The Building Blocks of Behavioral Health Integration
Care Delivery Expectations Assessment

Practice name: _____

Names and roles of people completing assessment: _____

Behavioral health integration is the care that results from a practice team of primary care and behavioral health clinicians, 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 and 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.

Instructions: This assessment is meant to help us gain a better understanding of the work that your practice is doing related to behavioral health integration and to help you and your practice facilitator in planning your work. **Please score your practice on a scale of 1-4 (1 = Not Started, 2 = Just Beginning, 3 = Actively Addressing, 4 = Completed).** Please do not spend more than 30-45 minutes completing this assessment and feel comfortable responding with your best estimate. We will be collecting answers to these assessment questions now and at regular intervals across the project to gauge progress over time and to plan for future work.

Foundational Care Delivery Expectations

These care delivery expectations are foundational for any practice integrating behavioral health. They include identifying patients who will benefit from services, providing and/or linking them to care, ensuring follow up, and monitoring measures at the practice level.

Leadership	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.1. Practice has defined vision related to meeting behavioral health needs.				
1.2. Practice has a defined behavioral health champion or team. (A behavioral health champion is someone in the practice with the capacity and interest to help lead behavioral health-related initiatives).				
1.3. Practice has a budget with allocated resources for work related to behavioral health, including behavioral health professional(s) if part of the care team, that incorporates planning for sustainability of services.				
Data Driven Quality Improvement	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.4. Practice, including any behavioral health professionals, meets regularly (minimum monthly) to review data and processes for quality improvement, including those related to behavioral health efforts.				
1.5. Practice reviews data disaggregated by subpopulations (such as race, ethnicity, sexual orientation, and gender identity) to identify and address disparities.				

1.6. Practice collects measures specific to behavioral health efforts and tracks performance relative to targets, including outcomes with validated measures (such as the PHQ-9, GAD-7, Edinburgh maternal depression scale). In practices caring for children, this includes developmental screening.				
1.7. Measures from 1.6 include tracking proportion of target population screened.				
1.8 Measures from 1.6 include tracking proportion of positive screens that are addressed.				
1.9 Practice collects holistic patient-reported measures of experience of care and/or patient-reported functioning or quality of life.				
Team-Based Care	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.10. Practice has clearly defined roles, responsibilities, and workflows related to behavioral health services.				
1.11. Practice incorporates behavioral health training into onboarding and ongoing professional development efforts, including for primary care providers and all clinic staff.				
Patient and Family Engagement	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.12. Practice educates patients and family members/caregivers on availability of behavioral health services, including substance use disorder services.				
1.13. Practice obtains feedback from patients and/or family members/caregivers on behavioral health services. Feedback may be obtained through patient experience surveys, Patient and Family Advisory Councils (PFACs), or focus groups.				
1.14. Practice takes steps to ensure those providing feedback reflect the diversity of the practice population.				
1.15. Practice routinely provides self-management support and/or incorporates principles of shared decision making for patients with behavioral health issues.				
Population Management	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.16. Practice identifies patients who need or would benefit from behavioral health services, including: a) universal screening for at least one priority mental health condition. b) one priority substance use condition c) one lifestyle behavior				

1.17. Practice ensures positive screens are offered treatment within the practice or referred to appropriate services outside of the practice.				
1.18. Practice reassesses symptoms, side effects, complications, and treatment adherence at regular intervals and utilizes evidence-based stepped care guidelines in adjusting treatment plans if patients are not improving as expected.				
Access	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.19. The practice ensures physical spaces and services are accessible and responsive to patients' and families' disability status, sexual orientation, gender identity, racial and ethnic backgrounds, cultural health beliefs and practices, preferred languages, and health literacy.				
1.20. Patients can receive behavioral health services by either audio-only or audio-visual telehealth.				
1.21. Patients can communicate asynchronously with providers.				
Comprehensiveness and Care Coordination	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.22. The primary care provider diagnoses and offers medication management for mild to moderate behavioral health conditions and links patients to therapy and/or specialty mental health settings as indicated.				
1.23. Practice has referral pathways for patients with behavioral health conditions, including potential referral sources for populations with specific needs (e.g. LGBTQIA+ friendly).				
1.24. Practice ensures primary referral sources have appointment availability and are accepting new patients.				
1.25. Practice tracks proportion of behavioral health referrals where patients successfully complete an initial appointment.				
1.26. Practice provides crisis resources and referrals as indicated.				
1.27. In practices that care for children, the practice has developed protocols for care transitions to adult behavioral health services.				

Additional Care Expectations by Selected Components of Behavioral Health Integration (BHI)

Any or all of these approaches may be selected by a practice as an area of focus for their BHI work. For each of these areas, please indicate whether it is an area of focus for your upcoming work on BHI. Please then assess your current level of implementation of the various care expectations whether or not it is an area of focus.

