

Instructions for Completing the Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey Facilitation Guide

The MeHAF Site Self-Assessment (SSA) is used to evaluate progress towards bi-directional behavioral and physical health integration. This facilitation guide accompanies the site self-assessment survey to assist primary care practices and behavioral health agencies in completing the SSA. We recommend completing the assessment with a coach or practice facilitator, in addition to using this guide.

Instructions provided by the Maine Health Access Foundation:

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site's current extent of integration for patient and family-centered primary care, behavioral and mental health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA.

Please respond in terms of your site's current status in each dimension and rate your patient care teams on the extent to which they currently do each activity for the patients/clients at the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff.

Using the 1–10 scale in each row, circle one numeric rating for each of the 18 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.

This form was adapted from similar formats used to assess primary care for chronic diseases.

Identifying Information:

Name of your site: _____ Date: _____

Name of person completing the SSA form: _____ Your job role: _____

Did you discuss these ratings with other members of your team? YES NO

Adapted with permission from the Maine Health Access Foundation Site Self-Assessment Survey

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.



Before you Begin

Identify a multidisciplinary group of practice staff

We recommend that the MeHAF SSA be completed by a multidisciplinary group (e.g., providers, nurses, medical assistants, counselors, social workers, operations and administrative staff) to capture the views of individuals with different roles within an agency or practice. We recommend that staff members complete the assessment individually, then meet to discuss the results, produce a consensus version, and develop an action plan for priority improvement areas. We discourage sites from completing the MeHAF SSA individually and then averaging the scores to get a consensus score without a group discussion. The discussion is a great opportunity to identify opportunities and priorities for integration.

Have each site in an organization complete an assessment

If an organization has multiple practice sites, each site should complete a separate MeHAF SSA. Even when directed and supported by organizational leaders, practice transformation and integration happen differently at the site level. Organization leadership can compare scores and use this information to share knowledge and improvement ideas.

Consider where your organization is on the integration journey

Answer each question as honestly and accurately as possible. There is no advantage to overestimating scores and doing so may make it harder for to demonstrate real progress in future administrations. It is typical for teams to begin with average scores for some (or all) areas of the assessment. As your understanding of integrated care increases and you continue to implement effective practice changes, you should see your scores improve.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
1. Level of integration: primary care and mental/behavioral health care	... none; consumers go to separate sites for services	... are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist	.. are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services	... are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings.
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree is behavioral health care integrated into your primary care setting(s)?

Facilitation notes: While “A” may be the ideal, the focus is on moving the individual practice/agency through the continuum, wherever it may be now and considering what resources are realistic/available.

Level C example: Behavioral health providers are located at a separate site; there is some communication and coordination, but teams are separate.

Level B example: Behavioral health providers are located on site; staff meet and communicate regarding clients.

Level A example: The behavioral health provider and primary care provider (PCP) are in the same location, using the same electronic health record (EHR), and both are considered part of the care team.

Behavioral health: To what degree is primary care integrated into your behavioral health setting?

Facilitation notes: While “A” may be the ideal, the focus is on moving the individual practice/agency through the continuum, wherever it may be now and considering what resources are realistic/available. Note that co-location can occur at either the behavioral health or the primary care site.

Level C example: Primary care providers are not located at the same site; there is communication and linkage, but the teams are separate.

Level B example: The behavioral health agency (BHA) and PCP are in the same location, but they use different EHRs. Staff meet and communicate regarding clients, but it is not systematic.

Level A example: The BHA and PCP are in the same location, using the same EHR, and both are considered part of the care team.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
<p>2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)</p> <p>2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)</p>	... are not done (in this site)	... are occasionally done; screening/assessment protocols are not standardized or are nonexistent	...are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented.
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree are you currently screening your patients for behavioral health needs?

Facilitation notes: Behavioral health screenings can include assessment for depression, anxiety, post-traumatic stress disorder, and drug and alcohol use.

Level C example: Some screenings are completed on an occasional or as-needed basis, but there is no established or routine process in place to screen patients.

Level B example: A process has been implemented to screen patients at regular intervals (e.g., annually) or for a certain patient population (e.g., patients with diabetes), and scores are documented in the client record.

Level A example: There is a standardized workflow in place to ensure that screenings are completed and documented for all patients, and there are care pathways in place to address the needs of patients. The processes and protocols are followed uniformly.

Behavioral health: To what degree are you currently screening and assessing for medical care needs, such as blood pressure, height/weight and chronic health conditions?

Facilitation notes: For BHAs, including questions regarding general medical concerns, substance use and tobacco use is required as part of the client's initial intake assessment. Consider asking more direct questions about chronic health conditions like hypertension, diabetes and asthma.

Level C example: BHA staff assess for health concerns if an issue is brought up by the client.

Level B example: BHA staff assess and document health concerns, but there is no standardized process in place to gather the information.

Level A example: The BHA uses standardized health assessment tools for all its clients, including a screen for chronic health conditions. For example, during intake, if a client says they have hypertension, staff ask more questions to ascertain if they take medications, and whether the condition is controlled or uncontrolled. A release of information is signed to get medical records from the PCP.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
3. Treatment plan(s) for primary care and behavioral/mental health care	... do not exist	... exist, but are separate and uncoordinated among providers; occasional sharing of information occurs	... Providers have separate plans, but work in consultation; needs for specialty care are served separately	... are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree do you share treatment plans that address both primary care and behavioral health care goals with behavioral health providers?

