ADVANCING BEHAVIORAL HEALTH INTEGRATION WITHIN NCQA RECOGNIZED PATIENT-CENTERED MEDICAL HOMES

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Center for Integrated Health Solutions

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SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first "national home" for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), and run by the National Council for Behavioral Health, CIHS provides training and technical assistance to community behavioral health organizations that received SAMHSA Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

CIHS's wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

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Behavioral Health Integration and the Patient-Centered Medical Home

HRSA's Patient-Centered Medical/Health Home (PCMHH) Initiative supports safety-net providers across the country in gaining recognition under the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Program. The PCMH model provides whole person care that is proactive, evidence-based, and coordinated, with attention to high-quality care. To fully achieve whole person care, providers and practices must focus on the physical, behavioral, and psychosocial dimensions of the people they serve, which requires an integrated care approach to behavioral health[i] and primary care.

NCQA has included more rigorous standards for behavioral health integration in its updated, 2014 PCMH Standards.[1] The following is a review of NCQA's PCMH standards as they relate to the integration of behavioral health and primary care. The review takes two approaches:

- **Part A** highlights standards that are specific to behavioral health integration,
- **Part B** applies an expanded interpretation of all standards with a lens of behavioral health integration.

Although this expanded approach is not required to achieve NCQA recognition, it is helpful information for organizations wanting to fully understand the aspects of behavioral health integration in the PCMH. This review is a resource to practices that may apply for NCQA PCMH recognition and/or those starting to integrate behavioral health and primary care.

2014 BEHAVIORAL HEALTH INTEGRATION PCMH PRINCIPLES

The PCMH model was formally described with the delineation of the PCMH joint principles and their endorsement by the four primary care professional societies in 2007.[14] In 2014, with the growing understanding that integrated behavioral health must be a core principle of the PCMH, six family medicine professional societies put forth joint principles to integrate behavioral health care into the PCMH, an expansion of the original joint principles.[15] The table below highlights both the 2007 joint principles and the expanded 2014: [15]

2007 Joint Principle	2014 Expansion Behavioral Health Integration
Personal Physician	Each patient has a personal physician who knows that patient's situation and biography.
Physician Directed Medical Practice	The health care team focuses on the physical, mental, emotional and social aspects of the patient's health care. Behavioral health providers may be part of the primary care practice, or may be connected to the primary care practice as part of the medical neighborhood.
Whole Person Orientation	To achieve a whole person orientation, care must focus on both the behavioral and physical aspects of the patient.
Care is coordinated and/or integrated	Behavioral and physical health care must be coordinated and integrated via shared registries, medical records (especially shared problem and medication lists), shared decision making, shared revenue streams and shared responsibility for patient care plans
Quality and safety are hallmarks	Care plans are developed in partnership by the patient, family, physician and behavioral health provider. Electronic health records must incorporate the behavioral health provider's notes, mental health screening and case finding tools, and behavioral health outcomes must be tracked.
Enhanced access to care	This includes access for patients, families, and physicians to behavioral health care resources through systems of collaboration, shared problem solving, flexible team leadership, and enhanced communication.
Payment recognizes the added value of the PCMH	Payment recognizes the added value of behavioral health care as part of the PCMH, and the value of behavioral health clinicians as members of the team. Funding streams should be pooled and applied flexibly such that fragmented care ends.

i. The term behavioral health is used here as an umbrella term that includes diagnosis and treatment of mental health conditions and unhealthy substance use, and to support behaviors that promote health and wellness.

To better understand the continuum of behavioral health and primary care integration, a standardized framework has been developed[2-5] that referenced throughout this review, is founded on the three primary levels of integration: coordinated, co-located, and integrated care.

- In **coordinated care**, primary and behavioral health care are provided at different locations in the medical neighborhood, but care is coordinated through enhanced communication across the two disciplines.
- In **co-located care**, primary and behavioral health care are offered at the same site, via referral and use of separate treatment plans.
- In **integrated care**, behavioral health and primary care providers work together in a team and use one treatment plan.

Part A. 2014 NCQA PCMH Standards Specific to Behavioral Health Integration

NCQA recognition standards are categorized into six standards, each of which includes several elements and factors.[1] The following table, directly from NCQA standards, highlights the four standards which include elements and factors *specific* to behavioral health integration. Further detail about implementation of these elements is provided in the Appendix.