Advanced Coordination and Care Management

Practices develop shared expectations and exchange information with behavioral health providers, manage a registry of patients with target behavioral health condition(s), and screen for social needs and link patients and families to services.

Is this an area of focus for your upcoming work?

- Yes
- No

	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
2.1. Practice tracks rates of follow up after behavioral health related emergency department visits or hospitalizations.				
2.2. Practice has roles, responsibilities and workflows related to registry management, communication, and shared care plans.				
2.3. Practice maintains a registry of patients with target behavioral health condition(s).				
2.4. Practice conducts proactive outreach to reassess symptoms and ensure follow-up for patients that are not improving.				
2.5. Practice risk-stratification processes incorporate behavioral health diagnoses.				
2.6. Practice risk-stratification processes incorporate health-related social needs.				
2.7. Practice provides brief interventions (such as problem-solving treatment) in parallel with population health management.				
2.8. Practice contacts patients within 3 business days after behavioral health-related emergency department visit or hospitalization.				
2.9. Behavioral health care management is documented in a shared EHR or other mechanism to share care plans and patient information.				
2.10. Practice has care compact or other collaborative agreement in place with at least one behavioral health group or practice which covers timely access, communication, and coordination of services.				
2.11. Practice routinely assesses patients for social needs and links them (or offers links) to appropriate community resources, including those that support behavioral health and wellness.				

2.12. Practice partners with at least one community organization or local agency (e.g. social services providers, schools, child welfare) to improve bidirectional communication regarding patient population needs.				

Integrated Behavioral Health Professional

An integrated behavioral health professional (which could be a psychologist, licensed clinical social worker or other licensed professional) works as part of the primary care team. They provide in-house counseling, diagnostic support, crisis management, and behavior change support in partnership with the primary care provider. Services can be provided in person or via telehealth. For smaller, independent and/or rural practices, a behavioral health professional may be shared across practice sites.

Is this an area of focus for your upcoming work?

- Yes
- No

	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
3.1. Practice tracks adequacy of FTE and availability of appointments with integrated behavioral health provider.				
3.2. In addition to defined roles and responsibilities, practice has a planned approach to communication and development of shared care plans.				
3.3. The behavioral health provider shares integrated workspace within the practice if providing in-person services.				
3.4. Schedules for behavioral health providers allow for warm handoffs and real-time consultations in addition to appointments.				
3.5. Integrated behavioral health providers support and participate in educational efforts for primary care providers and clinic staff.				
3.6. Behavioral health providers deliver therapy, diagnostic support, crisis management, and behavioral change management support for any patient in the practice.				
3.7. Behavioral health and primary care providers use a shared EHR or other mechanism to document shared care plans and patient information.				
3.8. Shared care plans include patient goals, treatment plans, and relapse prevention plans, where relevant.				

Psychiatry

A psychiatrist supports complex diagnostic evaluation and medication management, providing consultation to the primary care provider. They may provide direct patient care either in person or via telehealth.

Is this an area of focus for your upcoming work?

- Yes
- No

	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
4.1. Practice tracks adequate FTE and availability of consultation with psychiatrist.				
4.2. In addition to defined roles and responsibilities, practice develops planned approach to communication (delineation of asynchronous vs real time communication) and shared care plans.				
4.3. If providing on-site or telepsychiatry direct patient services, practice assesses access to behavioral health services for its patients through availability of appointments.				
4.4. Psychiatrists support complex medication management and diagnostic support.				
4.5. If implementing the Collaborative Care Model, the psychiatrist regularly reviews the behavioral health registry and provides recommendations.				
4.6. Psychiatrists and primary care providers use a shared EHR or other mechanism to document shared care plans and patient information.				
4.7. Shared care plans include:				
a.) patient goals				
b.) treatment plans				
c.) relapse prevention plans, where relevant.				

Advanced Care of Substance Use Disorders

The primary care provider prescribes medication for at least tobacco use disorder, alcohol use disorder, and opiate use disorder. Counseling related to substance use disorders is provided in the practice or coordinated with resources outside of the practice.

Is this an area of focus for your upcoming work?

- Yes
- No

	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
5.1. Practice tracks outcomes related to patient initiation and engagement in substance use disorder treatment.				
5.2. Practice follows up after substance use disorder-related hospitalizations.				

5.3. Practice assesses access to substance use treatment services through availability of appointments.				
5.4. Practice provides medication management for tobacco use disorder, opioid use disorder, and alcohol use disorder, which may include outpatient management of alcohol withdrawal.				
5.5. Practice provides or refers patients to substance use disorder counseling.				
5.6. Practice provides resources on peer support groups.				