Facilitation notes: Coordination of physical health and behavioral health treatment goals can lead to improved overall health and patient outcomes.

Level C example: When issues are brought up by the patient, staff reach out to the patient's behavioral health provider to gather more information and request treatment plans, and primary care staff share their separate treatment goals.

Level B example: When a patient has ongoing behavioral health needs, the behavioral health provider is always contacted and information regarding treatment goals is requested. Treatment plans are stored on separate EHR systems or different parts of the EHR. On occasion, primary care providers reach out to behavioral health providers to discuss patient goals.

Level A example: Treatment plans are stored in the same, easy-to-access place in the EHR for all providers to see. Regular (e.g., monthly) meetings are scheduled between behavioral health and primary care providers to review and re-align the shared treatment plan if treatment has stalled. The BHA and PCP work together to coordinate care and support patients with primary care and behavioral health needs.

Behavioral health: To what degree do you share treatment plans that address both behavioral health and primary care goals with primary care providers/providers?

Facilitation notes: BHAs are required to address any medical concerns reported by the client in the treatment plan. Coordination of physical health and behavioral health treatment goals can lead to improved overall health and patient outcomes.

Level C example: When issues are brought up by the client, the BHA reaches out to the PCP to gather more information and request treatment plans, and the BHA shares its separate treatment plan.

Level B example: Treatment plans are stored in separate client records, or different parts of the client record. The behavioral health provider discusses care with the primary care provider on occasion.

The BHA always requests medical information for clients, and when clients have ongoing health needs, the BHA reaches out to the PCP to discuss how they can work together.

Level A example: Treatment plans are stored in the same, easy-to-access place in the client record. Regular (e.g., monthly) meetings occur between the behavioral health provider and primary care provider to review and re-align the shared treatment plan if treatment has stalled.

The BHA and PCP work together to coordinate care and support of clients with primary care and behavioral health needs.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
4. Patient care that is based on (or informed by) best practice evidence for BH/ MH and primary care	... does not exist in a systematic way	... depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases	... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers	... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree do you deliver care that is informed by best practice evidence for **both** primary care and mental/behavioral health care?

Facilitation notes: In a primary care setting evidenced based interventions will be different for a primary care diagnosis than for a behavioral health diagnosis. In primary care, if the patient's blood pressure is X, the provider does Y. Primary care staff are trained in common behavioral health/MH conditions, and staff have general knowledge regarding when patients should be referred to a behavioral health provider AND have a decision support system for primary care.

Level C example: Providers use some evidence-based approaches, but it is up to their discretion to choose which best practices to use and when to use them. Some providers refer patients to behavioral health providers, but there is no clear process in place for when to refer a patient to a behavioral health provider. Referrals are made on a case-by-case basis.

Level B example: Providers use appropriate treatment guidelines for a patient's diagnosis, but there are no standard treatment best practices utilized, and the individual provider chooses which evidence-based treatment approach to use. All clients are screened for behavioral health needs, but the provider chooses which patient screening scores and situations should prompt a referral to a behavioral health provider.

Level A example: The clinic uses a set of evidence-based guidelines that all providers follow. Team members are trained in best practices, and the EHR has alerts and reminders in place for follow-up and ongoing patient care. For example, the clinic has a protocol in place that requires a behavioral health referral for patients who score 10 or above on the PHQ-9.

Behavioral health: To what degree do you deliver care that is informed by best practice evidence for **both** mental/behavioral health and primary care?

Facilitation notes: In a behavioral health setting evidenced based interventions will be different for primary care diagnosis than for a behavioral health diagnosis. Behavioral health providers use specific types of therapies for certain diagnoses; i.e., if the client is diagnosed with post-traumatic stress disorder, Trauma Focused Cognitive Behavioral Therapy (CBT) is used. If the client is diagnosed with a substance use disorder, Motivational Interviewing is used. Behavioral health staff are trained in some common physical health conditions and preventative care guidelines and have general knowledge regarding when clients should be referred to a PCP. Behavioral health staff without medical training and licensure should not give physical health treatment advice but should encourage clients to seek medical care.

Level C example: Providers use some evidenced-based approaches with clients in some instances. Some of the team is knowledgeable about select health conditions will occasionally refer clients to PCPs, but no clear process is in place.

Level B example: Teams use evidence-based practices to treat clients based on their own discretion, but the agency has not standardized the use of specific evidence-based practices for particular diagnoses. For primary care, teams encourage clients to seek medical care when concerns are reported by the client or if the client has not seen a PCP in over a year.

Level A example: Teams are trained in evidence-based practices and the agency has a procedure to ensure specific care guidelines and pathways are used based on the client's diagnosis. Primary care teams receive training on guidelines of when to refer clients for health care, e.g., well child visit, mammograms. These guide lines are applied consistently.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
5. Patient/ family involvement in care plan	... does not occur	... is passive; provider or educator directs care with occasional patient/ family input	... is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/ families and their provider(s)	... is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: How involved are patients and/or their families in developing the patient's care plan?

