doesn't mean that I can only work a patient in during that time, that's a buffer. So when I get running 30 to 45 minutes late because I've continued to absorb patients throughout the morning, that's my catch-up time.

And also I know that's a high-volume time for the clinic, so a lot of times that is actually when it ends up being that I'm getting asked to see a patient. What we'll do when we're getting behind, you know we've got someone in your office, two in the lobby, and I've got two providers asking me to see patients. First thing I'm going to do is call one of the other BHCs. And sometimes we'll just say, 'I've got this one, whoever gets done first touch base with this provider.' And that way it's really a coordinated effort."

CLEAR PATHWAYS FOR CARE

Workflows enable model-appropriate care, creating clear pathways for care that can be addressed in the clinic as well as clear pathways for coordinating treatment for the more severe needs that may need to be addressed by another area in the clinic (e.g., specialty mental health services) or by outside services.

Interview with behavioral health clinician

"Now I'm not going to treat borderline personality disorder in primary care, but I might see someone with borderline personality disorder and depression and diabetes and hypertension as a BHC, but my target would be very different. I'm not targeting the borderline personality disorder, but I'm targeting containment, care coordination, basic coping, and that's what I'm doing in primary care."

ROLES AND BOUNDARIES

Workflows enable appropriate roles and boundaries between different levels or areas of the organization, such as specialty mental health services and chemical dependency programs.

Interview with behavioral health clinician

"Well, in terms of intensity, you know, when we see patients that need more intensive levels of care, we'll send them on to a specialty mental health provider. What's really important is that the BHC not end up as a specialty mental health provider planted in the primary care clinic. They really want to see patients that they can work with for 30-minute sessions, four to six times maybe, and then taper those out, help stabilize the patient. They might see them for booster sessions on a periodic basis. But if this patient does need more intensive, frequent care, then they'll be sent to a specialty outpatient mental health provider."

INTERDISCIPLINARY COMMUNICATION

Workflows allow for communication among professionals from different disciplines (e.g., primary care, behavioral health, psychiatry) before and after a handoff between clinicians. Before a handoff, professionals discuss concerns and problems for their colleague to focus on. After a handoff, professionals summarize their visit, offer their assessment, and decide on next steps. (For more on this, see *Communication Among Clinicians and Staff*.)

Interview with behavioral health clinician

"We try to coordinate with primary care. I want to know where the primary care provider is in their flow. This is because I have two consumers of my services—the patients and the providers. I don't want to clog up their exam rooms. So a lot of times if they're done with the patient, we'll agree [to] put them in lab waiting, let them get their labs, the doctor will be with them within 15 minutes, so that we can put them in another location. The primary care provider can keep seeing patients, and pulling patients back from the lobby. But then I'll still find the primary care provider after I see the patient. Sometimes they may even alter the treatment plan or talk with the patient briefly again afterwards, but we're just kind of keeping the clinic churning, not slowing things down. So it's kind of a balancing act of working with providers."

3.3.1.1.3 *Workflows for Behavioral Health Clinicians*

BALANCING CONSULTS AND APPOINTMENTS

BHCs gracefully step out of current appointments for brief consults, as needed. They determine whether the consult takes precedence, and are able to execute this decision by either ending the visit with the current patient, identifying a time frame when they can engage the new patient, or strategizing with the provider on care and returning to the current patient to pick up where they left off.

Field notes

The doctor knocks on her door and says he needs her help. He has a patient in for acupuncture with bruises on her legs. The BHC asks for the patient's name and looks her up in the chart. The doctor says she in a room on the third floor and asks if the BHC has time to see her. The BHC is looking at her schedule and says, "I'll put her in at 2 p.m." The doctor says, "I don't think she'll come—she says she has a hard time talking about it." The BHC says, "I bet. That's why I'm coming up to see her first.' The doctor says, "Thank you so much, come up when you can." The BHC says, "Give me a few minutes."

Field notes

There is a knock on the door and the doctor is called out to talk with the BHC. I can't hear what she is saying, but I am guessing that she is reporting on what she was doing with another patient. The doctor comes back in and picks up where she left off.

STRATEGIC SCHEDULING

BHCs construct their appointment templates to match the primary care clinic flow—more follow-up appointments at quiet times in the clinic and more open slots during busy times.

Interview with chief executive officer

"Mental health people are so used to seeing people so many minutes. I mean, our billing is in so many minutes. So we have sessions, right? And maybe they're an hour. Maybe they're 45 minutes. Maybe they're 30, but they're by the clock. It doesn't work that way in primary care. A primary care provider might have their schedule segmented in 15-minute blocks, but they don't pay attention to that. I mean, it's a flow, and you do what you need to do. So behaviorists have to think that same way about schedule."

UNSCHEDULED TIME

BHCs arrange their daily schedules with sufficient unscheduled time to collaborate on unanticipated behavioral health issues with the primary care team.

Interview with mental health operations director

"If folks come in and try to establish a specialty mental health clinic within primary care and are doing a traditional model of 60-minute appointments and things like that, then you begin to see a system breakdown. Because if you set up a specialty mental health clinic within primary care, quickly peoples' schedules get filled up, and they're no longer available for those 5-minute consultations in the hallway with the primary care physician. Then they're seen as less relevant because they're not available for those brief interventions."

BRIEF VISITS

BHCs conduct brief visits, keeping appointments and primary care workflow on track. (For more on this, see *Clinical Practices of Integrated Care Teams*.)

Interview with primary care provider

"It's definitely not for everybody. You've got to find the people with the right mindset that are comfortable working under a medical model, kind of in a high-paced clinical setting, because without that it definitely is like a square wheel. It won't flow very well."

3.3.1.2 Documentation and Information Sharing

An important aspect of integrated care is being able to document information in a manner that is accessible, meaningful, and actionable by clinicians from other disciplines on the care team. All of the primary care organizations we observed used electronic health record (EHR) systems. In the section on organization-level professional practices, we share our observations about how the organizations structured the EHR system for integrated care. As we show in that section, documentation and information sharing via the EHR system can be highly structured and template-driven, and what is included in the narrative sections, such as progress notes, is determined at the organization level so that there is consistency among and across clinicians.

In this section, we identify specific professional practices for clinicians who are documenting and sharing information with other members of the patient's integrated care team.

CONCISE NOTES

Clinicians write concise notes that contain all information relevant to the shared care or clinical handoff. Notes typically include a brief description of the problem and symptoms, the diagnosis, and the treatment plan.

Field notes

Templates are selected based on the purpose of the visit. It auto-populates some information. Some history will auto-populate. They select from a drop list under visit type the amount of time spent in the appointment. This is for billing purposes. It also lists the referral source. After the note is saved and signed, it gets sent to the person listed as the referral source. This happens automatically. They can add additional issues beyond the chief complaint, but it isn't searchable.

The BHC templates have a space for listing symptoms that auto-populate and through free text. The auto-populated items are searchable. There's space to include info on modifying factors, associated symptoms, and social history. The physical exam includes info on mood, judgment, thought process, etc. The diagnosis codes are in impression/plan. They can also document a GAF [Global Assessment of Functioning] here. Course of diagnosis, plan and follow-up, patient instructions. The summary section is free text.

DOCUMENTATION PROTOCOLS

Clinicians follow the documentation "rules" defined by the organization, using the templates, mineable data fields, or other features that the organization has developed for this purpose. This makes information accessible, easy to use, and easy to find. It also supports data tracking, data reporting, and quality improvement efforts.

Interview with analyst

"I would probably say making the information easily accessible. That's the biggest way to support integrated care. One conversation that we were having was about psychosocial assessments. They're very long, and to a mental health person they get it. They know what's going to be where and how to find the information, that you go to your summary at the end, and that should have a lot of information. But to a medical provider it looks convoluted and too cumbersome to go through. So we just had a discussion about ways that we can make that clinical summary more accessible to a medical provider, so they can quickly look at a patient's chart and know what's going on with them as far as their mental health care goes. Making that easily accessible so that you get the information right off the bat, you know what's going on. Ease of access is a huge thing."

NOTES IN STYLE OF MEDICAL CHARTS

BHCs write notes that fit not only the "rules" but the style and substance familiar in medical charts, e.g., clear structure, easy-to-find facts and plans, and limits on long or rambling discourses or hypotheses that aren't solid information.

TEAM COMMUNICATION VIA EHR

Clinicians use EHRs to communicate with others on the team and to document throughout the patient visit, and as a patient education tool.

EHR COMMUNICATION FEATURES

Clinicians use EHR features, such as in-baskets and messaging tools, to communicate with others on the team. They may task encounter notes to others on the integrated care team as a request for action or for review. Clinicians know when to use and when not to use these features. (For more on this, see *Communication Practices That Facilitate Integrated Care*.)

Interview with psychiatrist

"One of the things is with our integrated health record, we basically share the chart, we document in the same chart. So we get to see their [physical health] notes. They get to see our [mental health] notes. We get to communicate back and forth via the messaging system in the record, because you can attach charts to messages, and you can just add as many people as you want out of the team. And so you can carry on an ongoing conversation about the patient via the in-basketing."

