PRIMARY CARE MODERNIZATION

Adult Behavioral Health Integration

CORE CAPABILITY

A team-based, primary care approach to identifying and managing less complex behavioral health conditions, co-occurring health conditions, and behaviors that affect health.

HOW CARE WILL IMPROVE

CONSUMERS CAN...

- Connect with a behavioral health clinician right away at your primary care visit
- Have a care team that understands how stress and worry can affect your physical health and how chronic illness can affect your emotional health and wellbeing
- Meet with a care coordinator to connect you to community-based support and additional behavioral health treatment services
- Have primary care and behavioral health clinicians who share information before your visits

PRIMARY CARE TEAMS CAN...

- Offer behavioral health assessment and brief treatment services
- Offer cognitive and behavioral strategies to manage stress, anxiety, sleep problems and pain, and make lifestyle changes to support chronic illness management
- Access practice-based behavioral health expertise to improve the care of patients with behavioral health conditions and co-occurring medical conditions
- Access psychiatric consultation to support primary care prescribing and behavioral health management
- Coordinate access to behavioral health, medical and community-based services
- Access behavioral health care information on your Electronic Health Record (EHR)

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Nate is 62 years old and lives alone after his divorce. He has diabetes and is overweight. He tries to eat healthy but hates cooking. He tries to take walks on weekends when his son visits, but he's mostly alone.

When Nate goes to his primary care office for his diabetes check-up, the nurse administers the PHQ9 (Depression Screening Tool). His score indicates a possible moderate depression. He says that he just wants to watch TV all the time.

He agrees to see the licensed clinical social worker in the practice. His doctor walks him down the hall to introduce them. They make an appointment for him to come see her when he comes back for blood work in a few weeks.

When Nate returns, the social worker introduces him to the practice's behavioral health care coordinator. She connects Nate to a local support group for divorced men and a walking club and records this in his medical record.

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HOW

Care Team and Network Requirements

- Standardized screenings to identify depression, substance use, anxiety, and social determinants of health
- Dedicated behavioral health clinician, on-site or via telemedicine, responsible for assessment, brief interventions, and care team consultation
- Protocol for "warm-hand off" to and telemedicine visits with behavioral health clinician
- Care coordinator with behavioral health expertise
- Referral assistance and tracking to support access to community behavioral health specialists, higher level behavioral health services, behavioral supports (e.g., peer support) and community resources (e.g., housing, legal assistance)
- E-Consult arrangement with community-based psychiatrist or psychiatric APRN
- Memorandum of Understanding with at least one behavioral health clinic if behavioral health specialty services are not available within the network.
- Bi-directional communication as needed between primary care team and community-based behavioral health specialists and community supports.
- Care team training on behavioral health teaming, chronic illness, and care coordination.

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for primary medical and behavioral health care
- EHR configuration or complementary platform to support telemedicine and e-Consult
- EHR configuration and protocols to ensure capture of all interactions between patient and care team members, including non-office-based care
- EHR configuration to support outcomes measurement and performance accountability
- Referral management platform with interoperability to confirm visits with behavioral health specialists and community-based organizations
- Bi-directional communication solution to support coordination with community-based BH specialists
- Consent and confidentiality management solution

MEASURING IMPACT

✓ Patient Experience

- Improved patient experience with respect to timely care, communication, coordination, access to BH care (practice-based and/or community), provider support, discussing stress, and overall provider satisfaction
- Less time off of work, improved functioning at work

★ Quality

- Earlier identification and treatment of behavioral health conditions
- Improved behavioral health outcomes (e.g., depression remission rates)
- Improved chronic illness outcomes (e.g., A1C control)
- Reduced preventable hospital admissions for ambulatory care sensitive conditions
- Reduced all-cause unplanned hospital readmissions

$ Cost

- Lower out of pocket costs for patients when treated in primary care
- Reduced avoidable physical health utilization related to unmet BH needs
- Reduced ED and hospital utilization

Access

- Easier access to BH services and reduced wait time for treatment
- Assistance with referral and linkages to community-based behavioral health specialty services and community supports

IMPROVING HEALTH EQUITY

Patients with behavioral health needs face obstacles in getting care. To reduce this disparity, primary care will change in the following ways:

✓ **Improved access for populations** who might be less inclined to seek behavioral health treatment in other settings due to stigma.

✓ **Expanded connections** with culturally appropriate behavioral health services and coordination to address social determinant barriers.

✓ **Care coordinators and medical interpreters** improve communication between primary care and behavioral health providers.

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