Standard	Element	Description
Standard 2: Team-based Care	• Element 2B: Medical Home Responsibilities • Element 2D: The Practice Team*	• Documenting and communicating to patients is the process by which practices address the behavioral health needs of patients/families • Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and *behavior change*
Standard 3: Population Health Management	• Element 3B: Clinical Data+ • Element 3C: Comprehensive Health Assessment and • Element 3E: Implement Evidence Base Decision Support *	• Capturing status of tobacco use for patients 13 years and older in the electronic record in structured fields. • Performing comprehensive health assessments that include: (1) attention to an individual's behaviors that affect health, (2) history and family history of behavioral health conditions and (3) an understanding of social and cultural factors that impact the individual's health • Screening for depression using a standardized tool for practices with access to relevant services when results are positive • Implementing clinical decision support following evidence-based guidelines for a mental health or substance use disorder+ and a condition related to unhealthy behaviors
Standard 4: Care Management Support	• Element 4A: Identify Patients for Care Management **	• Identifying through a systematic process, patients who benefit from clinical care management by using criteria that consider (1) behavioral health conditions, (2) certain social determinants of health and (3) high use/high costs of healthcare services. Populations serviced by care management have a high prevalence of behavioral health conditions/issues
Standard 5: Care Coordination and Transitions	• Element 5B: Referral Tracking and Follow-up++	• Maintaining agreements with behavioral health providers to enhance access, communication and coordination across the two disciplines • Describing the approach to integrate behavioral health providers within the practice site

* 3E, Factor 1, a critical factor that must be met for practices to receive a 75% or 100% score

+ A Stage 2 core meaningful use requirement

** 4A includes a critical factor (Factor 6) that must be met for practices to receive a score above 0% on this element.

++ 5B is a must pass element and a stage 2 core meaningful use requirement: Practices that do not score above 50% will not receive recognition. In addition 5B, Factor 8 is a critical factor.

Part B. A Behavioral Health Integration Interpretation of the NCQA PCMH Standards

The previous section indicated the requirements for NCQA standards for behavioral health integration. This section provides an expanded interpretation of all standards through a lens of behavioral health integration. Although this expanded approach is not required to achieve NCQA recognition, it is provided to more fully describe behavioral health integration in the PCMH.

PCMH 1: Patient-Centered Access

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

With behavioral health integration, the ultimate goal is to provide access to team-based appointments to address physical and/or behavioral health concerns/conditions. This requires that the primary care team is skilled in addressing behavioral health concerns during office hours and can provide timely advice to patients after hours. In addition, the primary care team documents this advice and has access to a behavioral health record that includes current diagnosis, clinical status and medications, and a shared record or an agreement with a collaborating behavioral health provider. Also, patients would have access to their behavioral health record through secure electronic means and have the ability to use secure messaging for clinical advice, test results, medication refills, and appointment reminders for both physical and behavioral issues of concern.

To achieve this level of integration, it is necessary to implement training in behavioral health skills to the primary care team, incorporate formalized collaboration with a behavioral health provider on the primary care team, and have electronic capabilities for a patient portal.

PCMH 2: Team-Based Care

The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.

Team-based care is a PCMH component that emphasizes the importance of coordinating care among the clinical team and includes the patient/family and caregiver as part of the team. Element D is a "must pass" element. Factor 3 is a critical factor that addresses the importance of daily "huddles" to coordinate care.

In behavioral health integration, the behavioral health provider is an integral member of the care team. The framework for behavioral health integration describes a continuum for its implementation using coordinated, co-located, or integrated models.[ii] The team is trained to manage the care of vulnerable populations, which includes skillsets to engage vulnerable populations in care and in behavioral change. The team is further trained to develop and implement person-centered, integrated care plans.

With behavioral health integration, the practice informs patients about its processes for: (1) integrating care teams to include behavioral health providers, (2) developing integrated care plans that include behavioral and physical health goals, (3) accessing and scheduling behavioral health appointments (including the ability to schedule a behavioral health appointment from the primary care practice) and (4) providing self-management support, which includes supporting behavioral change.

The practice also assesses the diversity of its patient population and tracks care for individuals with "non-dominant social systems who are underserved." [1] This could include tracking services to underserved populations with severe and persistent mental illness and/or substance use disorders to help ensure services are delivered in a culturally appropriate manner.

ii. Learn about different models of integrated care at www.integration.samhsa.gov/integrated-care-models

PCMH 3: Population Health Management

The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

In behavioral health integration, the complete problem list should include behavioral health/substance use conditions. For example, tobacco use assessment is a standard practice among populations with severe and persistent mental illness and substance use disorders. A complete medication list should be compiled, including behavioral health medications that may be prescribed outside of primary care. The Family History also includes behavioral health and substance use conditions. A practice may develop a registry of individuals with a behavioral health condition and apply evidence-based guidelines to manage such patients. Of note, patients with behavioral health conditions may be less engaged in care and thus more in need of outreach for prevention, as well as acute and chronic disease management and medication monitoring. Medication monitoring may require coordination across primary care and behavioral health.