Interview with care manager

"Everyone has access to the system, and you can flag someone with information, and it's connected to the patient's chart. So it's a quick and easy way to communicate with lots of people. It's how most everyone here communicates."

CHOICE OF COMMUNICATION MODE

The complexity of the patient's situation and the urgency of the situation are two factors that drive decisions about whether thin communication (email, instant message) or rich communication (phone call, face-to-face discussion) approaches are needed.

Interview with social worker

"You can tell that [the provider] had a long history with [the patient] and they want to be updated on what's going on throughout the process. It's kind of up to the provider. If I have time I'll chat with them about it, but usually I notify them by writing my note, saying what I've done and where we're at with things, and then signing them to the note too, to give them an update."

DOCUMENTATION DURING PATIENT VISITS

Clinicians document in the EHR while simultaneously engaging and interacting with patients. Clinicians know how to manage and modulate documentation during patient visits, including when to stop typing, make eye contact, and listen intently to patients. (For more on this, see *Designing Examination Rooms for Integration*.)

Interview with behavioral health clinician

"I do a lot of concurrent documentation when I'm seeing a patient for the first time. Most of our primary care providers do it, so I think of us as matching what they're doing in every way and kind of modeling. So they're doing concurrent documentation, I do concurrent documentation. I have a schema in my head of what I'm doing with a patient, and I'm just typing and filling in the blanks as I'm talking with them."

EHR AS PATIENT EDUCATION TOOL

Clinicians use the EHR as a patient education tool, such as by sharing the screen with patients to show trends in relevant clinical measures (e.g., BMI) and sharing educational information (e.g., self-management activities) in a visit summary.

Interview with medical assistant

"We can always just turn the screen so the patient can see and say, 'These are your medications here. This is the date that you got it.' It's good and easy to do that. Also their lab results are there. It's easy to just have them see it. If you need to Google something or search for something medical, you can just do it right there. It's easy to do. And the patient can look at it with you."

STRUCTURED CARE PLANS

Clinicians create and maintain a care plan that outlines treatment, describes plans for follow-up, and ensures that the patient and all involved clinicians are on the same page. The plan provides access to patient information and identifies who's responsible for addressing specific health care needs and goals. Care plans are often used for complex patients and pain management patients.

Interview with pharmacist

"In the care plan, we've worked really hard to identify what needs to be done and what has been done, so that we can know if that change made by me through a collaborative practice or if that's something I'm asking the physician to do when I route the chart to them. Or is it something I told the patient to do, and they're going to do that? So when we follow-up, we know who was responsible for which piece."

Interview with behavioral health clinician

"We have care plans in Epic. They're individualized to the patient. Generally, the more complex the patient is the more likely there is to be a significant amount of substance to my section. Since they're in the chart, everybody can access them. Everybody sees them. We will talk about the patient's care plan, one-on-one, as providers, and also when we do a psychiatric consult, which we'll do generally twice a month. We'll take a look at what the different disciplines are doing to address the patient's medical and mental health issues."

POPULATION MANAGEMENT USING REGISTRIES

Clinicians use registries and data tracking tools to manage the care of patients with chronic diseases, and to monitor screening and health maintenance activities.

Interview with registered nurse

"We do a lot of preventative stuff. We work off the Data Mall. So it's preventative, mammograms, breast exams, our diabetic patients—when was their last foot exam. So we work off of that list to make sure that they get those. … Or if they're due for a colorectal cancer screening, then we get that in there, too."

Field notes

The BHC gets the patient management tool up on the projector. This is something that has been recently developed. He looks at the main page and says he just learned to use this recently and is still learning. They're going to train all the BHCs to use it next week. You can sort by clinic, by patient condition, etc. When he looks at the top conditions across the system, the leading diagnoses are for chronic conditions. At this clinic the leading conditions are behavioral health and substance use. He says the great thing about this program is that you can pull and sort data for certain conditions. For example, you can pull all the diabetic patients with a PHQ-9 of a certain score. He says that anyone can pull data who's a provider.

3.3.1.3 Supervision

Among the exemplary primary care organizations we observed, clinician supervision is considered a key aspect of structure and delivery of integrated care, and not only an administrative or organizational function. Supervisors played an important role in hiring staff with the appropriate skills and qualities for the integrated care team, helped assist with problem-solving, and provided ongoing education and training for staff by identifying staff learning needs and modeling exemplary clinical behavior.

RECRUITMENT

Supervisors interview, select, and hire staff and clinicians with appropriate skills and qualities that fit the culture of the integrated clinic.

Interview with medical services administrator

"One of the things that we try and do with all new providers is in their actual interview before they're even hired, we have behavioral health consultants in the interview to try and set the stage that this is an environment where we do use integrated care. Most people find it great and they're interested in it, but if they're not interested in it, this might not be the place for them."

FEEDBACK AND COACHING

Supervisors listen to behavioral health and primary care clinicians and help assist with problem-solving. When this relates to patient care, supervisors help without taking over patient care.

Interview with registered nurse

"My boss is incredibly busy, but she's incredibly accessible also. She's really available to provide guidance where needed, and reinforcement sometimes, because I think with any organization, there are some times where things bottleneck, and she can help me break the bottleneck and get things flowing once again."

OPERATIONAL MANAGEMENT

Supervisors manage a clinical practice in addition to having supervisory responsibilities; maintaining a clinical practice is important as a way to stay relevant and engaged in patient care.

Interview with director of mental health services

"All of our administrative folks, heads, who are licensed as clinicians still carry caseloads from our CEO to ... I think that sets a tone, a recognition of if you're going to do the work ... or, you know, if you're going to administer the work, you've got to know what doing the work feels like and stay active with it."

MODELING BEHAVIOR

Supervisors model exemplary clinical behavior and are highly collaborative with other clinicians on the team.

Interview with behavioral health clinician

We also believe heavily in the value of on-the-fly supervision. That's the two phones. We are always available to them, especially initially when they're new to us. There's times early on that we're consulting on-the-fly after every patient that they're seeing. And sometimes a couple of times before they let the patient go, because we need to know, what do I need to tell this primary care provider? What should my plan be? What do I need to do with this patient? So we're kind of modeling for them, we're teaching them didactically. We're teaching them in supervision, we're consulting with them during the day. They're observing us, oftentimes for the first couple of weeks when they're here to see what we're doing with patients."

ONGOING LEARNING

Supervisors identify, execute, and implement learning opportunities to help integrated team members (e.g., primary care clinicians, BHCs, psychiatrists) and improve the clinic's integrated care model.

Field notes

Ideally they want the BHCs to see 8-12 patients per day. Before they introduced the EHR they only got to count the patients on their schedules. Now there are better ways to track productivity (e.g., brief consults) with the EHR. One of the ways administrators can tell if there's a problem with a BHC is if they're not being utilized. The BHCs can always find work to do. If they're not being used, it may be that they're not looking for work or they're not valued by the providers. They do chart reviews and peer shadowing regularly.

3.3.1.4 Inter-Professional Collaboration

Central to delivery of integrated care is the ability of professionals from different disciplines to work together. In this section, we describe the professional practices we observed among clinicians, regardless of discipline, that were important to integrating care for patients.

POOLING OF EXPERTISE

Clinicians acknowledge and integrate into patient care the priorities of other providers, using the contributions, skills, and knowledge of others who have different roles and expertise.

Interview with pediatrician

"I personally pull [the BHCs] in for a lot of the teenager visits. I feel they do an excellent job at identifying risk factors, doing more preventative counseling, getting a better sexual activity history, and whether there are needs that need to be met there. So I personally use them with the teenagers for that because I feel they do an excellent job there. And again, that's taking more of the time that I can spend with medical issues."

Interview with mental health director

"An elderly man and his wife just kind of dissolved in tears near the end of their primary care appointment. The PCP was really tied up, stayed with them long enough to know that it had something to do with losing income and their house being at risk, and probably could have had a lot of different ways to handle it, but thought, well, the [BHC] is down the hall. Let me ask them if they can talk with this guy for a few minutes. So he did."

USING INPUT

Clinicians incorporate and act on input from other team members.

Interview with behavioral health clinician

"Some of the settings that I've worked at … if you drew a graphic depiction of the team, it would look like a hierarchy, particularly if you're looking at like an ICU unit, where the medical specialists and medical providers are kind of at the top of the pyramid and then it descends from there. They give the orders, and then there are different levels of hierarchy as people carry those out. This team has been described more as an oval. I think there's more input from all players, as opposed to if you think of a hierarchy … a triangle.

The behavioral health clinician works under the direction of the primary care provider. So the PCP is directing the care, but I think the main difference is in a hierarchical setting, if the surgeon or the medical specialist gives an order, they aren't as interested in hearing input from other disciplines. It's like, 'I've given the order and this is what needs to happen.' And in this setting, the primary care provider still leads the care, but they are interested in input from the various disciplines. It's a setup that allows for that input to happen freely."

SHARING DECISIONS

Clinicians share decision-making with other members of the team by identifying points where team member perspectives need to be combined and an explicit decision needs to be negotiated.

