

## Principles and tasks for patient-centered integrated behavioral health care.

### Principles of care:

#### 1. **Patient centered collaborative care.**

Primary care and behavioral health providers collaborate closely. Patients have one problem list, one medication list, and one care plan that is shared by all providers including behavioral health providers.

#### 2. **Population-based care:** keep patients from ‘falling through the cracks’.

All patients with identified behavioral health needs such as depression or anxiety disorders are tracked in a registry to prevent patients from ‘falling through the cracks’. Providers and practices proactively track clients and reach out to patients who are not following-up.

#### 3. **Measurement-based practice and treatment to target:** provide care that works.

Each client’s treatment plan clearly articulates measurable goals that may include ‘personal goals’ and measurable clinical outcome goals related to the primary behavioral health problems that interfere with patients reaching their personal goals (e.g., a PHQ-9 depression score if the primary behavioral health problem being treated is depression). Providers routinely assess treatment progress using the appropriate clinical outcome measures (e.g., a PHQ-9) and if patients are not improving as expected, they obtain mental health specialty consultation and adjust treatments as clinically indicated.

#### 4. **Pay for performance:** pay for value, not volume.

Payment for behavioral health care should move the delivery system towards a model that pays for value (measurable quality of care, clinical outcomes, and patient satisfaction), not just the volume of care provided. Providers should demonstrate that patients are either reaching the desired clinical outcomes or obtain mental health specialty consultation and change treatments as clinically indicated if patients are not reaching the desired outcomes.

### Specific tasks:

Effective integrated care programs have core components such as patient identification and engagement, patient education and self management support, medication management and psychotherapy as clinically indicated, care coordination and management, standardized and systematic follow-up, measurement-based stepped care, and effective consultation and supervision for patients who are not improving as expected. Members of an integrated care

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team effectively and systematically 'share' a set of specific 'tasks' related to these core components. The AIMS Center Integrated Care Team Building Tool can help organizations build clinical workflows that 'fit' their unique setting and populations. Basic 'tasks' include the following:

## 1. Patient Identification and Diagnosis

- a. Screen for behavioral health problems using valid instruments
- b. Perform behavioral health assessment
- c. Diagnose behavioral health problems and related problems

## 2. Treatment Engagement and Initiation

- a. Engage patients in integrated care program
- b. Initiate patient tracking in population registry
- c. Develop and update care / treatment plan
- d. Patient education about symptoms and treatment options
- e. Prescribe medications
- f. Patient education about medications and side effects
- g. Provide brief counseling (e.g., MI, BA)
- h. Provide evidence-based psychotherapy (e.g., PST, CBT, IPT)

## 3. Follow-up and Treatment Adjustment

- a. Systematically follow patients and
  - i. track treatment response with valid outcome measures
  - ii. track side effects and treatment complications
- b. Proactively reach out to patients who don't follow-up
- c. Initiate and support treatment adjustments as clinically indicated

## 4. Communication and care coordination: coordinate communication among providers and consult with other team members about patient progress

## 5. Systematic case review and psychiatric consultation

- a. Facilitate and participate in regular (e.g., weekly) psychiatric case review and consultation for patients who are not improving (see b)
- b. Provide regular review of patients who are not improving and provide specific recommendations for additional work-up and treatments including medication changes as clinically indicated to the patient's primary care provider (PCP)
- c. Provide in-person specialty mental health assessments and treatment for challenging patients

## 6. Referrals: facilitate, coordinate, and track referral to social services or specialty care

## 7. Relapse prevention: create and support a relapse prevention plan

## 8. Administrative support: provide administrative support and supervision for program

## 9. Clinical support: provide clinical support and supervision for program

## 10. Quality improvement: routinely track and examine aggregate provider- and program level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) for ongoing quality improvement.