Facilitation notes: Note that not all patients will want family included in their care, but the primary care team asks if the patient would like their family included. If the patient indicates that they would like for their family to be involved, the care team makes efforts to ensure they are included. Ideally treatment options are discussed with the patient/family supports and care plans reflect the patient's wishes.

Level C example: Providers do not always ask for the patient's input when creating their plan of care, do not regularly ask if patients want their family/supports involved in treatment planning, and do not make an effort to include them.

Level B example: Providers develop care plans with patients and/or their families when they are proactive in their health care.

Behavioral Health: To what degree are clients and/or their families involved in developing their care plan?

Facilitation notes: For BHAs, client voice and signature is required on the treatment plan. Family involvement is also required when applicable.

Ideally treatment plans include consumer voice and choice. For some clients they may not have or may not wish for their families to be involved in treatment. Is the client asked if they want their family included in their treatment? When the client wants their family/supports involved, are they actively engaged in the client's treatment by the provider?

Level C example: Staff do not always ask for client input when creating treatment goals. Providers do not regularly ask clients if they want their family/supports involved in treatment planning.

Level B example: Treatment plans are developed with input from clients and/or their families who are proactive in their care.

Level A example: Care plans for each client are developed with the client and/or their family. Clients and families are encouraged to take on an active role in decision-making and self-management. Staff consistently talk about and address barriers to achieving the client's treatment goals.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
6. Communication with patients about integrated care	... does not occur	... occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style	... occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent	... is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what extent do providers communicate the relationship between physical health and mental/behavioral health needs? Are these communications tailored to the patient's specific needs?

Facilitation notes: Chronic conditions such as diabetes can cause complications and health issues that worsen symptoms of depression. Conversely, depression can lead to behaviors that can increase diabetic complications. Do staff discuss and ensure the patient understands the relationship between physical health and mental health and how a multidisciplinary care team can improve their overall health and wellness?

Level C example: On occasion, staff briefly discuss the connection between physical and behavioral health, hand out written materials and/or refer the patient to a website. Information is not individualized for the patient.

Level B example: Team members routinely discuss the connection between physical and behavioral health with the patient. Information is customized to the individual's culture and level of understanding. Patients and families are empowered to be active partners on the integrated care team.

Level A example: Team members are trained in talking with patients about integrated health care and consistently discuss the connection between their physical and mental health. Providing individualized, whole-person care is ingrained in the clinic's standard processes and workflows.

Behavioral health: To what degree do providers communicate the relationship between physical health and behavioral health needs? Are these interactions tailored to the client's specific needs?

Facilitation notes: Chronic conditions such as diabetes can cause complications and health issues that worsen symptoms of depression. Conversely, depression can lead to poor lifestyle choices that can increase diabetic complications. Do staff discuss and ensure the patient understands the relationship between physical health and mental health and how a multidisciplinary care team can improve their overall health and wellness?

Level C example: On occasion, staff briefly discuss the connection between physical and behavioral health, hand out written materials and/or refer clients to a website.

Level B example: Staff routinely discuss the connection between physical and behavioral health with the client. Information is customized to the individual's culture and level of understanding. Clients and families are empowered to be active partners on the integrated care team.

Level A example: Staff are trained in talking with clients about integrated health care and consistently discuss the connection between their physical and behavioral health. Providing individualized, whole-person care is ingrained in the agency's standard processes and workflows.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
7. Follow-up of assessments, tests, treatment, referrals and other services	... is done at the initiative of the patient/ family members	... is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up	... is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments	... is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/ lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: How consistently do you follow up with patients about assessments, tests, treatments, referrals, and other services provided?

Facilitation notes: For an integrated care system to be successful, primary care staff often need to coordinate with specialists, community agencies and therapists. Good care coordination improves patient engagement and helps to develop the patient's network of support.

Level C example: Staff occasionally follow up on referrals, appointments and test results, but there is no mechanism in place to ensure staff follow-up with patients.

Level B example: Staff follow up with patients and assist them in understanding test results and medications, when indicated, but there is not a set process in place for follow-up or for reaching out to patients who miss an appointment.

Level A example: The clinic has a systematic process (e.g., flags in the EHR) for following up with patients on appointments and test results; there is also a process in place to re-engage with patients who miss an appointment. Follow-up and outreach is tailored to the individual patient.

Behavioral health: How consistently do you follow up with patients about assessments, tests, treatments, referrals and other services provided?

Facilitation notes: Assisting clients with referrals to community-based organizations and medical providers is an integral part of care management. Strong care coordination can lead to improvement in a client's overall health and well-being, and assists the client in building a network of support.

Level C example: Staff occasionally follow up on appointments and test results, but client follow-up is not a standard expectation.

Level B example: Staff follow up with clients and assist them in understanding results and medications, when indicated and within the scope of the practice. There is not a set process in place to reach out to clients who miss an appointment.

Level A example: The agency has a systematic process (e.g., flags in the client chart) for following up with clients on appointments and test results; there is also a process in place to re-engage with clients who miss an appointment. Outreach and interventions are tailored to the needs of the individual client.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
8. Social support (for patients to implement recommended treatment)	... is not addressed	... is discussed in general terms, not based on an assessment of patient's individual needs or resources	... is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs	... is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: How consistently do your providers/case managers assess a client's social supports and needs, as well as potential barriers in carrying out recommended treatment plans?