Field notes

The psychiatrist asks his RN to get this patient's doctor. After a few minutes she comes to the psychiatrist's office. The psychiatrist debriefs the doctor. "The patient is 44 with a history of drugs and substance abuse. We switched his medications lately and he's going down the drain—the drug has an interaction with Plavix. We want to know if he's got other options. He said he'd rather stay on the medication than go down the drain. The nurse is in the computer chair, but she moves and the doctor sits there and looks at the patient chart. The doctor asks, "What are our other options?" Both doctors are looking at the patient's record. The nurse says "He's had an MI, so he has to stay on Plavix." The doctor says that he has diabetes, high blood pressure, and these are all risk factors. She asks what the level of interaction is. The psychiatrist says, "It's level 3." Then the psychiatrist says, "Perhaps we should listen to the patient." The doctor says, "Can we go back? Otherwise it sounds like he will relapse." The psychiatrist says, "Let me call the pharmacy manager and see if there's something we can do differently. I've been following this patient for a long time, and I don't want him to crash." The doctor agrees. The nurse adds, "I'm afraid this patient is going to kill himself if you don't do it (switch him back). I've never seen him so depressed before."

After his last patient, the psychiatrist calls the pharmacy manager on her cell. He summarizes the story about the patient. They make a plan to override the warning and flag the PCP to manage his Plavix more closely.

Interview with primary care providers

Provider 1: You're the captain of the ship, basically. But you have to hear your teammates for you to be sailing. So you're still the so-called primary decision-maker, but the decision is made as a team approach. Does that make sense?

Provider 2: Oh, it makes total sense to me. I mean, I defer to behavioral's judgment 99 percent of the time.

RESPECTING DIFFERENT WORK STYLES

Clinicians adapt to others' working styles and preferences, within the limits of the basic roles and processes established by the organization.

Field notes

She enters the appointment in the EHR and says that although [Doctor] scheduled the appointment, some doctors don't look at the patients' past and future appointments (which are on a separate screen she clicks to). Instead, she types it into the notes section of today's encounter, which [Doctor] will definitely see when she looks at the patient's record.

Field notes

We leave the examining room, and notice that the PCP seems a little flustered and tired. The BHC can gauge and see this. She gives the PCP a briefer version of the encounter compared to the other debriefs I've seen. The BHC tells me that she can update the PCP more later when there's a better pocket of time.

SITUATIONAL AWARENESS

Clinicians anticipate when they might be needed by other members of the team and remain accessible.

Interview with pharmacist

"I think you have to be proactive, overall. If you're waiting for things to come to you, it's just like the BHC, unless you're going in and looking at the schedules and saying, 'Hey, this guy is coming in. Can I work with him?' You have to be very proactive with your time, and then also with your relationships with other providers. So once you identify those patients, going to the provider and saying, "Hey, this guy is on this type of medication therapy. What can we do to help improve that?"

ARTICULATION OF ROLE

Clinicians early and clearly articulate their role to others, explaining "who I am and what I do."

Interview with social worker

"So, I think what it really is, is education to the providers. And I made sure that I did that right from the get-go. So it's not, 'Oh, who's that person in the corner there? What do they do?' I was just very out front. This is what I am. This is what I do. This is who I am. And they've been more than welcoming."

ACTING ON SHARED VALUES
Clinicians routinely act on the shared values for communication and collaboration articulated by the organization.

Interview with registered nurse

"My practice administrators and medical directors are in the same caliber in terms of integrity and dedication to the clients. And the same goes for psychosocial services. I have never once called any of my colleagues and been told, 'I have to call you back' or 'I can't help you.'…We're trying to take care of our clients. And at the end of the day, that's all that really matters."

3.3.2 Communication Practices That Facilitate Integrated Care

At the integrated primary care organizations we observed, clinicians were actively working together to deliver integrated care, as we describe above in the section on "Inter-Professional Collaboration." These activities involved a range of communication practices that we highlight in this section. We identify the communication practices in which clinic members engage to coordinate care, to collaborate with each other under both normal and difficult circumstances, and to communicate with patients.

3.3.2.1 Communication Among Clinicians and Staff

3.3.2.1.1 Communication Practices for General Coordination of Care

ACCESS TO CLINICIANS
Clinic members communicate to manage and adjust clinicians' schedules (behavioral health and primary care) and clinical workflow in order to provide patients with the best possible access to clinicians, even for patients who are not on the visit schedule.

Field notes

When the patient left after 15 minutes, the BHC told me that she was starting to back up. She had two scheduled patients who had checked in and two consults waiting. She got on the phone and called the BHC who was working in the women's clinic to see if she had time to help out. She said she was going in with a patient right then but that she would come over right after and take one of the consults. The BHC checked her voice messages and listened to a voicemail from a nurse who said she had a patient there who wanted a letter from her. The BHC called back and asked if she could do the letter in the afternoon when things were not so busy. The nurse said yes.

ACCESS TO PRACTICE RESOURCES
Clinic members communicate to ensure patient access to other practice resources (e.g., social workers, community health workers, insurance assistants) on the day of the visit or soon after, if necessary.

Field notes

The doctor asks the MA what is happening in Room 3. The MA says Room 3 is still waiting, but the BHC is done. The doctor says that another patient is done and can go to the lab. The MA tells the patient that they can go, and they'll see the doctor back in 2 weeks. The MA walks the patient to the lab.

Field notes

The BHC intern who had gone in with the first patient, long ago at this point, finally emerges from the room and comes to check in with the doctor. She thinks he's actually a good candidate for the chronic pain group, and she's got him signed up. The BHC intern says she needs the checkout sheet because they're done talking. The LPN hands it to her and asks if the intern will take him to the lab. The intern says she was planning to do this, and the LPN tells her to make sure he leaves a urine sample.

PATIENT VISIT SUMMARIES

Clinicians produce clear and concise summaries of a patient's situation so that another person in the practice can use the information in a subsequent visit or step of the clinical care process. Each summary includes enough information to allow other providers to rapidly assess the acuity of patient need.

Interview with director of integration

"You have to be very articulate. You have to be able to articulate goals for patients, needs to your team, present cases in a short period of time, and network with people that you need to help care for that patient. So you have to be able to be pretty articulate and clear."

3.3.2.1.2 Communicating During Collaborations and Consults

In order to collaborate effectively and coordinate care for patients, clinicians must use combinations of richer (e.g., dialogue) and leaner (e.g., emails) forms of communication among members of the care team.

INTERDISCIPLINARY COLLABORATION

Professionals from the same and different professional backgrounds engage in dialogue about patients and work together to understand what's going on, and to help patients through a range of problems and treatment modalities.

Field notes

The doctor has just left the exam room where he saw a patient who was experiencing alcohol withdrawal and also reported domestic violence. The doctor says to his MA and the BHC, "We've got a challenging situation here. She's going to be here for a while. This is going to be a team project." The MA and the doctor discuss which meds to give her. The doctor asks the MA to keep an eye on the patient. He tells the BHC that the patient has bruises all over her body. The BHC says that she'll have to file a report. The doctor also asks her to look up DV shelters. He tells her that the patient isn't in any hurry to leave the clinic, so she has some time. He tells the BHC that the patient is interested in stopping drinking. [The doctor is talking to the BHC as a peer. I don't get the sense that there is any hierarchy in their relationship]. The MA tells the BHC that she can go see the patient now—that she just gave her the phenobarbital shot.

ASSESSMENT OF PATIENTS

Clinical staff (e.g., medical assistant) and non-clinical staff (e.g., front desk staff) identify and communicate observations of patient needs to clinicians.

Interview with medical assistant

Q If you were to think about advice you might give to other MAs or other people who are trying to serve patients in integrated settings, what kind of advice would you give them?

A Be a little more sensitive. [Chuckles] Pay attention to what the patient says. Sometimes they say something, and they're screaming another thing. Some people just do regular work, blood pressure, and this and that. We say hello to the patient. Everybody says hello to the patient. But sometimes you see the patient, and they want to talk. They want to ask a question. Just take a little minute to see what they're trying to say. Maybe you could catch something over there. That's what I try.

COMMUNICATION ABOUT COMFORT LEVEL

Clinicians consult with each other regularly, either in person or over the telephone and email. Clinicians are aware of and/or explicitly communicate about one's comfort level with addressing certain problems and treatment modalities (e.g., managing medications).

Interview with behavioral health clinician

"Just like you have to know your patients, you have to know your providers. So I know some providers who always want me to see the patient in their room, for example. Because it's much easier for her if she can just keep the patient there and not have to worry about the patient leaving or not getting to see me. So she really likes me to see them in the office. There's also provider preference, in terms of comfort in prescribing medication. I have some providers that if I have a patient who is maybe even bipolar disorder and we're wanting to start a mood stabilizer, I know some providers that can manage that within primary care with consultation with a BHC and a psychiatrist. We often call our chief of psychiatry on the phone, so I know [their] comfort level."

