Behavioral Health – Primary Care Integration Assessment

For each, please indicate how often this occurs…..	Rarely or Never	Sometimes	Often	Almost Always
Patients are screened for **depression** at least annually.	☐	☐	☐	☐
Patients are screened for **anxiety** at least annually.	☐	☐	☐	☐
Patients are screened for **substance use** at least annually.	☐	☐	☐	☐
A **psychiatric consultant** is fully hired and trained to function as part of an integrated care team. (The psychiatric consultant is a behavioral health clinician will full prescribing privileges, typically a psychiatrist, psychiatric nurse practitioner or physician assistant trained in psychiatry. In this role, the psychiatric consultant does not prescribe medication when it is part of the treatment plan but advises the primary care provider in this activity.)	☐	☐	☐	☐
A **licensed behavioral health provider** is fully hired and trained to function as part of an integrated care team performing assessments, treatment planning, and delivering evidence-based behavioral interventions and brief psychotherapy when that is part of the treatment plan. This role may be filled by the behavioral health care manager.	☐	☐	☐	☐
A **behavioral health care manager** is fully hired and trained to function as part of an integrated care team by providing care management support to the patient and care team. The behavioral health care manager can be the licensed behavioral health provider or can be a separate staff member performing care management tasks. This role may also be the licensed behavioral health provider.	☐	☐	☐	☐
A **primary care provider** is fully hired and trained for their job providing and supporting behavioral health treatment for their patients. (Primary care provider is the primary medical provider for the patient and prescribes psychotropic medications as needed for patients enrolled in active behavioral health care management.)	☐	☐	☐	☐
Primary care and behavioral health providers use the same **EHR.**	☐	☐	☐	☐
Team **communication** is clear, functioning and documented.	☐	☐	☐	☐
Care team members use **team-centered language** to describe their activities.	☐	☐	☐	☐
Primary care and behavioral health providers use a **shared care plan** for each patient enrolled in integrated care.	☐	☐	☐	☐
Each care plan has **patient-centered goals** documented in writing and understood by all care team members.	☐	☐	☐	☐
Each patient is engaged in **shared decision making** about recommended treatment options.	☐	☐	☐	☐
Patients are provided with **education** about their condition(s) and their role in their care.	☐	☐	☐	☐
When **medication** is part of the treatment plan, patients are provided with a prescription as appropriate for evidence-based treatment of their mental health condition(s).	☐	☐	☐	☐
Each patient is offered appropriate evidence-based **behavioral interventions** (e.g. Behavioral Activation, Cognitive Behavioral Treatment) for their mental health condition(s).	☐	☐	☐	☐

PLEASE TURN OVER

Each member of the care team is trained in **suicide** prevention and the clinic suicide protocol to manage patients expressing suicidal thoughts.	☐	☐	☐	☐
Each patient actively engaged in treatment is listed in a behavioral health **registry**. (A behavioral health registry is a list of patients enrolled in active behavioral health treatment and includes data on encounters and behavioral health measures to support proactive outreach to patients and identification of patients needing a case review during weekly caseload supervision with the psychiatric consultant.)	☐	☐	☐	☐
When patients are treated for behavioral health conditions, symptoms and symptom severity are measured with a validated tool (e.g. PHQ-9) **at treatment initiation.**	☐	☐	☐	☐
When patients are treated for behavioral health conditions, symptoms and symptom severity are measured with a validated tool (e.g. PHQ-9) at **each follow-up visit**.	☐	☐	☐	☐
Each patient in active treatment is assessed for **response** to treatment with a mental health measure (e.g. PHQ-9, GAD-7, PCL-5).	☐	☐	☐	☐
Each week, a **systematic patient case review** session occurs between the behavioral health care manager and psychiatric consultant.	☐	☐	☐	☐
Each week, patients in active treatment needing **changes or intensification** of care are prioritized for systematic case review and case reviews are documented.	☐	☐	☐	☐
Patients in active treatment who need a level of care that cannot be delivered in primary care are **referred internally** to specialty behavioral health services.	☐	☐	☐	☐
Patients in active treatment who need a level of care that cannot be delivered in primary care are **referred externally** to specialty behavioral health services.	☐	☐	☐	☐
The behavioral health care manager has a second follow-up contact with patients **within 4 weeks** of the initial assessment.	☐	☐	☐	☐
Each week the registry is used to identify patients not **engaged** in care.	☐	☐	☐	☐
Each disengaged patient receives proactive **outreach** for engagement.	☐	☐	☐	☐
Each member of the care team can name population-level **quality goals** (e.g. % of patients expected to achieve response or remission).	☐	☐	☐	☐
Each month clinic leadership review data summarizing **performance** related to population-level quality goals.	☐	☐	☐	☐
The clinic regularly engages in **quality improvement** activities when care is not meeting quality goals.	☐	☐	☐	☐