PCMH 4: Care Management and Support

The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

In a fully integrated model of care, one care plan is used and includes both physical and behavioral goals. Behavioral health providers are part of the care team as needed. Developing and implementing a fully integrated model requires coordination and communication between primary care and behavioral health providers. The patient/family/caregiver is considered an integral member of the care team.

In behavioral health integration, a complete medication list includes medicines prescribed for physical and behavioral conditions. Ensuring the accuracy and dissemination of one medication list is an important safety issue for patients with multiple co-morbid conditions, including behavioral health conditions that require care management services. Developing an accurate medication list requires a skilled medication review with the patient, specialists, and the pharmacist. Drug interactions are more likely to occur when patients are receiving multiple medications. Behavioral health medications such as SSRIs and antipsychotics are frequently associated with drug-drug interactions. Many behavioral health medications are expensive, and many patients need assistance identifying a generic equivalent, if available.

Self-managing chronic diseases, wellness and disease prevention requires support in behavioral change. Providers need training in techniques to engage patients in behavioral change and to identify and use community resources to support patients' health and wellbeing. In an integrated model, an embedded behavioral health provider supports patients in behavioral change. A systematic approach to identify individuals for this service is needed to ensure that an integrated model is a routine part of the practice's health care delivery.

PCMH 5: Care Coordination and Care Transitions

The practice systematically tracks tests and coordinates care across specialty care, facility-based care, and community organizations.

Standard 5 Element B is a "must pass" element, and emphasizes the importance of referral tracking and follow up. Should a primary care facility have a behavioral health coordinated care relationship with community providers, Element B requires the practice have formal/informal agreements with behavioral health providers. Factor 8 is a critical factor which requires the practice to track referrals and flag overdue responses.

In behavioral health integration, there is adequate health information exchange to permit lab test and procedural results information sharing across primary care and behavioral health providers. Lab test results that monitor adverse effects of medications should be shared by primary care and behavioral health care to reduce test duplication and to provide a coordinated management approach. Coordinating transitions of care should address behavioral health emergency department and inpatient visits, residential and partial treatment facility stays, and stays at substance abuse treatment facilities. Information sharing for behavioral health and substance abuse is often filtered through the requirements for patient confidentiality stated in privacy regulations (such as 42 CFR Part II).

PCMH 6: Performance Measurement and Quality Improvement

This standard focuses on the practice's measurement of clinical quality, resource use and care coordination and patient experience. Practices are expected to have a continuous quality improvement plan, along with interventions to improve quality and to report its performance on these metrics.

In behavioral health integration, clinical quality measures may focus on: (1) screening for behavioral health and substance use, (2) chronic disease and prevention management in patients with behavioral health conditions, (3) managing behavioral health conditions such as depression, and (4) implementing behavioral health integration processes across primary care and behavioral health. The practice measures should also include measures specific to behavioral health care coordination. For example, see the Atlas of Integrated Behavioral Health Care Quality Measures from the AHRQ Integration Academy: integrationacademy.ahrq.gov/atlas. Measures of resource use specific to behavioral health integration might include behavioral health emergency department visits, potentially avoidable behavioral health inpatient stays and readmissions, and redundant lab tests.

For patient/family experience, a practice's patient experience survey questions should include whole person care/self-management support, including attention to behavioral health and support to make changes in health habits and health care decisions. The patient experience assessment might include questions specific to behavioral health integration: perceived coordination and communication across behavioral health and primary care, respect for privacy concerns, and routinely asking questions about behavioral health problems and concerns.

Practices' quality improvement plans and processes should include goal setting and interventions to improve performance on measures of behavioral health care and behavioral health integration, as described above. Practices should develop, implement, and document interventions to improve performance on these measures, and share reports on these measures at the levels of the individual clinician and practice.

Opportunities

Further detail on implementing these elements through a behavioral health integration lens is provided in the Appendix.

In summary, PCMHs must integrate behavioral health care to achieve its full principles. Four of the six standards in the 2014 NCQA PCMH recognition program include requirements regarding behavioral health integration, several of which are 'must pass' and/or 'critical factors'. A broader interpretation of the standards (although not required by NCQA) can be used to fully understand the breadth of integration of behavioral health in the PCMH. As safety net providers transform to PCMHs and seek NCQA recognition, they will be helped by understanding models of behavioral health integration, the NCQA recognition expectations for behavioral health integration, and resources available to support their efforts.