DE-ESCALATION OF CONFLICTS

Clinicians and staff members communicate in order to de-escalate conflicts with patients. This is especially important when working with patients where substance misuse is a concern; this is not left to the BHC to manage.

Interview with clinic administrator

"Now when a patient comes in and says, 'I want my controlled substance,' we can look up when was the last time they got this prescription. In many cases it was yesterday, or last week when they got 90 pills. That's supposed to last you a few months. Especially in a place like [City], but I think it's everywhere, people come up with stories. 'My prescription was stolen' or something like that. Then the provider has to tell them, 'I am not giving you this.' People don't always accept that in a nice way. The provider says, 'I will give you this, but you must take a urine test or something to show that you're not overdosing on this stuff.' They don't always take that. So I have to intervene in many cases to calm it down from literally a possible violent situation. So that's one thing that's been coming up more and more."

CONSISTENT MESSAGING

Clinical staff support each other in reinforcing messages to patients; this is especially important when working with patients for whom substance misuse is a concern.

Field notes

There's a knock on the door, and [Doctor] pulls [BHC] out of the patient room. [Doctor] tells him, "I'm not going to prescribe [patient's] medication until he does the urine test. He's telling me he'll just get it off the street. I'm wondering if you can come in to reiterate that?" [BHC] agrees and walks down the hall to the patient's room.

DEBRIEFING ABOUT PATIENT ENCOUNTERS

All clinical and non-clinical staff members can debrief as needed after challenging patient encounters, and explore ways to make practice-level changes to prevent problems from happening again. Clinicians can ask colleagues for a "gut check" or opinion about a patient when unsure of the patient's story, feeling manipulated, or simply uncertain about the best approach to working with the patient. This is especially important for patients for whom there is concern about illicit or prescription substance misuse.

Field notes

The PCP responds that he gets the feeling that there are some enablers in this patient's life. One of the reasons he wanted to call the BHC today was because he got the feeling in the appointment that this patient was being manipulative, and he wanted some confirmation from the BHC that his radar was correct.

PEER SUPPORT

Clinic members communicate to support colleagues who might be frustrated by a patient and need to discuss this in order to continue to provide the care the patient needs.

Interview with clinic administrator

"I would have gone insane without [BHC] those first few months. The BHC role provided as much support for the team as it did for the patients, and that's still the case. The BHCs are usually the voice of reason. There are some days you kind of feel kicked around a bit. I don't experience it at the level these guys do. I can only imagine what they go through. And you sort of feel taken advantage of on some days, and you just.… You let it go. There's nothing you can do about it. It's not personal. You have to kind of get over that. So I would say I think having the BHCs here helps support the team as much as they do the patients."

Field notes

After the BHC goes in to talk with this patient, she comes out and talks with the group of providers that are all standing in the pod. The social worker feels like this patient has pulled her leg a bit too much to get things, like bus passes, and she feels like she might be doing that again now. The BHC listens and gives the social worker her two cents. She says, "You bump heads with this patient. She's your frienemy. I understand how you feel, but I think she may really be in labor. She has had enough babies to know."

The Ob/Gyn goes into the examination room and sees the patient having a contraction. The patient says that she has been having these since 4 p.m. yesterday. The doctor leaves the examination room, interrupts the social worker, who is in with another patient, and tells her that they need emergency bus passes. The patient shouts from her exam room, "All day passes, and two." The social worker leaves the visit and gets the passes and gives them to the patient.

3.3.2.2 Communication With Patients

In this section we describe professional practices pertaining to communication with patients that we observed clinicians engage in, regardless of discipline. First we describe general communication practices. Then we describe communication practices that are specific to managing patient visits in which the patient has brought an additional party (e.g., family member, caregiver, friend) and where there are two clinicians of different professional disciplines.

3.3.2.2.1 General Communication Practices

MULTIPLE COMMUNICATION MODES

Clinicians communicate with patients via multiple modes, including the phone, secure email, and Web-based portals.

Interview with behavioral health clinician

"I check my like 50 voice mails. Go through the ridiculous amount of emails that I have. Normally they're from different patients through our EHR system. I respond to those."

AVOIDING UNNECESSARY VISITS

Clinicians use phone conversations and email correspondence to reduce unnecessary visits to the practice.

Interview with behavioral health clinician

"It's really great working with our clients because a lot of our high schoolers actually use the MyChart messaging. So they'll [send us a message through] MyChart on the weekend, if they're concerned about something. A lot of them are here for reproductive health care. So mom and dad can't know that they're coming, or they don't want them to know, which makes it really difficult to outreach at home if they don't have a cell phone. And we can't send letters. And I can't call them. And sometimes we have trouble outreaching in school because they're in classes, and we don't want to interrupt. So MyChart is great because then they can e-mail us and say, 'Sorry I missed my appointment. I need to reschedule,' and I don't have to worry about contacting parents and breaking their confidentiality."

TEAM ROLE CLARITY

Clinicians offer clear and succinct self-introductions that clarify each clinician's role on the care team and relationship to other care providers.

Field notes

We go in the room and the BHC says "Hey [patient name], [Doctor] asked me to help a bit. I'm trained as a psychologist, but I don't work as one. I work as a consultant here to the medical clinicians. I looked over your chart and I see that you've got a history of sleep problems, and with alcohol and drugs. Can we talk for a bit?" The man nods. She explains that what they talk about will be kept confidential. They don't share it with anyone else without the man's written consent. She says that it sounds like he's suffering a lot. The man starts to cry. He can't speak for a while he's so teared up. The BHC goes to get tissue, but there isn't any in the room. She gives him the towel and says, "This is almost enough to make anyone cry," and she feels bad giving it to him.

CELEBRATION OF SUCCESSES

Clinicians communicate appreciation for patients and celebrate patients' successes.

Field notes

The LPN comes in from rooming the patient. "She's got her insurance card!" The doctor is happy about this. He pumps his fist in the air a little. The doctor reviews her chart and sees that she's due for a TSH [thyroid-stimulating hormone], which was out of range last time. The LPN reminds the doctor that this patient just had a birthday 2 days ago. She turned 65. The doctor goes in with this patient, who is cheerful and gives him a coy smile, "Guess who got her insurance card?" The doctor congratulates her as he washes his hands in the sink.

ENCOURAGING POSITIVE BEHAVIORS

Clinicians use patient data (accessed in the EHR or obtained during the clinical encounter) to encourage patients toward positive behaviors.

Field notes

The patient has lost 41 pounds, and he is making health behavior changes (diet and exercise). The pharmacist congratulates the patient; that's great. His fasting blood sugar is 212/224 in the morning. The pharmacist shows the patient his drop in weight (turns out it's more like 30 pounds). The whole system is in metric, so he has to convert kilograms to pounds. He also shows the patient his A1c over time. In 2007 it was 7 percent, now in 2011 it's 11 percent.

CULTURALLY APPROPRIATE COMMUNICATION

Clinicians communicate in a culturally appropriate manner, and are careful when discussing sensitive or stigmatized issues, particularly those related to behavioral health and substance use.

Interview with medical assistant

A As we were learning how to integrate, we had to understand what the patients meant by depression or mental health disorder. We had to learn what it meant to them to have that diagnosis, or to mimic, sort of speak, in order to be able to treat it. So we have to have some cultural competency as well around it. And that lent itself to some interesting understanding between patients and providers. Because if you make the mistake of not saying what they know it to be, then you're not communicating at all.

Q Is there a special word you use?

A Oh, it depends. You know, once you learn what it means for a certain population, it might mean that they're nervous. And if you come in and say, "So how is your depression today?" they don't know what you are talking about. Because they've told you that nervous for them means they're depressed. So if they come in and you say, "So how are your nerves today?" then they understand what it is you're talking to them about. They don't know what depression is. So you have to understand what it is, how they name it, and how they understand it when you're interacting with them. And be consistent in doing that, because if I go in and say, "How's your depression?" they think I'm giving them another disease.

ACKNOWLEDGING PATIENT CONCERNS

Clinicians make a point of being aware of and communicating about clinical operations in order to address patients' concerns (e.g., long waits) and to mediate and manage difficult patient situations, as needed.

Interview with clinic administrator

"A big part of what I do is intervene when there's a problem. Problems can be waiting time. Problems can be miscommunication between patients and staff, between providers and patients. Sometimes they're legitimate, sometimes they're not, but in any case they require intervention to resolve. So that's become a big part of my role, because I seem to do that well. So things like that can be resolved many times just with the right approach, with the right explanation. A lot of what I do is teach staff how to approach a patient who may be irate."

GUIDANCE ABOUT COMMUNITY RESOURCES

Clinicians communicate knowledgeably with patients about community resources, programs, and other relevant services for patients. Clinicians provide insider guidance to help patients navigate what are often multiple and complex systems.

Field notes

The case manager tells them that she's "learned the hard way" that the best way for insurance applications to get expedited is for [Case Manager] to personally go to the office (which is located in the first floor of this building) to show her face and get an appointment made. She wants to try to make an appointment for the patient to meet with the Medicaid office on Friday, when the ultrasound is scheduled, so the patient only has to come here once.

