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The Building Blocks of Behavioral Health Integration

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Table of Contents

Acknowledgements & About the Authors	4
Background	5
Grounding Principles.....	7
Models and Frameworks of Behavioral Health Integration.....	8
Origins and Development.....	14
How to Read and Use this Framework.....	15
Practice Examples	17
Application to Payment Models	19
Accountability	20
Future Directions and Next Steps	21
References.....	22
Appendix A. The Building Blocks of Behavioral Health Integration Framework.....	23

The background of the page features a collage of colorful, three-dimensional geometric shapes, including triangles and polygons in shades of yellow, red, blue, and green. A semi-transparent green rectangular box is centered on the page, containing white text. The text describes a framework for behavioral health integration (BHI) in primary care, focusing on aligning expectations across payers, providers, and patients, and its application in alternative payment models.

This report introduces a framework of care delivery expectations for behavioral health integration (BHI) in primary care, designed to align expectations across payers, providers, and patients. The framework can be used in alternative payment models supporting flexible approaches to implement BHI so that payers know how additional support is being used, providers are able to choose their approach based on patient needs and local resources, and there are standardized care delivery expectations for patients.

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About the Eugene S. Farley, Jr. Health Policy Center

The Farley Health Policy Center develops and translates evidence into policy to advance comprehensive, integrated strategies that improve individual, family, and population health. This work includes providing adaptive, technical, and leadership assistance to state agencies and policy leaders related to system transformation, finance and payment policy, workforce development, community-based prevention and wellbeing, and social policy to advance equity.

About the Practice Innovation Program

The Practice Innovation Program at the University of Colorado Anschutz Medical Campus coordinates the Colorado Health Extension System (CHES), which convenes numerous Practice Transformation Organizations across the state. These organizations deploy Regional Health Connectors (RHCs) in communities and match Practice Facilitators (PFs) and Clinical Health Information Technology Advisors (CHITAs) into practices. Together, Practice Innovation Program at CU and CHES guide learning networks that spread best practices and connect participants to local, state, and national transformation resources.

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Background: Why create building blocks of behavioral health integration?

Integrated behavioral health 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.¹

Primary care and behavioral health are inseparable

The need for the integration of primary care and behavioral health exists for all people during their lives. Consider a middle-aged woman with diabetes who has been under increased stress and has had trouble staying on track with her diet and taking all of her medications; a young man with insomnia; a child having behavioral challenges after moving to a new neighborhood; a young individual with suicidal thoughts; an older man with major depression. All of these patients would benefit from behavioral health services.

Integrating behavioral health and primary care is effective

Receiving behavioral health services in primary care increases follow-up and receipt of such services,² improves coordination between behavioral health and primary care providers, and decreases the stigma of receiving behavioral health care.^{3,4} Integrated behavioral health care improves outcomes⁵⁻⁷ and decreases costs.⁸⁻¹⁰

“This [framework] would systematize and standardize the consistency of mental health being brought up in conjunction with the physical health concerns we have.”

—Patient

Current payment mechanisms limit the expansion of integrated behavioral health

Most primary care practices receive the majority of their payment in the form of fee-for-service (FFS) reimbursement for defined billable codes. For the purposes of integrated behavioral health care, this may include codes for traditional psychotherapy services as well as other codes that have been created for the purposes of integrated care. Despite the addition of some codes for integrated behavioral health services, FFS has been criticized as insufficiently covering the spectrum of integrated behavioral healthcare and for incentivizing increased volume of services. Additionally, separate carve-outs for payment of behavioral health services create barriers to taking care of behavioral health needs in primary care settings.¹¹

The need for the integration of primary care and behavioral health exists for all people during their lives.

Payers want demonstrated accountability to standardized care delivery expectations

Payers of health care services have expressed a need to understand how additional resources for behavioral health integration are being used and to have accountability from practices. The Bipartisan Policy Center report, Tackling America's Mental Health and Addiction Crisis through Primary Care Integration, calls for establishing core, minimum standards essential for integration.¹²

"I think from a payer and policymaker perspective this makes real good sense. They like models like this, not just to know what they are paying for but to understand how it fits together."