APPENDIX

Comprehensive Review: 2014 NCQA PCMH Standards with a Behavioral Health Integration Lens

Please note that each of the elements and their point values were developed by NCQA as part of their PCMH recognition process. For more detailed information, please go to http://www.ncqa.org/Home/PatientCenteredMedicalHome.aspx*. Our analysis with a behavioral health integration (BHI) lens is in italics. All other text was written by NCQA.*

***REMINDER:** This expanded approach is not required to achieve NCQA recognition, it is provided to more fully describe the aspects of behavioral health integration in the PCMH that organizations may ultimately want to attain.*

PCMH 1: Patient-Centered Access — 10 points

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

Element 1A: Patient-Centered Appointment Access — Must Pass — 4.5 points

The practice has a written process and defined standards to provide access to appointments, and regularly assesses performance on:

Factors:

1. Providing same-day appointments for routine and urgent care — CRITICAL FACTOR
2. Providing routine and urgent-care appointments outside regular business hours
3. Providing alternative types of clinical encounters
4. Appointment availability
5. Monitoring no show rates
6. Acting on identified opportunities to improve access

This element is not specific to behavioral health integration (BHI). The ultimate goal in BHI is to have this degree of access for all types of care, including behavioral health care. However, NCQA does not expect these access standards for behavioral health appointments.

In BHI, practices would have the skillset to address behavioral health concerns at appointments, whether in person or via alternative access modalities, such as telephone, email, etc., as well as access outside of routine business hours. Addressing behavioral health concerns includes addressing behavioral change, emotional and mental health, and substance use. Skill as well as knowledge of and linkage to behavioral health resources is necessary. In a coordinated or co-located model, linkage to a specialty mental health resource would occur by referral, either in the medical neighborhood or on-site, respectively. Access outside of routine business hours may be accomplished by referral to a hotline, or a behavioral health provider on-call in the practice. In an integrated model, there may be a behavioral health provider on the primary care team who extends and enhances the behavioral health skillset of primary care. Referral to specialty mental health may still be necessary.

Element 1B: 24/7 Access to Clinical Advice — 3.5 points

The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

FACTORS:

1. Providing continuity of medical record information for care and advice when the office is closed
2. Providing timely clinical advice by telephone — CRITICAL FACTOR
3. Providing timely clinical advice using a secure, interactive electronic system
4. Documenting clinical advice in patient records

This element is not specific to behavioral health but the same holds true as in element 1A. According to NCQA, this element does not require access to the mental health or substance use record for clinicians providing after hours advice.

In BHI there is an expectation that the practice is skilled in addressing behavioral health concerns after-hours and timely advice is provided and documented. In integrated care, there would be access to, at a minimum: current behavioral health diagnosis, clinical status and medications either through a shared record or as a result of a memorandum of understanding (MOU) with behavioral health providers that stipulates communication and coordination expectations, including sharing health information.

Element 1C: Electronic Access — 2 points

The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system:

FACTORS:

1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice+
2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+
3. Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits+
4. A secure message was sent by more than 5 percent of patients+
5. Patients have two-way communication with the practice
6. Patients can request appointments, prescription refills, referrals and test results

+Stage 2 Core Meaningful Use Requirement

This element, like Elements A and B above, does not require patients to have online access to their behavioral health record (per NCQA).

In an ideal integrated practice, patients could have access to their entire record, including behavioral health record, through secure, electronic means. Patients would also have the ability to use secure messaging for clinical advice, test results, medication refills and appointment reminders, for both physical and behavioral issues of concern.

PCMH 2: Team-Based Care — 12 points

The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches

Element 2A: Continuity — 3 points

The practice provides continuity of care for patients/families by:

FACTORS:

1. Assisting patients/families to select a personal clinician and documenting the selection in practice records
2. Monitoring the percentage of patient visits with selected clinician or team
3. Having a process to orient new patients to the practice
4. Collaborating with the patient/family to develop/implement a written care plan for patients transitioning from pediatric care to adult care

This element's Factors and documentation requirements focus on selecting a personal clinician, provide a process to select a clinician and to orient patients to team-based care, and to create a standard to monitor continuity of care. In BHI, the team may include a behavioral health provider, as per the patient/family's needs. Currently, NCQA does not require evidence that a behavioral health provider is on the team and is an active member of the team. In transitioning from pediatrics to adult care, Factor 4 includes developing a care plan and transfer to a new team. It may include a behavioral health provider, but again, there is no requirement that it does, nor is there a standard for the degree of integration of the behavioral health provider in the primary care team.

In BHI, the behavioral health provider may be embedded in the primary care team, as in an integrated model, or may be co-located or located in the medical neighborhood. In the latter two models, policies and procedures (if co-located) or MOU's, (if coordinated) would stipulate the communication and coordination that is required to function as members of a patient's team of providers.