Facilitation notes: There is a strong relationship between social and emotional supports and a patient's overall health and wellness.

Level C example: Using social supports and support groups are sometimes discussed as a way to improve the patient's well-being, e.g., when a patient has been newly diagnosed with depression and type 2 diabetes.

Level B example: Someone from the care team usually asks the patient if they have anyone to support their treatment goals, e.g., when a patient has been newly diagnosed with depression and type 2 diabetes. The patient would then be provided with information about diabetes management support and education groups.

Level A example: There is a system in place to ensure that each patient's social and emotional needs are assessed. When indicated a plan for support is created with the patient, and someone from the care team follows up with the patient on progress toward goals. For example, if a patient is newly diagnosed with depression and type 2 diabetes, a plan is created for the patient and a friend to walk for 30 minutes two times a week, and the patient is assisted in enrolling in a diabetes education group at a community center that is easily accessible to them.

Behavioral health: How consistently do your providers/case managers assess a client's social supports and needs, as well as potential barriers in carrying out recommended treatment plans?

Facilitation notes: There is a strong relationship between social and emotional supports and a patient's overall health and wellness.

Level C example: A provider may assess a client's needs and use of social supports for health and wellness, e.g., when a client is struggling with anxiety and a chronic health condition, but not consistently.

Level B example: For example, if a client is struggling with anxiety and a chronic illness, the therapist explores who in the client's life can support the client's goals and if there is a support group that might be a good fit. Staff provide the client with information about an anxiety group.

Level A example: A system is in place to ensure that staff routinely assess the needs of clients. Staff create a plan for support around a client's anxiety and chronic illness using client input, and staff follow up with the client on progress toward goals. For example, if a client suffers from anxiety and a chronic illness, a plan may be created for the client to leave their house three times a week with a family member, and the client may be assisted in enrolling in a chronic disease support group that is in an easily accessible location where the client feels comfortable attending.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
9. Linking to Community	... does not occur	... is limited to a list or pamphlet of contact information for relevant resources	... occurs through a referral system; staff member discusses patient needs, barriers, and appropriate resources before making referral	... is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients
Resources	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree are your staff involved in connecting patients with community resources?

Facilitation notes: As health care shifts toward whole-person care, it is important to recognize that socioeconomic factors may be impacting a patient's ability to make improvements on their treatment goals.

Level C example: If a patient expresses a need for a community resource, staff provide the patient with a list of resources. However, staff do not provide any direct linkage or assistance in connecting with the resources.

Level B example: If a patient states that they cannot afford to buy groceries on a regular basis, a staff member works with the patient to discuss resource options and together they create a plan for the patient to go to the food bank.

Level A example: Patients are routinely assessed for basic resource needs. For example, if a patient reports that they cannot afford to provide enough food for their family, staff work with the patient to create a plan to ensure the patient is able to obtain food. Staff may work with the food bank to arrange a time for the patient to go the food bank and provide assistance to ensure the patient has transportation to and from the food bank. Staff may then follow up with the patient either via phone call or at the next visit.

Behavioral health: To what degree are your staff involved in connecting clients with community resources?

Facilitation notes: As health care shifts toward whole-person care, it is important to recognize that socioeconomic factors may be impacting a client's ability to make improvements on their treatment goals.

Level C example: If a patient expresses a need for a community resource, staff provide the patient with a list of resources. However, staff do not provide any direct linkage or assistance in connecting with the resources.

Level B example: If a patient states that they cannot afford to buy groceries on a regular basis, a staff member works with the patient to discuss resource options and together they create a plan for the patient to go to the food bank.

Level A example: Patients are routinely assessed for basic resource needs. For example, if a patient reports that they cannot afford to provide enough food for their family, staff work with the patient to create a plan to ensure the patient is able to obtain food. Staff may work with the food bank to arrange a time for the patient to go the food bank and provide assistance to ensure the patient has transportation to and from the food bank. Staff may then follow up with the patient either via phone call or at the next visit.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
10. Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications	... does not exist in a systematic way	... depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases	... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers	... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree are your providers utilizing best practice evidence for prescribing psychotropic medications? If the practice does not have a prescriber, this question is not applicable.

Facilitation notes: The purpose of best practice guidelines is to support safe and appropriate use of psychotropic medications. This includes, but is not limited to, completing psychiatric and medical evaluations, prescribing medications as indicated by label, creating a treatment and monitoring plan, and ensuring the patient and/or family understand the medication rationale, how and when to take the medication, potential side effects, and when they should return for follow-up.

Level C example: The prescriber does use evidence-based practices in some instances of prescribing, e.g. using medications for specific conditions/populations as indicated by label. The clinic does not have standardized prescribing practice guidelines.

Level B example: The clinic has a set of practice guidelines accessible to prescribers. These guidelines may be used, but treatment is based on provider preferences.

Level A example: Providers always use set guidelines (e.g., FDA) when prescribing and review medications and side effects with the patient. These may include guidelines on titrating medications at a specific interval due to patient demographics, other health care conditions, and other medications they may be taking, or a follow-up protocol for starting a new medication or changing dosage of a current medication. Providers receive ongoing education on prescribing best practices. Prescribers can consult with providers who have expertise in prescribing best practices.