—Primary Care Provider

Grounding Principles

Several principles informed the development of this framework:

- Behavioral health and primary care services have both been chronically underfunded and traditionally separated in terms of training, delivery, payment, and administration.
- Practices implement integrated behavioral health using a variety of approaches. The approach may vary depending on the needs of the patient population, resources of the practice, and local workforce availability. Given this variation, there is not a single model of integrated behavioral health that will be the right fit for all practices.
- Different approaches to integrated behavioral health will require different levels of resources, including financial support.
- Integrating behavioral health in primary care is not a small quality improvement project but a transformative undertaking for the entire practice.

“Sometimes organizations who are attempting to implement any type of continuum of integrated care services can get incredibly stuck on the rigidity of the model. And they think that “if I can’t fulfill all of these functions then we can’t do it”. [This] says “Look, these are the basics. This is what you need to do to provide good care. As you are able, as your community requires, as your team requires, here are some other things that you can add on to enhance the care that you provide with every subsequent thing that you add on”.

—Behavioral Health Provider

Models and Frameworks of Behavioral Health Integration

Models of Behavioral Health Integration

For the purposes of this report, we use the term “model” to refer to specific approaches to behavioral health integration that have been defined, such as the Collaborative Care Model and the Primary Care Behavioral Health Model. The term “framework” is applied to an overarching conceptual structure that organizes how practices implement integrated care into domains of milestones or activities.

There is a lack of a framework independent of a particular model of integrated behavioral health care that is designed to allow for flexibility in approach and operationalizing a differential payment structure.

The Collaborative Care Model includes consultation with a psychiatrist, proactive outreach and population management by a behavioral health care manager, and a measurement-guided care plan. The demonstrated effectiveness of the Collaborative Care Model has led to a focus on this model in policy efforts to integrate care. While it is an important approach, it does not reflect the entire breadth of ways integrated behavioral health can and will be implemented in primary care practice. The Primary Care Behavioral Health model incorporates a behavioral health clinician into the primary care team who works as a generalist in providing accessible services for behavioral health problems and biopsychosocially influenced health conditions. Other models of behavioral health integration include integration into specialty care settings and integration of primary care into a behavioral health clinic.

Primary care practices often implement integrated care with a hybrid approach to these models, or with incorporation of some but not all of these components. For example, a practice might hire an integrated behavioral health professional who provides generalist counseling services in line with the Primary Care Behavioral Health model and might also establish a contract for telepsychiatry

services. Another practice might find hiring an integrated behavioral health professional or partnering with a psychiatrist outside of their current resources but choose to improve their coordination with outside behavioral health services and task their care manager with outreach for populations with high priority behavioral health conditions.

Frameworks of Behavioral Health Integration

Other frameworks have been developed for the purpose of assessing practice progress toward delivery of integrated behavioral health care. While these frameworks have other uses, as shown in the following table, their features do not accommodate the variability that exists in real world practices nor permit alignment of payment with such variability. There is a lack of a framework independent of a particular model of integrated behavioral health care that is designed to allow for flexibility in approach and operationalizing a differential payment structure.

Existing frameworks of behavioral health integration: components and limitations

Framework	Description	Limitations
Integrated Practice Assessment Tool (IPAT) ¹³	Includes 6 levels organized into 3 categories (Coordinated, Co-located, and Integrated). Level 1 is minimal collaboration and Level 6 is full collaboration in a transformed practice.	• Suggests a linear progression that is often not reflected in real world implementation. • Implies coordination with outside behavioral health is a precursor to having onsite integrated clinicians rather than a complementary, distinct, but also important component of care.

Continues.