Element 2B: Medical Home Responsibilities — 2.5 points

The practice has a process for informing patients/ families about the role of the medical home and gives patients/families materials that contain the following information:

FACTORS:

1. The practice is responsible for coordinating patient care across multiple settings
2. Instructions for obtaining care and clinical advice during office hours and when the office is closed
3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice
4. The care team provides access to evidence-based care, patient/family education and self-management support
5. The scope of services available within the practice including how behavioral health needs are addressed
6. The practice provides equal access to all of their patients regardless of source of payment
7. The practice gives uninsured patients information about obtaining coverage
8. Instructions on transferring records to the practice, including a point of contact at the practice

Present in the 2011 standards and maintained in 2014 is 2014 Factor 4 – self-management support. Since much of self-management is about supporting behavioral change, this applies to BHI.

Factor 5 is a new factor in the 2014 criteria that is specific to BHI. Documentation of the process by which the practice addresses behavioral health needs and informs the patient/family of this process, is required. According to NCQA, acceptable documentation might include that the practice has a social worker on-site and/or has a referral relationship with a behavioral health provider in the community.

Applying the elements of BHI more fully, the process should include (but documentation of these are not required): (1) a process for screening for behavioral health conditions, (2) a process for addressing positive screens – for example, brief interventions that might incorporate motivational interviewing, and (3) treatment by the primary care practice (by the PCP and/or with the help of a co-located or fully integrated behavioral health provider) or referral to non-co-located behavioral health providers. Information provided to patients should also include the behavioral health providers and treatment facilities with which the practice has MOU's – i.e. the practice's preferred behavioral health providers and provider organizations. The process should also include the practice's approach to information sharing between behavioral health and primary care (including both behavioral health outpatient and inpatient settings) and include information to patients/families on patients' privacy concerns.

Factor 8, which is new in 2014, could apply to behavioral health records if a deeper interpretation of BHI were used. NCQA, however is not requiring this.

Getting deeper into an integrated model of care, the process described to patients/families might also include the process for integrating care teams including behavioral health and primary care providers and developing integrated care plans. Integrated care plans, usually developed for the most complex, high-cost patients of a practice, would be developed by the integrated care team and include both behavioral and physical goals. Information for patients might also include the process for accessing and scheduling appointments for behavioral health. In an integrated model, this process would be streamlined so that patients receive timely appointment scheduling based on need, including appointments on the same day as a PCP visit, if necessary. The ability to schedule a behavioral health appointment from the primary care practice should also be included. The process for hand-offs of care between primary care and behavioral health providers, such that care is passed and communicated in an efficient, effective and respectful way, would also be communicated to patients.

Element 2C: Culturally and Linguistically Appropriate Services — 2.5 points

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

FACTORS:

1. Assessing the diversity of its population
2. Assessing the language needs of its population
3. Providing interpretation or bilingual services to meet the language needs of its population
4. Providing printed materials in the languages of its population

According to NCQA, Factor 1 documentation requires a report of the practice's assessment of the diversity ("including racial, ethnic and at least one other meaningful characteristic of diversity"1) and language composition of its patient population. The broader definition of diversity that is included in the 2014 criteria is meant to track care for "individuals within a non-dominant social system who are underserved." Although not required by NCQA, practices that focus on BHI, might choose to track care to underserved populations, such as patients with severe and persistent mental illness and/or substance use disorders.

Element 2D: The Practice Team (Must Pass) — 4 points

The practice uses a team to provide a range of patient care services by:

FACTORS:

1. Defining roles for clinical and nonclinical team members
2. Identifying practice organizational structure and staff leading and sustaining team based care
3. Having regular patient care team meetings or a structured communication process focused on individual patient care
4. Using standing orders for services
5. Training and assigning members of the care team to coordinate care for individual patients
6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change
7. Training and assigning members of the care team to manage the patient population
8. Holding regular team meetings addressing practice functioning
9. Involving care team staff in the practice's performance evaluation and quality improvement activities
10. Involving patients/families/caregivers in quality improvement activities and/or on the practice's advisory council

This element is not specific to BHI. Documenting the addition of a behavioral health provider to the team and communicating, coordinating, and practice functioning that includes a behavioral health provider is a plus, but not a requirement for points on this element.

However, in the BHI model, the behavioral health provider is an integral member of the care team for those patients/families who require behavioral health support and care. This can be accomplished through a coordinated model or co-located model where there is a formalized agreement, or policies and procedures between the primary care and behavioral health providers that stipulates communication and team functioning expectations. In the integrated model, the behavioral health provider is embedded in the primary care practice and is an active member of the care team, sees patients as a behavioral health generalist, and advises and arranges referrals to specialty mental health as required. The embedded behavioral health provider would participate in routine team communication structures, such as huddles and team meetings.