3.3.2.2.2 *Managing Shared Patient Visits*

Among integrated primary care organizations, it is not unusual for a visit to include multiple parties (patient, family member, caregiver, friend) and/or two clinicians from different disciplines. We observed clinicians of all disciplines engaging in social practices in order to manage the visit dynamics of these situations.

CARE TEAM INTRODUCTIONS

Clinicians may bring clinicians from other disciplines into a patient visit. When this happens, the clinician introduces the other member of the care team by describing this person's expertise and reinforcing his/her trust in this person's skills.

Interview with behavioral health clinician

"The doctor will introduce them to the behavioral health clinician. There will be this nice warm handoff. You know, 'I'm [Doctor], this is [BHC]. She's a trusted colleague of mine. She's safe to talk to.' So it's kind of that trust is developed there. And then the assessment happens there."

Field notes

Providers introduce the BHCs as part of the team that they work with. The doctor doesn't call them a 'BHC,' but instead, introduces them as someone who's really good with helping people cope with life stress.

RATIONALE FOR CARE TEAM APPROACH

Clinicians explain to patients why meeting with another type of clinician on the care team is valuable, and communicate his/her trust of this other care team member.

Interview with physician

"The doctor says 'Okay, I'm the primary care doc. This is my colleague. I think he or she is going to be able to help you with this particular condition. He and I will share and discuss your case so that I'm involved. You will see him and then you will have follow-up visits with me, so that we're not missing anything on your treatment on those particular disorders.' And that worked well, in terms of the buy-in from the patient."

LEADING THE APPOINTMENT

When a visit includes two clinicians from differing disciplines, the clinicians know who has the lead and will manage the encounter, and they are able to work together to discuss the patient's needs and identify how they will work on these together. This is done without overwhelming or overpowering the patient.

Field notes

The doctor and the BHC do the next part of the appointment in the room together. The BHC educates the patient again about deep breathing.

BHC: Focus on five counts in and five counts out, and practice.

The patient says that her right arm also gets numb.

Doctor: How much did you sleep?

Patient: Slept last night.

BHC: How much?

Patient: 8 hours.

The patient comments she's also down to a half a cigarette a day. The BHC and the doctor congratulate her.

BHC: When's your quit date?

Patient: I don't know.

Doctor: What's your pain level?

Patient: Now a zero.

BHC: Do you want to reschedule with your therapist today?

Patient: Yes.

The doctor is typing up notes as this exchange is occurring. The exchange is intense but not too overwhelming. They do a nice job complimenting and pausing for each other's questions. The doctor turns to the BHC and asks, "Do you want me to write practice deep breathing at home?"

BHC: Yes. I'll also give her a handout.

COMMUNICATION WITH OTHER PARTIES

When family members, friends, or other caregivers are present, clinicians know how to manage the discussion with patients and other parties.

Field notes

Wife: Is there a way to know how long he's had it? I just want to know if he's had it for a long time. Does the high viral load mean he's had it for a long time? Could he have gotten it from the ER? He cut his hand at work.

BHC: I'm not sure. [Doctor], do you want to address some of those questions?

Wife: He used to give plasma for money. Could that be it?

Patient: No, they always test for that. That was years ago.

Doctor: That's unlikely. I would recommend talking to your hepatologist. I've got some info I can print out and give to you. I think the biggest concern is your liver. I want to do a liver test today. Is that okay with you? I'd really like to see how your liver is doing.

The patient agrees to a liver test.

3.3.3 Clinical Practices of Integrated Care Teams

In the integrated primary care organizations we observed, all clinicians shared a set of professional practices related to how they engaged in clinical relationships with patients. In this section, we first examine the professional practices related to developing an individual clinical relationship. Then we examine the professional practices we observed in group visits. Finally, we look at the clinical practices we observed among behavioral health clinicians working in integrated primary care organizations.

3.3.3.1 Professional Practices Related to Engaging Individuals, Couples, and Families in Care

DESTIGMATIZATION OF CARE

Clinicians normalize and de-stigmatize care (e.g., behavioral health care) when necessary, and present integrated services as part of routine whole-person care.

Field notes

We go into the exam room and a young male patient is sitting on the table. The BHC sits in the rolling chair and pulls up close to him. She uses a series of comments to normalize why she's there … that he's seen a number of her colleagues and has some concerns about medications.

Patient: I'm scared of meds. I'm clean off dope, but I abused meds. Don't trust them.

The man goes to NA [Narcotics Anonymous] every day, and goes to various locations. The BHC compliments him on going through the 12-step program—good job. She asks how his mood has been lately.

Patient: Irritable, but a happy irritable. Maybe I'm crazy? I always think I'm crazy.

The BHC says that she learned long ago that "normal is just a setting on a dryer."

RAPID ASSESSMENT

Clinicians focus on rapid and accurate assessment; they ask probing questions in a way that invites honest responses, they present problems quickly with or without a screening tool, and they get a good understanding of the patient's needs even if some are not spelled out. This is especially important for patients on controlled medications for chronic pain.

Interview with vice president

"They have to have certain assessment skills. They have to be very strong diagnostically to really pick up symptoms and to take on a different role in treatment. You also can't be rigid in what your plan is. You have to be able to bring everybody else's plan into your plan."

Field notes

The BHC segues into asking about suicidal and homicidal ideation. "Sometimes when people have this much trouble, they might feel like it's just not worth it to get out of bed. Does that happen?" The patient does feel that way sometimes. "Ever feel like hurting yourself?" She doesn't. "Ever have serious thoughts about hurting someone else?" She doesn't. The BHC probes for any history of mania: "Ever have too much energy, where you're tearing up the house and don't need sleep?" No. "It's super common to see things or hear things sometimes, does this ever happen to you?" The partner jumps in to say, "She's asking if you're schizophrenic." The BHC corrects him to normalize this, "No, it's actually a very common experience. Really it is." The patient starts to nod—she actually has had the experience of seeing her puppy that recently died. Sometimes she sees him in the corner of her eye running across the carpet. The patient and her partner are living at the Economy Inn, and the dog died there, and she thinks that's why she still thinks she sees him there, because she was used to seeing him.

READINESS FOR CHANGE

Clinicians assess each patient's readiness for behavioral change and knew when to intervene.

Field notes

The doctor says, "If you want, I can order something to help you quit." He says that he's tried pills and patches. The doctor says, "You could try something else, like a lozenge." The patient doesn't say anything. The doctor says, "If you're not motivated, it's not going to work." The patient says, "Not at this time." He is stressed out with running around town for housing, and he can't quit now.

Field notes

The doctor asks if the patient would like another prescription for the nicotine gum she was on. The patient says no. That was nasty. The doctor offers the patch and some other things. The patient declines. The BHC offers that she does hypnosis.

Doctor: It sounds like you're not ready.

BHC: Yeah, let's help you with some of the other stuff first.

Patient: I quit 90% of the bad. I love my little cigarettes. For now, I'm okay with it.

AGENDA SETTING

Clinicians work with patients to determine priorities for care when patients present with multiple, complex needs.

Field notes

They talk about what to do if a patient has both mental health and addiction treatment needs. The BHC says, "Use your discretion for the referral consult." They talk about how some like to have patients get control of addiction issues first, then get mental health services. Some are concerned because patients can get overwhelmed if you suggest too much.

CONTEXTUAL FACTORS

Clinicians consider contextual factors in the context of screening, management, and treatment of pain, chemical dependency, and substance use.

Field notes

The doctor tells me he would never start narcotics on his own accord, but he has continued for this patient because he knows her, and she's never had any red flags. He tells me he has an individualized policy around narcotics. The patients sign a contract. He checks the State database every time the patients come; he might do a UDS [urine drug screen] if he has a suspicion, and he will never refill early. This patient has never asked for early refills, and her State database information checks out. She refills on the correct day every month and sometimes even a little late. He can see when she requests the refills from the pharmacy, through the State database. He knows her well, and she's an exceptional case. She also has been waiting for her Medicare to come through so she can get neurosurgery to actually fix the source of her pain, which is back pain.

TEACHABLE MOMENTS

Clinicians use teachable moments to reinforce or heighten motivation for change and engagement in health care behaviors or services.

Interview with behavioral health clinician

"One day this week I saw a man who had been discharged from the hospital. He'd had a below-the-knee amputation related to complications of diabetes. He'd lost his insurance. He'd been off all of his medications for a long time, so it was presumed that the main reason his diabetes was poorly managed was, of course, because he wasn't taking his medications. So I went to talk with him about that, to see how he's adjusting to all these health status changes, his amputation, to discuss behavioral management of diabetes. And any time I'm doing that I'm thinking, is this a skill deficit? Is this a motivational deficit? Is this an access to resource deficit? So on the surface this looks like access to resources. This man couldn't get his insulin. So that was of course part of it. But also this guy was drinking a case a day, so that's significant. He had not disclosed that to the primary care provider. … This man also had a sore on his other foot, so this was a real moment of distress and opportunity for intervention because he was scared. So probably for one of the first times in his life he's really motivated to start addressing this. At that point my target became more substance use and how alcohol impacts management of diabetes and how, 'We're going to have to treat the alcohol if we want to be able to manage your diabetes and save you from another amputation.' "

PATIENT EDUCATION

Clinicians address educational issues and support self-care activities by patients.