Framework	Description	Limitations
Continuum-based framework for integrated care ¹⁴	Includes 9 key domains of integrated care: case finding, screening, and referral to care; decision support for measurement-based, stepped care; information exchange among providers; ongoing care management; culturally adapted self-management support; multidisciplinary team used to provide care; systematic quality improvement; linkages with community/social services; and sustainability. Organized into a continuum of implementation from preliminary to intermediate to advanced.	The separate levels (preliminary, intermediate, advanced) are presented as progressive steps along a continuum to greater integration; there are not options for implementing different components of behavioral health integration.
Practice Integration Profile V 2.0 ¹⁵	Includes 28 items in 5 domains: workspace and integration methods, patient identification, clinical services, patient engagement, and practice workflow. Includes scoring criteria (for example, proportion of patients with behavioral and medical needs that have a shared treatment plan) and response options to report the percentage of the time each item is completed.	The separate levels (preliminary, intermediate, advanced) are presented as progressive steps along a continuum to greater integration; there are not options for implementing different components of behavioral health integration.

Continues.

Framework	Description	Limitations
National Committee on Quality Assurance (NCQA) Patient Centered Medical Home Behavioral health distinction ¹⁶	Requires meeting all core criteria (plus 2 elective credits): behavioral health care manager, behavioral health clinician in the practice, behavioral health referral expectations and relationship, referral tracking and monitoring, screening, evidence-based decision support for mental health and substance use disorders, monitoring and adjusting treatment plan over time for those not demonstrating improvement, and monitoring behavioral health clinical quality measures.	- While it includes elective options, it has a broad set of core requirements that do not allow for a more selective implementation of certain components of integrated care. - Unclear how to operationalize variable tiers or levels at which practices wish to engage for the purposes of enhanced payment.


Continues.

Framework	Description	Limitations
Comprehensive Healthcare Integration Framework ¹⁷	Includes eight domains: screening, referral and follow up; prevention and treatment of common conditions; continuing care management; self-management support; multidisciplinary teamwork; systematic measurement and quality improvement; linkages with community/social services for social determinants of health; and financial sustainability. Expectations across these domains are separated for three different “constructs” or steps along a continuum: screening and enhanced referral, care management and consultation, and comprehensive treatment and population management.	• The separate constructs are presented as progressive steps along a continuum to greater integration; there are not options for implementing different components of behavioral health integration. • All practices would be required to have a consulting psychiatrist to meet the expectations of the second and third constructs. • Somewhat ambiguous differentiation of care delivery expectations from one construct to another (e.g., from “some” or “common” to “routine” provision of a service).

A New Approach: The Building Blocks of Behavioral Health Integration

The framework introduced in this report differs from existing frameworks and checklists:

1. Components of different approaches to integrated behavioral health are separated so that:
 - Practices can flexibly choose their approach.
 - Levels of financial support can be designed to match the selected approach.
2. The framework is not specific to a certain model of integrated behavioral health.
3. The framework is not particular to a specific behavioral health diagnosis or diagnoses and reflects the wide spectrum of behavioral health services that can be provided in primary care, including for patients without a diagnosable behavioral health condition.
4. A core set of foundational expectations are established to enable primary care practices taking initial steps or for those that have fewer resources to make feasible progress towards improved behavioral health services.
5. Development of the framework has been driven by practice-based evidence and experience and refined through input from key informants of diverse roles and backgrounds.
6. The use of the building blocks as the overall organizing scheme allows for these behavioral health care delivery expectations to be overlaid on other work to advance primary care practice.

“It still boils down to all of these things ... that you have to develop and build on these foundations or it doesn’t work. And it is not just the foundation for behavioral health related work but practice-general transformation work. All of this is needed for the basics of value-based work.”

—Payer

Origins and Development of the Building Blocks of Behavioral Health Integration

This framework was developed through a multi-step process:

1. **Selected a nationally recognized framework.** The building blocks of high performing primary care¹⁷ categorize key components of advanced practice care delivery. These building blocks were chosen by the Colorado Multi-Payer Collaborative as the initial framework for advanced payment models and the Colorado State Innovation Model (SIM) initiative.
2. **Developed behavioral health integration milestones with partners and implemented these milestones in a statewide demonstration project.** The building blocks of high performing primary care were modified by the payers, state leaders of the SIM initiative, and the leaders of the practice transformation support program to incorporate a focus on behavioral health integration. The resulting set of milestones were then vetted through a larger group of partners through the SIM Practice Transformation Working Group and the SIM Advisory Board. Over 300 practices were provided practice facilitation and other support to implement the milestones, and both the internal and external project evaluations indicated that practices were very successful in progressing in the implementation of the milestones.^{18, 19}
3. **Selected milestones from the Colorado SIM project specific to behavioral health integration.** Based upon experiences in the Colorado SIM initiative, milestones used for this project were examined to select the care delivery expectations specific to behavioral health integration that could be overlaid on more general expectations for advancing primary care practice. These items were then divided into foundational and additional components of integrated behavioral health. Additional components of behavioral health integration were selected because they can each exist in isolation or in combination with one another to additively provide more comprehensive behavioral health services and coordination. Separating these components allows practices to select which are within their resources and best for meeting the needs of their patient population.

4. Reviewed other models and frameworks to identify any gaps.

Other frameworks and established definitions used to measure behavioral health integration (NCQA Behavioral Health distinction, Continuum-based framework for integrated care, Integrated Practice Assessment Tool, Practice Integration Profile, Comprehensive Primary Care Plus behavioral health integration menu of options, National Integration Academy Council Lexicon) were reviewed to ensure completeness.

5. Refined the resulting framework through key informant interviews.

Key informant interviews were held to obtain feedback on the adapted care delivery expectations with payers, policy experts, behavioral health and primary care providers, practice transformation experts, and patient advocates or representatives.

How to Read and Use the Building Blocks of Behavioral Health Integration

This framework outlines care delivery expectations for primary care practices seeking to improve the care of behavioral health needs in their patient population. Each practice would be required to meet the foundational care delivery expectations regardless of how the practice otherwise chooses to approach integrated behavioral health. Care delivery expectations for additional integrated behavioral health care components that practices may select from are specified and separately categorized for advanced coordination and care management, integrated behavioral health professional, psychiatry, and advanced care of substance use disorders. These components are color-coded in the right-most column of the table. Of these components, practices may choose any combination to implement.*

* With regard to currently defined models of behavioral health integration, the Collaborative Care Model is reflected in the psychiatry and advanced care coordination and care management components. The Primary Care Behavioral Health model is reflected by the integrated behavioral health professional component.

Component descriptions:

Foundational Care Delivery Expectations: These are requirements 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.

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.

Integrated Behavioral Health Professional (IBHP): 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 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.

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.

Advanced Care of Substance Use Disorders (ACSUD): The primary care provider prescribes medication for substance use disorders including tobacco use disorder, alcohol use disorder, and opioid use disorder. Counseling related to substance use disorders is provided in the practice or coordinated with resources outside of the practice.

See Appendix A for the complete framework.

What would this look like in practice?

Practice A

Description: Small independent primary care practice in the rural Midwest

Identified priority: high rates of substance use disorder

Framework components selected: advanced care of substance use disorders (in addition to the foundational care delivery expectations)

Implementation:

- All patients > 12 years of age are screened for substance use disorders, and those with needs are offered treatment within the practice.
- The practice establishes relationship with local community-based peer support organization for coordinating referrals.

Results: Over time, the practice is pleased to find patients are successfully maintaining engagement in treatment and there are decreased emergency department visits for substance use.



Practice B

Description: Midsize primary care practice in the Pacific Northwest

Identified priority: most patients being referred to behavioral health services are not getting connected to care

Framework components selected: integrated behavioral health professional and advanced coordination and care management (in addition to the foundational care delivery expectations)

Implementation:

- All patients are screened for depression and anxiety, and those with needs are offered treatment with both medication and counseling within the practice. For patients interested in counseling, the primary care provider offers a warm handoff to the behavioral health professional on the same day to engage them in care.



- The integrated behavioral health professional is available for counseling for other needs that do not fit a diagnosis, including support for lifestyle counseling and medication adherence for patients with chronic medical conditions.
- The integrated behavioral health professional maintains a registry of patients with depression and anxiety to track when patients are lost to follow up or not improving.
- The practice establishes a care compact with their local mental health center to develop shared expectations for mutual patients.