Factor 7 is also not specific to BHI. However, it does focus on training the care team to manage patient populations, especially vulnerable populations. The guidelines provide the definition of vulnerable populations, which may include vulnerability due to place of residence (such as homelessness), populations with disabilities, and "people with multiple co-morbid conditions or who are at high risk for frequent hospitalizations or ER visits."Behavioral health conditions, including substance use disorders, are common in these populations and thus in the BHI model. The care team will require training to manage the care of individuals in these populations. This also requires a skillset to engage such individuals in care, in behavioral change, and in the development and implementation of an integrated, person-centered and culturally appropriate care plan.

PCMH 3: Population Health Management — 20.0 for the standard

The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

Element 3A: Patient Information — 3 points

The practice uses an electronic system to record patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients:

FACTORS:

1. Date of birth+
2. Sex+
3. Race+
4. Ethnicity+
5. Preferred language+
6. Telephone numbers
7. E-mail address
8. Occupation (N/A for pediatric practices)
9. Dates of previous clinical visits
10. Legal guardian/health care proxy
11. Primary caregiver
12. Presence of advance directives (N/A for pediatric practices)
13. Health insurance information
14. Name and contact information of other health care professionals involved in the patient's care

+Stage 2 Core Meaningful Use Requirement

Factor 14 includes the name and contact information of behavioral health providers involved in the patient's care (if there are any). This is a new factor for 2014.

Element 3B: Clinical Data — 4 points

The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 as structured (searchable) data:

FACTORS:

1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients
2. Allergies, including medication allergies and adverse reactions* for more than 80 percent of patients
3. Blood pressure, with the date of update for more than 80 percent of patients 3 years and older+
4. Height/length for more than 80 percent of patients+
5. Weight for more than 80 percent of patients+
6. System calculates and displays BMI+
7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (N/A for adult practices)+
8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients+
9. Status of prescription medications with date of updates for more than 80 percent of patients
10. More than 20 percent of patients have family history recorded as structured data++
11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit++

+ Stage 2 Core Meaningful Use Requirement ++ Stage 2 Menu Meaningful Use Requirement

Factors 1, 8, 9 and 10, although not specific to BHI, have particular relevance. A complete problem list should include any behavioral health/substance use conditions. Tobacco use is highly prevalent (and often goes unaddressed)in populations with severe and persistent mental illness and substance use disorders making tobacco use assessment particularly important for these populations.6 Per the guidelines, the list of prescription medications should include all medications prescribed, including those prescribed by providers outside of the practice. This procedure is likely to be in place in a non-co-located setting and may be an issue to address in a co-located setting, if there is not a shared electronic record with e-prescribing functionality. Up-to-date lists of medications and documentation of behavioral health/substance use conditions may also be an issue for integrated models that refer patients to an outside provider for specialty mental health. In addition, a whole person orientation that includes behavioral health requires obtaining and documenting family history related to behavioral health and substance use conditions.

Element 3C: Comprehensive Health Assessment — 4 points

To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

FACTORS:

1. Age and gender-appropriate immunizations and screenings
2. Family/social/cultural characteristics
3. Communication needs
4. Medical history of patient and family
5. Advance care planning (N/A for pediatric practices)
6. Behaviors affecting health
7. Mental health/substance use history of patient and family
8. Developmental screening using a standardized tool (N/A for practices with no pediatric patients)
9. Depression screening for adults and adolescents using a standardized tool.
10. Assessment of health literacy

The comprehensive health assessment required in this element includes several factors that are specific to BHI, including Factors 2, 6, 7 and 9. Except for a change in language in Factor 7 (patient and family history of mental health/substance use), these factors were present in the 2011 standards.

BHI provides a whole person orientation that requires an understanding of an individual's behaviors that affect health, understanding the individual's history and family history of behavioral health conditions, and the social and cultural factors that impact the individual's health. BHI also attends to behavioral health conditions in primary care by routinely screening for such conditions as depression, anxiety, PTSD, and alcohol and substance use.

The NCQA standards for behavioral health screening require screening for depression only, using a standardized tool, such as a PHQ9. The guidelines also reference the U.S. Preventive Services Task Force (USPSTF) which states that adults and adolescents should be screened for depression when the practice has access to services that can be used if there is a positive result (e.g., mental health providers in the practice or external to the practice and to which the practice can refer patients). How a primary care practice handles positive screening results is an important component of BHI. BHI requires the primary care provider/practice to have a behavioral health skillset to manage or co-manage patients with less complicated behavioral health conditions. It also requires models for referral to behavioral health providers – coordinated, co-located or integrated, along with on-site or referral agreements with specialty mental health and substance abuse providers.

