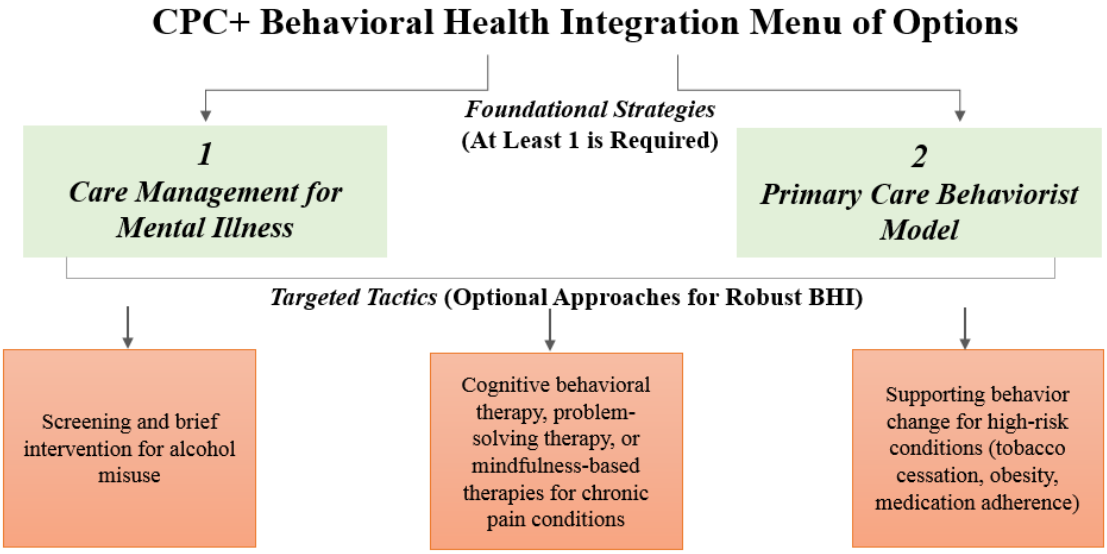
CPC+ Behavioral Health Integration Menu of Options (2017)

Behavioral health integration (BHI) refers to members of a primary care team and behavioral health practitioners working together with patients and families and using a systematic, 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] Addressing BHI in primary care will be essential for CPC+ practices, due to the high prevalence of behavioral health (BH) conditions in primary care (30% of patients have a BH co-morbidity), frequent co-existence of BH condition with chronic medical conditions (50% of patients with serious mental illness have ≥ 1 chronic medical condition), and the significant overall health care costs associated with BH conditions.

CPC+ BHI Foundational Strategies and Targeted Tactics

The strategies and tactics below offer the best evidence for building primary care capabilities to support BHI integration. Track 2 practices and Track 1 practices that participated in the original CPC model will be required to develop their capabilities to deliver at least one of these foundational strategies in 2017. As practices become familiar with the initial stages of the work and gain expertise, they will be ready to refine their work and seize opportunities to continue to improve the care of and outcomes for their own population of patients. For practices that have already integrated these strategies into their workflow, they will be required to refine at least one of the foundational strategies and may also implement the targeted tactics to support robust more BHI.



Foundational Strategies: *Care Management for Mental Illness or the Primary Care Behaviorist Model*

These strategies provide the framework for building integrated behavioral health into primary care settings, facilitated by payment reform, and integrated into the CPC+ Comprehensive Primary Care Functions.

When considering which strategy to use as the basis for behavioral health integration, practices may consider:

- Prevalence, severity, and range of mental health conditions in the population served by the practice.
- Effect of BH conditions on physical health in the population served by the practice.
- Current or planned practice-based screening for BH conditions and psychosocial stressors.
- Existing resources including: care manager background/interest/training; space; teleconferencing equipment; community resources including behavioral health specialists.
- New resources needed to achieve the integrated care goals including capital investments, personnel, and technology costs.

[1] Peek, C.H., & The National Integration Academy Council. (2013). *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus.* AHRQ: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon_ExecSummary.pdf

Option 1: Care Management for Mental Illness

Individuals with the identified mental health condition should be offered proactive, relationship-based **care management (CM)**, with specific attention to care management of the mental health condition (e.g., Major Depressive Disorder/Dysthymia, Generalized Anxiety Disorder, and Panic Disorder).

In 2017, practices that develop their capabilities to deliver care management for mental illness will:

- Select mental health condition(s) to prioritize and method to identify patients to target for care management. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
- Identify or develop stepped care, evidence-based, treatment algorithms for mental health condition(s) identified for care management, incorporating principles of shared decision making and self-management support.
- Develop a workflow for screening, enrollment in integrated care services, tracking, and communicating with patients.
- Identify a practitioner or team member (e.g., RN or BH specialist) who will provide care management and ensure training to support stepped care approach.

Option 2: Primary Care Behaviorist Model (PC Behaviorist)

The PC Behaviorist model integrates BH into the PC workflow through warm handoffs to a co-located BH professional to address mental illness in the primary care setting and behavioral strategies for management of chronic general medical illnesses, and facilitate specialty care engagement for serious mental illness.

In 2017, practices that develop their capabilities to deliver the primary care behaviorist model will:

- Select mental health condition(s) to prioritize and method to identify patients to target for referral to the primary care behaviorist. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
- Identify a credentialed BH provider (e.g., psychologist, social worker) trained in the primary behaviorist model of co-located care.
- Identify space in the primary care practice for the BH provider; test and implement a method for engaging BH services.
- Develop a workflow to integrate referrals (warm hand-offs) to the BH specialist.

Targeted Tactics

In 2017, CPC+ Track 2 practices and Track 1 practices participating in the original CPC model will build a foundation of BHI by developing the foundational strategies. Optional targeted tactics support more robust BHI.

Screening and brief intervention for alcohol misuse: Adults should be screened for alcohol misuse using a validated instrument. For those who screen positive, brief interventions should follow evidence-based practice.

Cognitive behavioral therapy (CBT), problem-solving therapy (PST), or mindfulness-based therapies for chronic pain conditions: As part of a patient-centered, multimodal treatment approach, practices should offer group or individual CBT, PST, and/or mindfulness-based therapy for patient with chronic pain conditions, offered in the primary care setting or by secure video or telephone.

Supporting behavior change for high-risk conditions (e.g., tobacco cessation, obesity, and medication adherence): **Behavioral change support specialists (BHS) (e.g., health coaches) are trained in collaborative communication (e.g., motivational interviewing) to improve understanding of, and adherence to, mutually agreed upon care plans; often supporting the patients' self-management goals.**