Results: Patients express their appreciation of being able to get counseling and medical treatment all at one location. For those patients who are referred to outside behavioral health services, the rate of completed appointments improves.

Practice C

Description: Large urban primary care practice

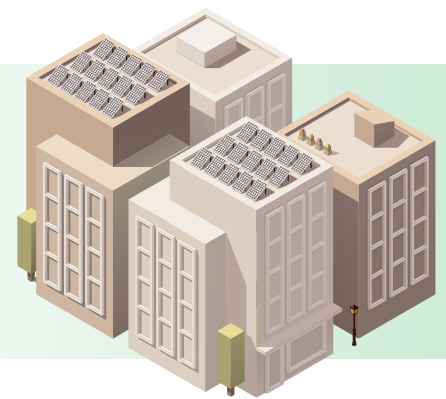
Identified priority: large proportion of patients with serious mental illness as well as medical comorbidities that prefer to receive their care in one place

Framework components selected: psychiatry (in addition to the foundational care delivery expectations)

Implementation:

- The psychiatrist comes to the practice twice a month to provide direct patient care and is available during the rest of the month for electronic consultations on initiating and adjusting psychiatric medications.
- Once a month when the psychiatrist is at the practice, the providers meet together over lunch for a case conference to review particularly challenging cases.

Results: Patients with serious mental illness have improved measures of chronic disease management for medical comorbidities and improved adherence to their psychiatric medications.



How could this be applied to payment models?

Operationalizing integrated behavioral health in primary care requires upfront transformational work. This includes establishing a behavioral health champion and team, determining the practice's mission and vision related to behavioral health, developing a sustainable business model, defining roles, and creating workflows. These activities are crucial before new services can be implemented. Given this, increased investment is required to begin integrating behavioral health and get the work “off the ground” in addition to covering the subsequent ongoing costs.

For this alternative payment approach to be maximally effective for practices, there must be alignment in requirements and payment structures across payers.

Payers should consider a prospective payment (delivered either as a per member per month [PMPM] amount or a calculated annual or quarterly lump sum payment) intended to cover the costs of integrated behavioral health care not entirely reflected in reimbursement for FFS codes. As services would be available to all patients, a PMPM amount would be based on the entire patient population rather than a specific subpopulation. Different patient populations will have variation in extent of behavioral health needs. PMPM amounts should be risk-adjusted to account for such variation; optimal risk adjustment would incorporate physical health and behavioral health diagnoses in addition to social risk factors.

Applied to the building blocks of integrated behavioral health, a potential approach to support a practice seeking to integrate behavioral health care could include an initial lump sum payment to support initial practice transformation followed by a supplemental PMPM tied to successfully meeting care delivery expectations. The support required for each of the components of integrated behavioral health care could be determined separately; for example, a practice seeking to integrate behavioral health by adding telepsychiatry and improving coordination and care management could receive a base PMPM for foundational activities and additional amounts for psychiatry and advanced coordination and care management activities. For this alternative payment approach to be maximally effective for practices, there must be alignment in requirements and payment structures across payers.

If additional primary care services are being covered through a PMPM global payment, this could be combined with the support for behavioral health integration, and FFS reimbursements could be reduced accordingly if appropriate.

Integrated behavioral health in primary care is one key service across a continuum of behavioral health care, particularly relevant for coverage of mild to moderate behavioral health needs. The full continuum of behavioral health care spans prevention and health promotion, outpatient services, residential care, inpatient services, crisis services, and recovery supports. Public health and community-based providers and organizations serve complementary roles to traditional medical and behavioral health care across this continuum.

Short of entirely eliminating carve-outs of payment for behavioral health services, inclusion of coverage of mild to moderate behavioral health needs as part of physical health services can support integration.

How would accountability be determined?

Practices would be assessed in terms of meeting care delivery requirements through attestation; payers could also implement site visits for auditing.