Element 3D: Use Data for Population Management Must Pass — 5 points

At least annually, the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:

FACTORS:

1. At least two different preventive care services+
2. At least two different immunizations+
3. At least three different chronic or acute care services+
4. Patients not recently seen by the practice
5. Medication monitoring or alert

+ Stage 2 Core Meaningful Use Requirement

This element is not specific to BHI. However, for Factor 3, a practice may choose to develop a list or registry of individuals with a behavioral health condition and apply evidence-based guidelines to manage such patients. Choosing a behavioral health condition is not required for this element.

Also, patients with behavioral health conditions, many of whom might be classified as members of vulnerable populations, may need outreach and reminders for preventive care services, immunizations, acute and chronic disease management and medication monitoring, since these populations may be less engaged in primary care.

Factor 5, may have additional relevance to BHI, since BHI requires a single medication list that may include behavioral health medications. Patients prescribed such medications often require routine monitoring and management for adverse effects. If the prescriber is the primary care provider, then responsibility would fall on the primary care practice to perform the monitoring/management. If the prescriber is the specialty mental health provider, then communication across behavioral health and primary care is necessary to clarify roles/responsibilities, share monitoring results and coordinate approaches to manage adverse effects. For example, if a patient has significant weight gain as a result of the prescription of an antipsychotic medication, coordination and communication across primary and behavioral health care are necessary to manage the patient's care.

Element 3E: Implement Evidence-Based Decision Support — 4 points

The practice implements clinical decision support + (e.g. point-of-care reminders) following evidence-based guidelines for:

FACTORS:

1. A mental health or substance use disorde CRITICAL FACTOR
2. A chronic medical condition
3. An acute condition
4. A condition related to unhealthy behaviors
5. Well child or adult care
6. Overuse/appropriateness issues

+ Stage 2 Core Meaningful Use Requirement

This element has factors specific to BHI – Factors 1 and 4. Further emphasis was given to behavioral health conditions and unhealthy behaviors in the 2014 standards by splitting them into two factors, from the original one factor in 2011. In this element, a practice is required to choose a mental health or substance use disorder that has evidence-based guidelines, to identify the population of their patients that carry this diagnosis and to use clinical decision supports to implement the evidence-based guidelines. The same is true for identifying populations with an unhealthy behavior.

BHI requires an attention to behavioral health conditions and health-related behaviors in the primary care setting. This element emphasizes that attention. Note that Factor 1 is a must pass factor.

In all models of integration, there is co-management of patients with behavioral health/substance use disorders across primary care and behavioral health, whether coordinated, co-located or fully integrated. Thus, protocols or formalized agreements delineating roles and responsibilities and communication processes are necessary, but not required by NCQA, for this element.

PCMH 4: Care Management and Support — 20 points

The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

Element 4A: Identify Patients for Care Management — 4 points

The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

FACTORS:

1. Behavioral health conditions
2. High cost/high utilization of services
3. Poorly controlled or complex conditions
4. Social determinants of health
5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver
6. The practice monitors the percentage of the total patient population identified through its process and criteria CRITICAL FACTOR

This element focuses on identifying patients who would benefit from care management, emphasizes the identification criteria, and emphasizes that care management must have a whole person orientation. It is specific to BHI, since criteria to identify this high-risk population includes individuals with behavioral health conditions. Also, high utilizers, individuals with poorly controlled physical conditions and vulnerable populations due to certain social determinants of health, have an increased prevalence of behavioral health conditions.[7, 8] Thus, the population served by care management will have a high prevalence of behavioral health conditions/issues.

Also pertinent to BHI, is that care management has a whole person orientation, meaning it is integrated care management, and requires the development of an integrated care plan that has both physical and behavioral goals.

Element 4B: Care Planning and Self-Care Support — Must Pass — 4 points

The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A:

FACTORS:

1. Incorporates patient preferences and functional/lifestyle goals
2. Identifies treatment goals
3. Assesses and addresses potential barriers to meeting goals
4. Includes a self-management plan
5. Is provided in writing to the patient/family/caregiver

This element is not specific to BHI, however in an integrated model, the expectation is that there is one care plan that includes both physical and behavioral goals, and that the care team includes behavioral health providers as needed for an individual patient. The care plan development and implementation requires coordination and communication even when the behavioral health provider is not co-located with the PCP. In the latter case and in the case of a co-located model, and with the addition of specialty mental health on a referral basis, this is accomplished through formalized agreements between primary care and behavioral health providers that stipulate access, communication and coordination expectations. The expectation is that the care plan is developed with the patient/family/caregiver as integral members of the care team.