Field notes

The BHC asks, "What is a typical day like for you?" The patient says that she is waiting to go back to school so right now she spends the day with the baby. The BHC asks if she gets out of the house sometimes. The patient says sometimes. The BHC asks if the patient has a car. She says, no. The BHC asks what helps the patient deal with stress? She says "Reading the Bible, writing, holding her son." What kind of writing? The patient says, "Poetry." The BHC says that religion can be a big source of social support. "Is that worth looking into here?" The patient says something about possibly visiting a church this weekend, and indicates her interest in Pentecostal churches. The BHC says that she doesn't know of a Pentecostal church, but she bets the patient can find one by looking on the Internet.

3.3.3.2 Professional Practices Related to Group Visits

BROAD EXPERTISE

Group facilitators/leaders have the expertise to cover a variety of physical and behavioral health issues.

Interview with registered nurse

"I've sat in on a few diabetes education classes. Those I find kind of interesting because our role is talking about the stress and how that actually impacts diabetes and can increase your blood sugar. When I sat in one class, one of the patients was from my old job. So you have the people with SMI [serious mental illness] as well as your general population."

KNOWLEDGE OF GROUP VISIT AVAILABILITY

Group facilitators/leaders communicate with integrated care teams about the availability of group visits.

Interview with registered nurse

The doctor refers the patient to an inhaler class.

Doctor: They can make sure that you're using it correctly. I'll ask the nurse if we can get you into the class. There's one today you could go to.

The doctor steps out and speaks to the nurse in the room across the hall. The nurse says that there's an opening, but today's group is focusing more on COPD and wouldn't be as applicable for an asthma patient. The nurse offers to give the patient a training session after his appointment.

USE OF EVIDENCE-BASED STRATEGIES

Group facilitators/leaders use evidence-based strategies, such as motivational interviewing, during group visits.

Field notes

The group leader summarizes what they've talked about so far: "Let me summarize for you: [Patient 1], you're going to get back to the gym. [Patient 2], you're going to talk to [Name] about how important it is to you. [Patient 3], you're a 7 out of 10 on how important you think this is, and 9 out of 10 on how confident you are about getting there. That's really important!"

[Patient 1] tells her that it's really important. "What might get in the way?" she asks. He replies, "Family." [I am thinking this is motivational interviewing done very well. Smooth.] It comes out that he is retired and has daughters that ask him frequently for favors and rides that take up a lot of time. This is who he was supposed to talk to about the importance of exercise. The group leader raises her hand and he stops talking again.… She asks a clarifying question. She then turns to [Patient 3], and asks him if he has any suggestions for [Patient 1]. "Yes," he says, "it sounds like he is on the right track and has a good plan. He just needs to follow through."

MANAGEMENT OF GROUP

Group facilitators/leaders manage the dynamics of the group visit and are able to balance individual and group needs.

Field notes

In the following observation, a BHC leads a diabetes monthly maintenance group.

Patient #3 tells the group he's tired. He thinks it is the anxiety medication he's taking that makes him tired, but if he doesn't take it he "freaks out." Patient #2 asks, "What are you taking?" Patient #3 stumbles over the med name. He doesn't know how to say it. Patient #3: "Sero …sera …" [This is an antipsychotic he is trying to name, Seroquel. I think it is very artful that the BHC doesn't try to finish the medication name for him—he might not realize it's an antipsychotic and may or may not want the group to know he's on that particular medication.] The BHC moves on and asks, "How's your diabetes?" Patient #3 says jokingly, "Not as good as #2 over here!" But his A1c did recently go from 10 down to 8. Patient #2 gives him words of encouragement. "Oh, I was like that too. Mine was 12 when I started!"

CONNECTING PATIENTS TO RESOURCES

Group facilitators/leaders identify patients' needs and connect patients to appropriate resources.

Field notes

She says that she is the BHC a lot for smoking cessation. The first group is about midway through, and she is getting positive feedback. If a patient in her group is depressed or suicidal she gets another BHC, and that BHC helps the patient or helps coordinate the patient's mental health care.

Field notes

She tells me about a success story patient that she's been working with—a woman who had been going to the IOP [intensive outpatient] substance abuse group here during the early part of her pregnancy. One day she came into the group smelling strongly of alcohol, "like she'd sprayed herself down with alcohol." The IOP facilitator called her and let her know what was going on. The case manager went down and got her out of the group, and did a brief intervention—she really thinks this patient was "trying to get caught." She found her another IOP in town that was more intense, every day, 4 hours, and since then this patient has been clean and doing well—she delivered 6 weeks ago, and she's on track to get custody back of her baby who has been living with relatives. She's been clean for 2 months. The case manager tells me how proud she is of this woman, but she also can't help but worry every time she thinks about her that she's going to relapse.

UPDATING THE CARE TEAM

Group facilitators/leaders communicate with the patient's care team regarding actions/outcomes of group participation. This updating can be done in a variety of ways, including communicating through the EHR.

Field notes

She pulls up the EHR and shows me a few of its features. She says if there's something another provider or staff member wants her to see, then they can do a flag. For example, the patient she was just on the phone with, the dietician flagged her about the patient's mood. He had been in a weight-loss class and thought this was a concern. The BHC had actually seen the patient a year ago and remembered him—he has chronic pain and uses a lot of the [Organization] resources well. She notes that they have access to a lot of resources—physical therapy, providers, medication reconciliation, and various classes (pain, sleep hygiene, CBT, etc.). She says that the pain groups are to help patients get the best out of life even with pain, rather than to get rid of it. She says the interesting thing about this patient is that he has good coping skills—he goes to the gym here, he uses the senior center, he's active. However, now he said at the class he wants to "get rid of the pain." She wants to get him back in to see what could help now.

3.3.3.3 Professional Practices of Behavioral Health Clinicians

BUILDING RAPPORT

After introducing himself or herself, the BHC builds rapport and connection to the patient and the primary care team.

Field notes

The BHC introduces himself to the patient: "I work with [Doctor]. I am part of your health care team. My job is in counseling and social work. He mentioned to me that he wanted me to talk to you about how you've been feeling lately." The patient starts crying. She has a cup with a straw with her that she is trying to drink out of to help her calm herself and stop her tears. It takes her a while. The BHC hands her a tissue. She ends up using several tissues.

Field notes

She introduces her role: "I'm a member of your primary care team, an integrated member, just like the dietician or the RN, or the pharmacist. I'm a licensed clinical psychologist, and I'm here because your doctor had some concerns about how you were doing." She pauses for a second. "I understand that you've just been given a pretty difficult medical diagnosis?"

CONNECTING PATIENTS TO RESOURCES

The BHC negotiates treatment for patients among different providers and resources within the health system and the community. The BHC has professional connections to people in the community, including substance use counselors, traditional therapists, and psychiatrists.

Field notes

The BHC checks in with the patient about chemical dependency treatment. The BHC tells him that Medicare won't cover the MICD [mental illness and chemical dependency], but there are some other choices. He could just do a 3-hour day session that focuses on his depression and anxiety, or he could get treatment at the VA. The patient says he has an appointment at the VA at 2:30.

BHC: You sound really ready for that. I'm so glad you're going to the VA, and I'd like to follow up with you about that.

Patient: I have an appointment here on 10/2, but I should find something out from the VA today.

The patient goes on a tangent about being interested in doing some volunteer work, and the BHC recommends the social worker as someone who could give him some ideas on places to volunteer.

Patient: Anything that takes the focus off me and the trouble I'm going through. Every night I go to bed, and I'm thankful I made it through this day.

BHC: I hear that you're getting close, but things numb you up and alcohol is one of them. I want to see that we follow up in a week. How do you feel about that?

Patient: Okay, okay.

BHC: And if the VA doesn't work out—we have options. One is medication. One is treatment at [Organization]. We'll look into something if they can't get you in quickly.

The BHC tells the patient to make an appointment with him at the front desk in one week and tells him he'll talk to him soon. He walks the patient toward the waiting room and goes back to his desk. He tells me that he'll probably just set up a phone appointment to call the patient later this week to check in about the VA. That appointment at the VA is very important, and he wants to make sure that the patient gets the help he needs.

HELPING PATIENTS GET ACCESS TO SPECIALTY CARE

The BHC supports patients who are waiting for access to specialty mental health services (outside the primary care clinic/service area). The BHC does this in a way that reinforces the patient's understanding that specialty mental health care is the appropriate path, while noting that the BHC is providing interim support.

Field notes

The BHC begins by asking how things are going. They discuss the approaching summer, current medications, the couple's anticipated move to a new housing situation, and an approaching vacation.

BHC: That's great—really something to look forward to. So the last time we talked, we discussed marriage counseling. What's going on with that?

Patient: Well, behavioral health said there would be a 3-month wait to get in, so nothing.

BHC: Well, there are a couple of things you can do. Do either of you have private insurance?