Importantly, several key outcomes are embedded within these care delivery expectations. First, reach of screening and addressing positive screens are included in the foundational expectations. Payers and practices could partner to determine an appropriate target for this measure. Second, expectations around access incorporate availability of services, including for urgent appointments. Reach and access are particularly key outcomes. Evidence suggests that people with behavioral health needs have difficulty accessing care and most are not having those needs addressed in any setting.²⁰ Finally, practices are required to regularly review measures and processes related to their specific integrated behavioral health efforts for quality improvement.

Future Directions and Next Steps

Additional next steps identified to support implementation of the building blocks of behavioral health integration include:

- Creation of an implementation guide or playbook for use in practice transformation support
- Development of recommendations regarding clinical quality metrics and targets
- Research and development of PMPM cost estimates for the different components of integrated behavioral health delineated
- Further piloting and evaluation

In the interviews conducted to refine the framework, key informants shared the building blocks of behavioral health integration would work for them—and added that more important than the particulars of the framework is the need to get started and proceed with operationalizing enhanced payment and practice support. Integrating behavioral health

in primary care is necessary to provide whole person care and ensure there is sufficient access to meet the entire spectrum of population behavioral health needs. Ultimately, the foundational expectations at a minimum should be

integrated into the work of every primary care practice. Practices want to provide this, patients want to receive this, and payers want to support it. This framework independent of approach and conducive to differential payment is a starting point for implementing this necessary and desired practice change to prevent, identify, and address behavioral health needs.

Practices want to provide this, patients want to receive this, and payers want to support it.

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Appendix A. The Building Blocks of Behavioral Health Integration Framework

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Leadership	- Practice has defined mission and vision related to meeting behavioral health needs and a defined behavioral health champion or team. - Practice has budget with allocated resources for transformation and quality improvement work related to behavioral health, including behavioral health professional(s) if part of the care team, that incorporates planning for sustainability of services.	<i>No component-specific expectations.</i>
Data Driven Quality Improvement	- 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. Where available, practice reviews data disaggregated by subpopulations to identify and address disparities. - Practice collects and reports on measures specific to behavioral health efforts and tracks performance relative to targets. This includes tracking reach (level 1—proportion of target population screened; level 2—proportion of positive screens that are addressed) and outcomes with validated measures such as the PHQ-9, GAD-7, and Edinburgh maternal depression scale. In practices caring for children, this includes developmental screening.	Advanced Coordination and Care Management—Includes tracking rates of follow up after behavioral health related emergency department visits or hospitalizations. Integrated Behavioral Health Professional—Includes tracking adequate FTE and availability of appointments with behavioral health provider.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Data Driven Quality Improvement <i>Continued.</i>	Practice collects and reports on holistic patient-reported measures of experience of care, access to care, and/or patient-reported functioning or quality of life.	Psychiatry—Includes tracking adequate FTE and availability of consultation with psychiatrist. Advanced Care of Substance Use Disorders—Includes tracking of outcomes related to patient initiation and engagement in substance use disorder treatment and follow up after substance use disorder-related hospitalizations.
Team-Based Care	- Practice has clearly defined roles, responsibilities, and workflows related to behavioral health services. - Practice incorporates behavioral health training into onboarding and ongoing professional development efforts, including for primary care providers and all clinic staff.	Advanced Coordination and Care Management—Includes roles, responsibilities, and workflows related to registry management, planned approach to communication and shared care plans.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Team-Based Care <i>Continued.</i>		Integrated Behavioral Health Professional • In addition to defined roles and responsibilities, practice develops planned approach to communication and development of shared care plans. • The behavioral health provider shares integrated workspace within the practice if providing in-person services. • Schedules for behavioral health providers allow for warm handoffs and real-time consultations in addition to appointments. • Integrated behavioral health providers support and participate in educational efforts for primary care providers and clinic staff. • Psychiatry—In addition to defined roles and responsibilities, practice develops planned approach to communication (delineation of asynchronous vs real time communication) and shared care plans.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Patient and Family Engagement	- Practice educates patients and family members/caregivers on availability of behavioral health services, including substance use disorder services. - Practice obtains feedback from patients and/or caregivers/family members on behavioral health services. Feedback may be obtained through patient experience surveys, Patient and Family Advisory Councils (PFACs), or focus groups. If establishing a PFAC, practice takes steps to ensure those participating reflect the diversity of the practice population. - Practice routinely provides self-management support (including caregiver/family support) and/or incorporates principles of shared decision making for patients with behavioral health issues as well as those without identified behavioral health issues to work towards goals that support wellness and prevention of illness.	<i>No component-specific expectations.</i>

