### Key categories of integrated care

<table>
<thead>
<tr>
<th>#</th>
<th>Domains</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Case finding, screening, and referral to care</td>
<td>Patient/clinician identification of those with symptoms—not systematic, Systematic screening of target populations (e.g., diabetes, CAD), with follow up for assessment, Referral to external BH specialist/psychiatrist, Enhanced referral to outside BH specialist/psychiatrist through a formal agreement, with engagement and feedback strategies employed</td>
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<tr>
<td>2</td>
<td>Multi-disciplinary team (including patients) used to provide care</td>
<td>Communication with BH specialist driven by necessity or urgency, Formal written communication (notes/consult reports) between PCP and BH specialist on complex patients, Occasional interaction, possibly through ancillary staff members, perhaps sharing reports or labs</td>
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<tr>
<td>3</td>
<td>Ongoing care management</td>
<td>Limited follow up of patients provided by office staff, Proactive follow up to assure engagement or early response to care, Maintenance of a registry with ongoing measurement and tracking, and proactive follow up with active provider and patient reminder system</td>
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<tr>
<td>4</td>
<td>Systematic quality improvement</td>
<td>Informal or limited review of BH quality metrics (limited use of data, anecdotes, case series), Identified metrics and some ability to review performance against metrics, Identified metrics and some ability to review performance against metrics, with designated individual to develop improvement strategies</td>
</tr>
</tbody>
</table>

### Integration Continuum

- **Preliminary**
  - Patient/clinician identification of those with symptoms—not systematic
  - Systematic screening of target populations (e.g., diabetes, CAD), with follow up for assessment
  - Referral to external BH specialist/psychiatrist

- **Intermediate**
  - Communication with BH specialist driven by necessity or urgency
  - Formal written communication (notes/consult reports) between PCP and BH specialist on complex patients
  - Occasional interaction, possibly through ancillary staff members, perhaps sharing reports or labs

- **Advanced**
  - Limited follow up of patients provided by office staff
  - Proactive follow up to assure engagement or early response to care
  - Maintenance of a registry with ongoing measurement and tracking, and proactive follow up with active provider and patient reminder system

### Notes:
- BH Specialist refers to any provider with specialized behavioral health training;
- CM can refer to a single person or multiple individuals who have training to provide coordinated care
- Ancillary staff member refers to non-clinical personnel, such as office staff or receptionist;
- EBP refers to evidence-based psychotherapy

### Appendix A. An Evidence-Based Framework for Primary Care–Behavioral Health Integration

#### Case finding, screening, and referral to care

- **Screening, initial assessment, and follow up**
  - Patient/clinician identification of those with symptoms—not systematic
  - Systematic screening of target populations (e.g., diabetes, CAD), with follow up for assessment
  - Referral to external BH specialist/psychiatrist

- **Referral facilitation and tracking**
  - Enhanced referral to outside BH specialist/psychiatrist through a formal agreement, with engagement and feedback strategies employed

#### Care team

- **PCP and patient**
- **PCP, patient, and BH specialist**
- **PCP, patient, CM, and psychiatrist (consults and engaged in CM case reviews)**

#### Systematic team-based caseload review and consultation

- **Communication with BH specialist driven by necessity or urgency**
- **Occasional interaction, possibly through ancillary staff members, perhaps sharing reports or labs**

#### Availability for interpersonal contact between PCP and BH specialist/psychiatrist

- **Limited follow up of patients provided by office staff**
- **Proactive follow up to assure engagement or early response to care**
- **Maintenance of a registry with ongoing measurement and tracking, and proactive follow up with active provider and patient reminder system**

#### Ongoing care management

- **Use of quality metrics for program improvement**
- **Identified metrics and some ability to review performance against metrics**
- **Identified metrics and some ability to review performance against metrics, with designated individual to develop improvement strategies**

#### Systematic quality improvement

- **Ongoing systematic quality improvement with monitoring of population-level performance metrics and implementation improvement projects by designated QI team**
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<td>5</td>
<td>Decision support for measurement-based, stepped care</td>
<td>Evidence-based guidelines/treatment protocols, Use of pharmacotherapy, Access to evidence-based psychotherapy treatment with BH specialist</td>
</tr>
<tr>
<td>6</td>
<td>Self-management support that is culturally adapted</td>
<td>Tools utilized to promote patient activation and recovery, Clinical registries for tracking and coordination, Sharing of treatment information</td>
</tr>
<tr>
<td>7</td>
<td>Information tracking and exchange among providers</td>
<td>Linkages with community/social services, Linkages to housing, entitlement, and other social support services</td>
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### Integration Continuum

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<tr>
<td>None or limited training on BH disorders and treatment</td>
<td>PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment</td>
<td>Standardized use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms</td>
<td>Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate</td>
</tr>
<tr>
<td>PCP-initiated, limited ability to refer or receive guidance</td>
<td>PCP-initiated, and referral when necessary to prescribing BH specialist/psychiatrist for follow up</td>
<td>PCP-managed with prescribing BH specialist/psychiatrist support</td>
<td>PCP-managed with CM supporting adherence between visits and BH prescribe/psychiatrist support</td>
</tr>
<tr>
<td>Supportive guidance provided by PCP</td>
<td>Available off-site through pre-specified arrangements</td>
<td>Brief psychotherapy interventions provided by BH specialist on-site</td>
<td>Brief interventions provided by BH specialist (with formal EBP training) as part of overall care team, with exchange of information as part of case review</td>
</tr>
<tr>
<td>Informal method for tracking patient referrals to BH specialist/psychiatrist</td>
<td>Brief patient education on condition including materials/workbooks but limited focus on self-management coaching and activity guidance</td>
<td>Patient receives education and participates in self-management goal setting and activity guidance/coaching</td>
<td>Systematic education and self-management goal setting with relapse prevention guidance, with CM support between visits</td>
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<tr>
<td>Formal patient registry to manage and track patients, including severity measurement, attendance at visits, and care management interventions</td>
<td>Exchange of treatment information through in-person or telephonic contact, with chart documentation</td>
<td>Registry integrated into EHR, including severity measurement, attendance at visits, and care management interventions; selected medical measures tracked when appropriate</td>
<td>Routine sharing of information through electronic means (registry, shared EHR, and shared care plans)</td>
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<tr>
<td>No sharing of treatment information</td>
<td>Exchange of treatment information through in-person or telephonic contact, with chart documentation</td>
<td>Exchange of treatment information through in-person or telephonic contact, with chart documentation</td>
<td>Routine sharing of information through electronic means (registry, shared EHR, and shared care plans)</td>
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<td>Referral resources available at practice, no formal arrangements</td>
<td>Referrals made to agencies, possibly some formal arrangements, but little capacity for follow up</td>
<td>Patients linked to community organizations/resources, with formal arrangements and consistent follow up</td>
<td>Developing, sharing, and implementing a unified care plan between agencies</td>
</tr>
</tbody>
</table>

### Notes
- BH Specialist refers to any provider with specialized behavioral health training; CM can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice; Ancillary staff member refers to non-clinical personnel, such as office staff or receptionist; EBP refers to evidence-based psychotherapy.