Behavioral health: To what degree are your prescribers utilizing best practice evidence for prescribing psychotropic medications?

Facilitation notes:

- Sometimes there is no prescriber present at the assessment—ask if they are aware of any type of peer reviews or pharmacy and therapeutics meetings.
- Some BHAs do not have prescribers; some use telemedicine or contract with other providers. Answer this question based on prescriber notes and/or from consultative meetings prescribers have with BHA staff.
- If the BHA has no relationship with a prescriber, the score is "1."

The purpose of best practice guidelines is to support safe and appropriate use of psychotropic medications. This includes, but is not limited to completing psychiatric and medical evaluations, prescribing medications as indicated by label, creating a treatment and monitoring plan, and ensuring the client and/or family understand the medication rationale, how and when to take the medication, potential side effects, and when they should return for follow-up.

Level C example: The prescriber does use evidence-based practices in some instances of prescribing, e.g., using medications for specific conditions/populations as indicated by label. The agency does not have standardized prescribing practice guidelines.

Level B example: The agency has a set of practice guidelines accessible to prescribers. These guidelines may be used, but treatment is based on provider preferences.

Level A example: Providers always use set guidelines (e.g., FDA) when prescribing and review medications and side effects with the patient. These may include guidelines on titrating medications at a specific interval due to patient demographics, other health care conditions, and other medications they may be taking, or a follow-up protocol for starting a new medication or changing dosage of a current medication. Providers receive ongoing education on prescribing best practices. Prescribers can consult with providers who have expertise in prescribing best practices.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
11. Tracking of vulnerable patient groups that require additional monitoring and intervention	... does not occur	... is passive; provider may track individual patients based on circumstances	... patient lists exist and individual providers/ care managers have varying approaches to outreach with no guiding protocols or systematic tracking	... patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree are you using patient lists or registries to track population health information and provide outreach to patients?

Facilitation notes: A registry is a system for uniform information collection to evaluate specified outcomes for patient populations defined by a particular disease or condition. Keeping lists/registries can be a helpful tool for monitoring population health and ensuring no one “falls through the cracks.”

Level C example: Staff know their patients and are generally aware of which patients have high-risk issues.

Level B example: Staff from specific care teams keep a list of patients identified as potentially high risk, e.g., whose PHQ-9 score was greater than 10, who has an HbA1c level greater than 9 and/or who have high emergency department usage.

Level A example: The clinic has created and regularly updates a list/registry of patients who have a PHQ-9 score greater than 10 and an HbA1c level greater than 9 in order to reach out to them every few weeks to review their mood and medication use by phone. Staff regularly assess for change in the indicators.

Behavioral health: To what degree are you using client lists or registries to track population health information and provide outreach to patients?

Facilitation notes: A registry is a system for uniform information collection to evaluate specified outcomes for patient populations defined by a particular disease or condition. Keeping lists/registries can be a helpful tool for monitoring population health and ensuring no one falls through the cracks. This doesn’t mean behavioral health staff would need to take blood pressure or interpret lab results. Some medical information can be gathered on a subset of clients who see a prescriber. Generally, prescribers obtain information such as height, weight, blood pressure and other labs depending on the medication prescribed.

Level C example: Staff know their clients and are generally aware of which clients have high-risk issues.

Level B example: Staff from specific care teams keep a list of patients identified as potentially high risk, e.g., who have a PHQ-9 score greater than 10 and a BMI over 29.

Level A example: The agency has created and regularly updates a list/registry of clients who have a PHQ-9 score greater than 10 and a BMI over 29 in order to reach out to them every few weeks to review their mood and progress on goals by phone. Staff regularly assess for change in the indicators.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
12. Accessibility and efficiency of behavioral health providers	... behavioral health provider(s) are not readily available	... is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear how much population penetration behavioral health has into primary care population	... is partially present; behavioral health providers may be available for warm handoffs for some of the open clinic hours and may average less than 6 patients per clinic day per provider (or comparable number based on clinic volume)	... is fully present; behavioral health providers are available for warm handoffs at all open clinic hours and average over 6 patients per clinic day per provider (or comparable number based on clinic volume)
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree are behavioral health professionals currently available and accessible within your setting for warm handoffs and to provide behavioral health care?

Facilitation notes: Practices often have very little control over this. Improving accessibility can be accomplished by reaching out to behavioral health providers and building relationships.

Level C example: The practice has some access to behavioral health providers, but there is no clear process in place to refer patients.

Level B example: Behavioral health providers are sometimes available for referrals or warm handoffs. There is a process or informal agreement in place for behavioral health referrals.

Level A example: Behavioral health providers are fully accessible for patient referrals; they may be co-located at the practice, or there may be a memorandum of understanding (MOU) in place for seamless patient referrals.

Behavioral health: To what degree are medical professionals currently available/accessible within your setting for warm handoffs and to provide physical health care?

Facilitation notes: The standard of six patients per provider per day is not relevant in behavioral health ; however, improving accessibility of physical health care providers can be accomplished by reaching out to primary care staff and building relationships to enhance access.

Level C example: The agency has some access to primary care providers, but there is no clear process in place to refer clients in need of medical care.