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Population Management	- Practice identifies patients who need or would benefit from behavioral health services, including through universal screening for at least one priority mental health condition, one priority substance use condition, and one lifestyle behavior. - Practice ensures positive screens are offered treatment within the practice or referred to appropriate services outside of the practice. - 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. Practice considers individual patient barriers to treatment.	Advanced Coordination and Care Management - Practice maintains registry of patients with target behavioral health condition(s). - Practice conducts proactive outreach to reassess symptoms and ensure follow-up for patients that are not improving. - Practice risk-stratification processes incorporate behavioral health diagnoses and health-related social needs.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Access	• The practice ensures physical spaces and services are accessible and responsive to patients' and families' disability status, sexual orientation and gender identity, racial and ethnic backgrounds, cultural health beliefs and practices, preferred languages, and health literacy. • Patients are able to receive behavioral health services by either audio-only or audio-visual telehealth and communicate asynchronously with providers. Video visits are not a requirement.	• Integrated Behavioral Health Professional—Practice assesses access to behavioral health services for its patients through availability of appointments. Practice ensures availability of urgent (within 1 week) behavioral health appointments. • Psychiatry—If providing on-site or telepsychiatry direct patient services, practice assesses access to behavioral health services for its patients through availability of appointments. • Advanced Care of Substance Use Disorders—Practice assesses access to substance use treatment services through availability of appointments.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination	• 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. • Practice has referral pathways for patients with behavioral health conditions including potential referral sources for populations with specific needs (e.g. LGBTQIA+ friendly). • Practice ensures primary referral sources have appointment availability and are accepting new patients. • Practice tracks proportion of behavioral health referrals where patients successfully complete an initial appointment. • Practice provides crisis resources and referrals as indicated. • In pediatric practices, the practice has developed protocols for care transitions to adult behavioral health services.	Advanced Coordination and Care Management • Practice provides brief interventions (such as problem-solving treatment) in parallel with population health management. • Practice contacts patients within 3 business days of behavioral health-related emergency department visits or hospitalizations. • 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. • 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.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination <i>Continued.</i>		Advanced Coordination and Care Management <i>Continued.</i> - 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. - Behavioral health care management is documented in a shared EHR or other mechanism to share care plans and patient information.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination <i>Continued.</i>		Integrated Behavioral Health Professional - Behavioral health providers deliver therapy, diagnostic support, crisis management, and behavioral change management support for any patient in the practice. This care may address mental health and substance use conditions, health behaviors, life stressors and crises, stress-related physical symptoms, developmental transitions, and ineffective patterns of health care utilization. - Behavioral health and primary care providers use a shared EHR or other mechanism to document shared care plans and patient information. Care plans include patient goals, treatment plans, and relapse prevention plans, where relevant.

Continues.

Building Block	Foundational Care Delivery Expectations <i>Recommended requirements for any practice integrating behavioral health</i>	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination <i>Continued.</i>		Psychiatry • Psychiatrists support complex medication management and diagnostic support. If implementing the Collaborative Care Model, the psychiatrist regularly reviews the behavioral health registry and provides recommendations. • Behavioral health and primary care providers use a shared EHR or other mechanism to document shared care plans and patient information. Care plans include patient goals, treatment plans, and relapse prevention plans, where relevant. Advanced Care of Substance Use Disorders • Practice provides medication management for tobacco use disorder, opioid use disorder, and alcohol use disorder, which may include outpatient management of alcohol withdrawal. • Practice provides or refers patients to substance use disorder counseling. Practice provides resources on peer support groups.



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