Patient: My husband's will kick on in July.

BHC: That's one way you can access marital counseling. You also should continue to call behavioral health and follow up. Let them know you are still interested. You can also do couples counseling here with either myself or one of my coworkers. We could do a few sessions before you are able to get into behavioral health. Would you be interested in that?

Patient: Yes, but with my husband's schedule it's so hard to schedule things. [BHC later tells me her husband is a longshoreman who drives to the coast to unload freight and cruise ships.]

ONGOING COMMUNICATION WITH PATIENTS

The BHC maintains communication with patients regarding the potential use of behavioral health services (e.g., by phone or by dropping by during primary care appointments), including communication with patients who may not be ready yet to engage in BHC treatment.

Field notes

The BHC calls one more patient. This is a 60-year-old male who is alcohol dependent. He doesn't drink during the week, but he'll drink for 10 hours Saturday and 10 hours Sunday. He then spends the whole week recovering. She talked with him last week, and he was going to try to go to AA meetings on Friday and Saturday. The BHC notes that this guy has a brother who is in recovery. However, the patient doesn't want to talk to him because the brother is younger. He doesn't want to ask him for help. When the BHC calls no one picks up, so she leaves a message. She plans to follow this patient from primary care, as he refuses to go to specialty mental health. It's a great idea for this patient, but she wants to follow him until he agrees to go.

CLARIFICATION OF ROLE

Through action and communication, the BHC differentiates between the work done by the BHC and the primary care physician or other team members, while reinforcing how members of the care team work together to integrate the patient's care.

Field notes

The patient reports that her husband is sleeping all day and night. This is stressful. She thinks this is because he has a cyst in his brain. It is frustrating that they're not going to do anything about it. He also has a mass near his pancreas. The blood work, the patient reports, says that it's cancer. "I'm hoping that they caught it early enough to take it out and that's that." The BHC says, "We can't talk to your husband. I'm not a medical person, and I can't talk to those issues. I want to make sure that we're doing what we can to support you. What can we do now that would be beneficial for you?"

ADJUSTMENT OF CARE

The BHC adjusts treatment quickly in response to new or acute issues (e.g., suicidal ideation, sudden loss or grief, extreme situational distress), develops a safety plan if needed, and connects patients with additional resources when needed.

Field notes

The BHC looks in the EHR. She tells me that she looks at the consult request from the doctor. … She is scanning it and says aloud: bipolar, anxiety, recently widowed suddenly. She walks to the waiting area and brings the patient back. The BHC explains to this patient that she got a referral from her doctor. She explains that she will do an intake and try to figure out what's going on. She runs through the same questions in the same order that she did with the previous patient, at least the first one about physical pain and the PHQ-9. The patient does have physical pain—sciatica. She is going to acupuncture for the first time today. The BHC says everyone has a different experience with this, but tells her that's good. She does the PHQ-9 and the patient has a high score. She also indicates that she has been thinking about suicide. This changes the focus of the visit. Now she does a suicide assessment.

AGENDA SETTING

During time-limited patient visits, the BHC rapidly develops treatment plans that help patients identify problems and set goals, and concisely brings the relevant information into the picture.

Interview with behavioral health clinician

Q What about for other aspects of integrated care, not just the health record? Are there other clinical skills you're helping people develop?

A Yeah. We'll select short-term therapies like problem-solving therapy, motivational interviewing. I was helping them when they're with the person to do something in the moment that can help, like even behavioral activation. Those are all things that help get to the next step in their care and improve their outcomes.

COMMUNICATING THE AGENDA

The BHC negotiates and communicates a visit agenda that meets the patient's needs for behavioral health care in the context of the patient's overall care.

Field notes

After the quick signature of the form, the BHC said that she had heard the patient had been coping with depression. She says, "Can we talk about that? When did you first start to feel depressed?" The patient said that in the 90s she lost a lot of people, all in a span of about 2 years. (She lists about six people including her parents and her husband). All were surprises. It was quite a startling list. She says that's when she first had her attack. She describes a panic attack when she was driving and began to feel like she was going to drive across the median into oncoming traffic. The story started to be very vivid, about how she felt and how she pulled the car over. At that point the BHC cuts her off with a reflection. "You lost a lot of people who were very close. The patient says, "Yes," and then says, "I'm doing better now. I don't have the attacks so much." The patient says she prays a lot and that helps.

CONCLUDING VISITS

The BHC communicates the closing of brief counseling visits by offering a summary of the visit and next steps (e.g., reviewing and reinforcing the patient's care plan).

Field notes

At the end of the visit, the BHC checks on suicidal and homicidal ideation. Both are negative. Then she asks about alcohol and drugs. The patient says no drugs. She is not a regular drinker, but "I do like my wine from time to time." Last time she drank anything was 2 months ago and she has no parties on the horizon. The BHC says that she would like to continue to meet with her for now. Could she book her for a visit when she comes again to see her doctor? The patient is happy with that arrangement. We leave the room. The BHC reports to [Doctor] that she thinks this lady probably will not need medication, but that she wants to keep meeting with her. The doctor is happy about this.

Interview with behavioral health clinician

"As I am wrapping up my sessions with a patient, with even that initial consult, the last thing we're doing is making a treatment plan. And oftentimes when I'm describing and setting my schema for my contact with a patient, I'll say, 'I want to work with you and [Doctor] to make a plan to get you feeling better.'

So I will talk with the patient initially about their motivation to change, how motivated are they, how confident are they in their ability to do that. Once I get an idea of where that is, the patient and I may engage in some initial goal setting, some initial planning. Then I'm going to step out and talk with the primary care provider before we finalize that plan. A lot of times what that entails is giving some more information to the primary care provider about what my assessment and my thinking about the plan is, and then seeing what the primary care provider's plan is for the patient."

REFRAMING LIFE EVENTS

The BHC teaches patients the skills to reframe how they think about key life events (e.g., ability to turn negative thoughts into positive achievements).

Field notes

The BHC says, "So what do you do to take care of yourself?" The response was in a totally different voice, a tiny little girl voice, "Nothing." The BHC says she knows that the patient likes puzzles. [This reflects some good PCP/BHC or good EHR communication.] "What else do you like?" The patient says she likes to get outside, especially to go fishing. The BHC encourages walking (can't, bad feet) and just getting out (can't, doesn't like the cold). The BHC then goes back to the question of what can she do for herself. Again the little girl's voice says, "I can't think of anything." She says she needs to take care of her husband and her autistic grandson. The BHC says, "We need to work on finding something you can do for yourself, something you enjoy. It doesn't need to be something big. Just some way to take a few minutes." She mentions the fact that the patient came today as an indication that either they can be left alone or that she can get coverage, though the patient doesn't respond. The patient is crying. She says, "I am crying because I am happy. You are listening to me. You care about what happens to me, even though I just met you." The BHC says that she will teach the woman something that will help with her worry and offers the breathing technique that she taught before. The BHC and the woman go through a couple of repetitions.

Field notes

BHC: Well it sounds like you have some things to look forward to. Your kids are coming, you're friendly with your ex-wife, more physical therapy for your leg. I think you're an excellent candidate for treatment now. You're using tools you've learned previously, and I think you're in a good place. You're tired of this, even though you've hit a couple of bumps.

Patient: I've been really pissed off lately. I'm mad I can't walk anymore.

BHC: It's not the end of the road.

4 Conclusion

Health care continues to transform in ways that are increasingly team-based and patient-centered. Primary care, as the front line of much of this care delivery, has a history of seeing more behavioral health conditions than are seen in any other setting. Integrating behavioral health providers into primary care is a promising solution to better addressing some of these often unmet needs. However, for primary care organizations to know how to succeed at integration, there needs to be a practice-based set of professional practices to follow. That is what we have aimed to identify in this project.

This project is different from other integration competencies efforts in that it started with the end in mind. Our team started with primary care organizations that had demonstrated a high quality of integration; many of these primary care organizations were pioneers in the area and had been integrating care for many years. We spent several days at these practices observing what they do to integrate care for patients. We used rigorous qualitative methods—observation, interview, and document collection—to learn how care can be integrated in primary care organizations. The result is this guidebook; a thorough and comprehensive overview of the professional practices we observed in organizational leaders that create and structure an organization that delivers integrated care, and the professional practices of clinical team members that integrate care for the population of patients they serve. The supporting data we provide come directly from our observations and interviews with the people working in these settings, and may be useful to others aiming to develop high-quality integrated care delivery.

Without a comprehensive understanding of the professional practices that are at the foundation of integrated care, primary care organizations may attempt to integrate, but not know how to organize or re-organize their operations. With this guidebook, organizations and their members can work toward achieving a level of integrated care seen in some of the best primary care organizations in the country.