Level B example: The agency has an informal agreement with a PCP or PCP's care team to be able to contact the PCP's clinic and send a client in need of medical care to the clinic and wait in the regular queue of patients to be seen.

Level A example: The agency has a MOU with a PCP or PCP's care team, and there is a clear referral process and a designated point of contact to assist in getting clients into the PCP's clinic as soon as possible for urgent needs. There may be a specific provider the agency works with who understands the BHA's client population and is responsive to working with behavioral health staff on client care.

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
1. Organizational leadership for integrated care	... does not exist or shows little interest	... is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care	... is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)	... strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: How involved and supportive is your organizational leadership of integrated physical and behavioral health care? Who is supporting the need for integration?

Facilitation notes: It is important to have leadership support and engagement to successfully implement practice transformation initiatives. Leadership should be defined as the chiefs and directors who oversee the programmatic, operational and financial decisions for the organization.

Level C example: Leadership supports the concept of integrated care, but no resources or staff time have been allotted to focus on practice transformation.

Level B example: Leadership is generally supportive of integrated care, and a minimal amount of internal resources have been invested in practice transformation.

Level A example: Leadership fully embraces the concept of integrated care and has provided the necessary internal and external resources to support the organization's practice transformation efforts.

Behavioral health: How involved and supportive is your agency's leadership of integrated behavioral health and primary care? Who is supporting the need for integration?

Facilitation notes: It is important to have leadership support and engagement to successfully implement practice transformation initiatives. Leadership should be defined as the chiefs and directors who oversee the programmatic, operational and financial decisions for the organization.

Level C example: Leadership supports the concept of integrated care, but no resources or staff time have been allotted to focus on practice transformation.

Level B example: Leadership is generally supportive of integrated care, and a minimal amount of internal resources have been invested in practice transformation.

Level A example: Leadership fully embraces the concept of integrated care and has provided the necessary internal and external resources to support the organization's practice transformation efforts.

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
2. Patient care team for implementing integrated care	... does not exist	... exists but has little cohesiveness among team members; not central to care delivery	... is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills	... is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: Do you currently have a patient care team structure in place for integrated care? If so, to what degree is your patient care team prepared to deliver integrated care?

Facilitation notes: Having a patient care team makes integrated care easier, because each team member is able to perform to their strengths and at the top of their license. Not every patient will need an integrated care team, but those with chronic conditions and/or behavioral health needs may benefit from a multidisciplinary team. The integrated care team may or may not all be employed by the organization.

Level C example: Patient care teams are present, but there is no sense of teamness. The care team is not an integral part of patient care.

Level B example: Each member of the care team has clear and distinct roles and responsibilities. Team members are aware of each other's roles, and staff regularly communicate with one another. As appropriate to licensing, staff members are cross-trained.

Level A example: Care teams are strongly supported by the organization's leadership. The use of care teams is ingrained in the organization's culture. Huddles, consults, case conferences and team meetings are regularly scheduled.

Behavioral health: Do you currently have a client care team structure in place for integrated care? If so, to what degree is your client care team prepared to deliver integrated care?

Facilitation notes: Having a client care team makes integrated care easier, because each team member is able to perform to their strengths and at the top of their license. Not every client will need an integrated care team, but those with chronic conditions or other issues may need a multidisciplinary team. Wraparound with Intensive Services (WISe) is a good example; the care team can include the school, a probation officer, and community members depending on the types of support needed by the client.

Level C example: Client care teams are present, but there is no sense of "teamness." The care team is not an integral part of client care.

Level B example: Each member of the care team has clear and distinct roles and responsibilities. Team members are aware of each other's roles, and staff regularly communicate with one another. As appropriate to licensing, staff members are cross-trained.

Level A example: Care teams are strongly supported by the organization's leadership, and the use of care teams is ingrained in the organization's culture. Case consults, case staffings and team meetings are regularly scheduled.

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
3. Providers' engagement with integrated care ("buy-in")	... is minimal	... engaged some of the time, but some providers not enthusiastic about integrated care	... is moderately consistent, but with some concerns; some providers not fully implementing intended integration components	... all or nearly all providers are enthusiastically implementing all components of your site's integrated care
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree are your staff engaged and/or interested in integrated care?

Facilitation notes: Similar to Q1 of this section, staff members need to be engaged and supportive to successfully integrate primary care and behavioral health care.

Level C example: Staff are somewhat engaged, but many have questions and concerns about implementing integrated care.

Level B example: Most staff understand the value of integrated care, but there are concerns about potential changes in workflow and additional responsibilities. Integrated care is not fully implemented, and workflows are inconsistently utilized.

Level A example: Staff fully support the concept of integrated care and consistently implement all aspects of the organization's integrated care workflows.

Behavioral health: To what degree are your staff engaged and/or interested in integrated care?

Facilitation notes: Similar to Q1 of this section, staff members need to be engaged and supportive to successfully integrate primary care and behavioral health care.

Level C example: Staff are somewhat engaged, but many have questions and concerns about implementing integrated care.

Level B example: Most staff understand the value of integrated care, but there are concerns about potential changes in workflow and additional responsibilities. Integrated care is not fully implemented, and workflows are inconsistently utilized.

Level A example: Staff fully support the concept of integrated care and consistently implement all aspects of the organization's integrated care workflows.

II. Practice/Organization (Circle one NUMBER for each characteristic)				
Characteristic	D	C	B	A
4. Continuity of care between primary care and behavioral/mental health	... does not exist	... is not always assured; patients with multiple needs are responsible for their own coordination and follow-up	... is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only	... systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: How consistently do staff coordinate patients' primary care with their mental/behavioral health care?

Facilitation notes: Sharing information and coordinating care between primary care and behavioral health are critical components of integrated care.

Level C example: The organization has no clear process to share or receive patient information or to ensure ongoing coordination and follow-up.

Level B example: There is some mutually agreed-upon information sharing with designated points of contact. For example, a care manager or clinic social worker may reach out to a patient they are already working with about a recent psychiatric hospitalization or emergency department (ED) visit to ensure prompt follow-up.

Level A example: The clinic has a process in place to ensure patient follow-up occurs, e.g., the clinic receives real-time PreManage/EDIE* notifications when any of its patients visit the ED/hospital. There is a system in place for the care manager or clinic social worker to follow up with the patient within 24 to 48 hours, depending on the acuity of the ED/hospital visit.

* EDIE = Emergency Department Information Exchange | PreManage = real-time notifications for patients being admitted to hospital (ED and/or inpatient).

Behavioral health: How consistently do staff coordinate patients' behavioral health care with their primary care?

Facilitation notes: Sharing information and coordinating care between behavioral health and primary care are critical components of integrated care.

Level C example: The organization has no clear process to share or receive patient information or to ensure ongoing coordination and follow-up.

Level B example: There is some mutually agreed-upon information sharing with designated points of contact. For example, a case manager, therapist or other designated staff may reach out to a client they are already working with about a recent hospitalization or ED visit to ensure prompt follow-up.

Level A example: The clinic has a process in place to ensure patient follow-up occurs, e.g., the clinic receives real-time PreManage/EDIE* notifications when any of its patients visit the ED/hospital. There is a system in place for the care manager or clinic social worker to follow up with the patient within 24 to 48 hours, depending on the acuity of the ED/hospital visit.

* EDIE = Emergency Department Information Exchange | PreManage = real-time notifications for patients being admitted to hospital (ED and/or inpatient).

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
5. Coordination of referrals and specialists	... does not exist	... is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team	... occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care	... is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree do staff make referrals to and coordinate care with specialists? How involved are the specialists in contributing to the care plan?

Facilitation notes: Ask the organization to define how they use the term specialist and encourage them to consider an integrated care definition. For example, behavioral health staff may consider a sexual assault counselor a specialist, whereas primary care staff may consider a cardiologist a specialist.

Level C example: Staff inconsistently follow up on referrals, review results and recommendations, and/or include specialists' care plans into the clinic's care plan. Specialists are not regularly contacted or included as part of the patient care team.

Level B example: Clinic staff work as a team to coordinate specialist referrals and follow-up. The clinic shares patient information as part of the referral. Specialists regularly work with the patient's primary care team to create a care plan.

Level A example: There is a systematic process in place to ensure patients receive appropriate referrals and follow-up.

Behavioral health: To what degree do staff make referrals to and coordinate care with specialists? How involved are the specialists in contributing to the care plan?

Facilitation notes: There should be consistency throughout all of the BHA's programs, especially if a variety of adult and youth programs are offered. Ask the organization to define how they use the term specialist and encourage them to consider an integrated care definition. For example, behavioral health staff may consider a sexual assault counselor a specialist, whereas primary care staff may consider a cardiologist a specialist.

Many behavioral health staff refer to neuropsychiatry, occupational therapy, or specific departments at a children's hospital. Note that other than prescribers, behavioral health staff cannot make referrals to medical specialists and must work in coordination with PCPs to refer clients to specialists.

Level C example: Some staff coordinate with primary care providers to refer clients to medical specialists, but there is little to no follow-up.

Level B example: Staff work in conjunction with primary care providers to refer clients to specialists, share information to assist specialists, and follow up on results if/when results are received.

Level A example: There is a systematic process in place to ensure clients receive appropriate referrals and follow-up, e.g., EHR flags are used to remind staff to follow up on referrals.

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
6. Data systems/ patient records	... are based on paper records only; separate records used by each provider	... are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps	... use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals	... has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree do you utilize your record systems (paper or EHR) in coordinating patient care? Do various patient care team members have access to a shared EHR?

Facilitation notes: The ability to share patient information among care team members and pull data out of the EHR are key components of integrated care.

Level C example: Patient information is not stored in an easily accessible, centralized location. Patient data is not input in a way that it can be extracted from the record and utilized for quality improvement (QI) purposes.

Level B example: All staff have access to the same client information, and data is aggregated for specific QI initiatives.

Level A example: The organization has a fully functional EHR that is accessible to all care team members, and patient data is regularly aggregated for trends and key indicator reports. Patient data can be pulled into a registry to track population health outcomes.

Behavioral health: To what degree do you utilize your record systems (paper or EHR) in coordinating client care? Do various care team members have access to a shared record?