4.1 Limitations

There are limitations to this project. First, we often get the best of a primary care organization when providers and staff are aware that they are being observed. We mitigated this problem by spending several days in an organization and doing our best to blend in. Primary care organization members understood that we were there to learn from them, rather than to evaluate, and we were able to immerse ourselves in regular clinic work. Second, organization selection began with a list of known integrated primary care practices generated with assistance from our expert panel. While our expert panel members possess diverse connections through their professional networks, it is possible that other practices meeting our exemplary criteria were not included in our initial list. The criteria we employed for identifying an integrated care exemplar, while vetted through this expert panel, may not have been comprehensive, and some specific criteria may have been left off. Nonetheless, even with the criteria we used, it was challenging to find primary care organizations that met these criteria. Additionally, for our state-focused site visits (Maine and California), we relaxed the inclusion criteria and selected the best primary care organizations in the State. Third, primary care organizations are constantly in a state of change and trajectory of improvement; all of the practices we observed had new ideas that they planned to implement to improve their care model. Our observations are a snapshot of one moment in time when primary care organizations may have been at their best (or worst). Additionally, we recognize that all organizations have a growth trajectory, and in some cases, it has taken years for the sites we visited to achieve their current level of integration. This guidebook does not describe how these primary care organizations got to where they are today.

4 Conclusion

4.2 Implications

From a practical perspective, this guidebook and these data can provide a useful direction for those interested in integrating behavioral health and primary care. Each professional practice described here can be seen as a practice activity or action, and a potential milestone for primary care organizations to work toward in their goal to achieve high-quality and effective integrated care. This guidebook demonstrates the breadth of professional practices at an organization and individual level needed for integrated care delivery.

Policymakers may find this guidebook useful to identify pragmatic, practice-based benchmarks that can be used to assess integrated care in primary care organizations. These practices could be linked to incentives or other forms or payment reform as they provide a solid set of standards and practice for integrated care.

With such rich data, many interesting research questions emerge from this work. Areas for exploration include, but are not limited to, examining how communication among professionals and patients differs in integrated settings and non-integrated settings, how the professional practices we identified are connected to clinical outcomes, and how these practices can be best implemented and then disseminated to primary care organizations motivated to integrate care for the patients they serve.

4.3 Additional Agency for Healthcare Research and Quality Resources

AHRQ has supported the development of other integrated care products to which this work is connected. The AHRQ Lexicon for Behavioral Health and Primary Care Integration was used as our conceptual framework and underlying definition for how we defined integrated behavioral health and primary care, and how we created our selection criteria, and also how we made sense of some of our observations and findings during the analysis process. For more information on the Lexicon, see http://integrationacademy.ahrq.gov/lexicon.

Another useful resource is the Atlas of Integrated Behavioral Health Care Quality Measures (the IBHC Measures Atlas) that supports the field of integrated health care measurement by presenting a framework for understanding measurement of integrated care; providing a list of existing measures relevant to integrated behavioral health care; and organizing the measures by the framework and user goals to facilitate selection of measures. In developing the IBHC Measures Atlas, the Lexicon for Behavioral Health and Primary Care Integration was used to inform the Integration Framework, which is a main feature of the IBHC Measures Atlas. Primary care organizations attempting to work toward higher-quality integration or achieve the practices outlined in this guidebook can use tools in the IBHC Measures Atlas to evaluate their efforts. For more information on the IBHC Measures Atlas, see http://integrationacademy.ahrq.gov/atlas.

In addition to the Lexicon and Measures Atlas, the AHRQ Academy Portal includes other resources, such as a literature repository and webinars, for administrators, clinicians, staff, researchers, policy makers, and others. See http://integrationacademy.ahrq.gov for these resources and more.

5 References

1 Schoen C, Davis K, How SK, Schoenbaum SC. US health system performance: a national scorecard. Health Affairs. 2006;25(6):w457-w75.

2 Dougherty D, Conway PH. The "3T's" road map to transform US health care. JAMA. 2008;299(19):2319-21.

3 Kellermann A, Vaiana M, Hussey P, Chari R, Lowsky D, Mulcahy A. Flattening the trajectory of health care spending: Insights from RAND Health Research. 2012.

4 Unützer J, Katon WJ, Fan M-Y, Schoenbaum MC, Lin EH, Della Penna RD, et al. Long-term cost effects of collaborative care for late-life depression. Am J Manag Care. 2008;14(2):95-100.

5 Kroenke K, Taylor-Vaisey A, Dietrich AJ, Oxman TE. Interventions to improve provider diagnosis and treatment of mental disorders in primary care: A critical review of the literature. Psychosomatics: J Consultation Liaison Psychiatry. 2000;41(1):39-52.

6 Bauer AM, Azzone V, Goldman HH, Alexander L, Unutzer J, Coleman-Beattie B, et al. Implementation of collaborative depression management at community-based primary care clinics: An evaluation. Psychiatric Services. 2011;62(9):1047-53.

7 Primary Care:America's Health in a New Era. Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, editors: The National Academies Press; 1996.

8 Peek CJ, the National Integration Academy Council. Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, (MD): Agency for Healthcare Research and Quality, 2013.

9 Edmondson AC. Teamwork on the fly. Harv Bus Rev. 2012;90(4).

10 Edmondson AC. Teaming how organizations learn, innovate, and compete in the knowledge economy. San Francisco: Jossey-Bass; 2012.

11 Edmondson AC. Psychological Safety, Trust and Learning: A Group-level Lens. In: Cook KS, Kramer RM, eds. Trust and Distrust in Organizations: Dilemmas and Approaches. New York: Russell Sage Foundation; 2004. p. 239–72.

12 Mulder M, Weigel T, Collins K. The Concept of Competence in the Development of Vocational Education and Training in Selected EU Member States: A Critical Analysis. J Vocational Education and Training. 2007;59(1):67-88.

13 Norris N. The trouble with competence. Cambridge J Education. 1991;21(3):331-41.

14 Bohmer RM, Edmundson, AC.. Organizational learning in health care. Health Forum J. 2001;44(2):32-5.

Appendix A Expert Panel Members

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Jürgen Unützer, M.D., University of Washington

The project team and Expert Panel held monthly conference calls to provide feedback on data collection tools, refine site selection strategy, and advise on sites chosen. Additionally, Dr. Blount joined the research team on a site visit. Drs. Boober, Kathol, Khatri, Korsen, Linkins, and Peek debriefed with the research team during site visits. Drs. Blount, Khatri, Korsen, and Peek provided input during the data analysis and writing process.

Appendix B Exemplary Practice Screening Sheet

The Academy
Integrating Behavioral Health and Primary Care

Practice:

Date: **Time:**

Operational Definition of Exemplar

An integrated practice is considered to be an "exemplar" if it meets the criteria in the list below.

We are going to read you a list of statements about integrated practices. Please answer yes or no if your practice has or does the following:

1 Behavioral health professionals are onsite.

☐ Yes ☐ No ☐ Don't know

2 Behavioral health professionals are "integrated," in that they work, communicate, and collaborate with other providers in the clinic in the delivery of patient care.

☐ Yes ☐ No ☐ Don't know

3 The practice has not taken a financial loss in the last year. In other words, the practice is financially solvent.

☐ Yes ☐ No ☐ Don't know

4 The practice consistently identifies/screens patients who have mental and behavioral health needs. Here, consistently means that there is a standard protocol and clear routine for doing this for all patients that the practice determines need screening.

☐ Yes ☐ No ☐ Don't know

5 The practice consistently monitors progress for patients who have screened positive for mental and behavioral health needs. Here, consistently means that there is a standard protocol and clear routine for doing this. In this case, there may be a "tool" (e.g., patient registry) and a person who manages that registry.

☐ Yes ☐ No ☐ Don't know

6 The practice has a standard approach to using the data that it collects through screening and monitoring to reflect on how it is doing with care delivery, and make improvements and adjustments on an ongoing basis, as needed. Thus, there is the leadership in place to support this process, and the engagement of practice members in ongoing learning and quality improvement.

☐ Yes ☐ No ☐ Don't know

6a If the practice regularly looks at data reports for quality improvement purposes, ask practices to describe what reports they use and if they could provide an example of the reports.

☐ Yes ☐ No ☐ Don't know

Appendix B Exemplary Practice Screening Sheet

7 Good patient outcomes are defined as:

7a Among the patients with a behavioral health issue identified, and when referral is appropriate, there is a high rate of engagement in services.

☐ Yes ☐ No ☐ Don't know

7b Among patients who are engaged, patients usually go to the first visit.

☐ Yes ☐ No ☐ Don't know

7c Among patients who are referred to a behavioral health professional, there is improvement in symptoms.

☐ Yes ☐ No ☐ Don't know

7d In addition, among those not referred, there is ongoing monitoring for improvement, or subsequent offer of treatment (i.e., referral).

☐ Yes ☐ No ☐ Don't know

8 The practice has a written workflow description or practice manual that clearly states the practice's mission, primary workflow tasks, training processes, program evaluation plan, etc.

☐ Yes ☐ No ☐ Don't know

Practice Selection Criteria

Geography

☐ Rural ☐ Urban

Predominate Payment Type

☐ Public ☐ Private

Practice Size

☐ Small ☐ Medium ☐ Large

Type of Patients

☐ FQHC ☐ Academic ☐ Independent

Practice Selection Criteria

Name of Practice:

Contact Person:

Contact Information:

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