Facilitation notes: Some BHAs do not have an EHR, this question is not solely referring to EHRs, client records can also be paper or hybrid. The ability to share client information among care team members and pull data for quality improvement initiatives are key components to optimizing integrated care.

Level C example: All client information is not stored in an easily accessible, centralized location. Staff do not always know when clients are participating in other programs and cannot see notes for all of the agency's programs.

Level B example: All staff have access to the same client information, and client data is aggregated for QI initiatives.

Level A example: The agency has a fully functional EHR that can aggregate data and trends and pull information into a registry.

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
7. Patient/family input to integration management	... does not occur	... occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make suggestions	... is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate	... is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: How involved are patients and/or their families in providing input and feedback that informs practice policies and service delivery?

Facilitation notes: A key piece of patient-centered care occurs through input and ideas from patients and/or their families.

Level C example: There is no clear process for patients to provide input and only occurs when patients or family members make an effort to share suggestions.

Level B example: The clinic encourages patient input through one or more mechanisms, e.g., patient surveys, advisory groups, suggestion boxes, etc.

Level A example: The clinic's processes and procedures are informed by input from patients and families.

Behavioral health: How involved are clients and/or their families in providing input and feedback that informs practice policies and service delivery?

Facilitation notes: A key piece of client-centered care occurs through input and ideas from patients and/or their families.

Level C example: There is no clear process for clients to provide input and only occurs when patients or family members make an effort to provide feedback, such as when a client files a grievance.

Level B example: The agency encourages client and family input through one or more mechanisms, e.g., patient surveys, advisory groups, suggestion boxes, etc.

Level A example: The clinic's processes and procedures are informed by input from patients and families. The agency may have a former client or family member on their board or on client care committees.

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
8. Physician, team and staff education and training for integrated care	... does not occur	... occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic	... is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation	... is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: To what degree are trainings and educational opportunities on integrated care available and encouraged for staff members?

Facilitation notes: (Emphasis on **integrated care** training) Implementing integrated care requires that care team members are trained in the concepts and skills of care integration. Example: Primary care doctor is encouraged and/or incentivized to attend behavioral health-related trainings as well as trainings on bi-directional integration.

Level C example: Educational materials and information on integrated care are available for staff to review, but information is largely theoretical. There are no regular opportunities to put the learned knowledge into practice.

Level B example: The organization provides standardized integrated care training to all staff; i.e., integrated care training occurs as a part of a new employee's orientation. Training includes theory and practical application of integrated care protocols and workflows.

Level A example: The organization provides ongoing education and encourages staff to pursue additional training opportunities on integrated care and evidenced-based practices. All staff are trained on job-specific integrated care competencies, and expectations are incorporated into job descriptions.

Behavioral health: To what degree are trainings and educational opportunities on integrated care available and encouraged for staff members?

Facilitation notes: (Emphasis on **integrated care** training) Implementing integrated care requires that care team members are trained in the concepts and skills of care integration. Ask about Relias Learning online trainings, they have courses on behavioral health integration. Example: behavioral health staff is encouraged and/or incentivized to attend trainings on basic primary care issues as well as trainings on bi-directional integration.

Level C example: Educational materials and information on integrated care are available for staff to review, but information is largely theoretical. There are no regular opportunities to put the learned knowledge into practice.

Level B example: The organization provides standardized integrated care training to all staff; i.e., integrated care training occurs as a part of a new employee's orientation. Training includes theory and practical application of integrated care protocols and workflows.

Level A example: The organization provides ongoing education and encourages staff to pursue additional training opportunities on integrated care and evidenced-based practices. All staff are trained on job-specific integrated care competencies, and expectations are incorporated into job descriptions.

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	D	C	B	A
9. Funding sources/ resources	. . . a single grant or funding source; no shared resource streams	. . . separate PC/ MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/ agencies	. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training	. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly
Circle one	1	2 3 4	5 6 7	8 9 10

Primary care: What are the organization's funding source(s)/stream(s) for integrated care?

Facilitation notes: Organizations must ensure that whatever processes are developed for better integrated care is financially feasible and sustainable.

Level C example: Primary care and behavioral health departments have their own funding sources to support integrated care. There is little sharing of funds or resources, including staff.

Level B example: Primary care and behavioral health departments have their own funding sources to support integrated care, but there are some shared resources for staff and training. Integrated care codes are available to cover some of the costs of integrated care. Primary care and behavioral health may share costs of the on-site space when the behavioral health provider is in the clinic.

Level A example: Funding resources for integrated care are shared among departments. Integrated care billing codes are used whenever possible and staff are shared among departments to support patients as needed.

Behavioral Health: What are the organization's funding source(s)/stream(s) for integrated care?

Facilitation notes: Organizations must ensure that whatever processes are developed for better integrated care is financially feasible and sustainable.

Level C example: Behavioral health and primary care programs have their own funding sources to support integrated care. There is little sharing of funds or resources, including staff.

Level B example: Behavioral health and primary care programs have their own funding sources to support integrated care, but there are some shared resources for staff and training. Integrated care codes are available to cover some of the costs of integrated care. Primary care and behavioral health may share costs of the on-site space when the primary care provider is in the agency.

Level A example: Funding resources for integrated care are shared among departments. Integrated care billing codes are used whenever possible, and staff are shared among departments to support clients as needed.