Element 4C: Medication Management — 4 points

The practice has a process for managing medications, and systematically implements the process in the following ways:

FACTORS:

1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions+ CRITICAL FACTOR
2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions
3. Provides information about new prescriptions to more than 80 percent of patients/families/ caregivers.
4. Assesses understanding of medications for more than 50 percent of patients/families/ caregivers, and includes assessment dates
5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates

+Stage 2 Core Meaningful Use Requirement

This element is not specific to BHI. However, in a BHI model, medication management requires a complete medication list that includes medicines prescribed for physical and behavioral conditions. This means that there may be multiple prescribers within and across organizations, yet one medication list. The issue of multiple prescribers is more complicated for patients with multiple co-morbid conditions who are seen by specialists, both in physical or behavioral specialties. Patients in the high-risk category often have multiple co-morbid conditions, including behavioral conditions. Thus, ensuring the accuracy and dissemination of one medication list is an important safety issue for them.

Ensuring the accuracy of the medication list requires an understanding of what the patient is actually taking. Prescribers should perform a skilled medication review with the patient (not simply reviewing a list, but asking, are you taking this medication, how do you take it, have you missed any doses in the last 3, 7 days and if so, why?). It is also necessary to review medication lists from other prescribers and from the pharmacy at which the patient receives medications. Using these methods, the primary care provider as the coordinator of care, should disseminate an updated medication list to all providers on the team.

A minimum expectation of communication across primary care and behavioral health is sharing of diagnoses, clinical status, and medication lists.

The other Factors in this element represent general good prescribing practices.

Element 4D: Use Electronic Prescribing — 3 points

The practice uses an electronic prescription system with the following capabilities:

FACTORS:

1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies+
2. Enters electronic medication orders in the medical record for more than 60 percent of medications+
3. Performs patient-specific checks for drug-drug and drug-allergy interactions+
4. Alerts prescriber to generic alternatives

+ Stage 2 Core Meaningful Use Requirement

This element is not specific to BHI. Of note, however is that Factors 3 and 4 are particularly relevant to behavioral health medication prescribing and for prescribing to patients with multiple co-morbid conditions. Drug-drug interactions are more likely to occur when patients are receiving multiple medications. Behavioral health medications, such as SSRIs and antipsychotics, are frequently associated with drug-drug interactions. Many behavioral health medications are expensive. An important consideration is identifying a less expensive generic equivalent, if available.

Element 4E: Support Self-Care and Shared Decision-Making — 5 points

The practice has, and demonstrates use of, materials to support patients and families/ caregivers in self-management and shared decision-making:

FACTORS:

THE PRACTICE:

1. Uses an EHR to identify patient-specific education resources and provides them to more than 10 percent of patients+
2. Provides educational materials and resources to patients
3. Provides self-management tools to record self-care results
4. Adopts shared decision-making aids
5. Offers or refers patients to structured health education programs such as group classes and peer support
6. Maintains a current resource list on five topics or key community service areas of importance to the patient population, including services offered outside the practice and its affiliates
7. Assesses usefulness of identified community resources

+ Stage 2 Core Meaningful Use Requirement

The Factors apply to both physical and behavioral conditions and prevention of these conditions.

This element is not specific to BHI. However, supporting individuals in their self-management of chronic diseases, both physical and behavioral, and in wellness and disease prevention, requires support for behavioral change. The care team needs the skillset and resources available in the practice and/or identified in the community, to help support individuals in choosing and maintaining healthy behaviors. The care team must be trained on techniques to engage patients in behavioral change, such as motivational interviewing, and identifying community resources to support patients in achieving their health goals. An expanded care team that includes paraprofessionals, such as peer supports, community health workers, health coaches, etc., can enhance the support provided to patients in making behavioral changes.

In an integrated model, the generalist behavioral health provider who is embedded in primary care may take on the role of supporting patients in behavioral change. Given that healthy behaviors are an important part of good health, many patients will benefit from this support. The practice will need a systematic approach to identify individuals for this type of integrated care to ensure that behavioral change is a routine part of the practice's healthcare delivery.

PCMH 5: Care Coordination and Care Transitions — 18 points

The practice systematically tracks tests and coordinates care across specialty care, facility-based care, and community organizations.

Element 5A: Test Tracking and Follow-Up — 6 points

The practice has a documented process for and demonstrates that it:

FACTORS:

1. Tracks lab tests until results are available, flagging and following up on overdue results — CRITICAL FACTOR
2. Tracks imaging tests until results are available, flagging and following up on overdue results — CRITICAL FACTOR
3. Flags abnormal lab results, bringing them to the attention of the clinician
4. Flags abnormal imaging results, bringing them to the attention of the clinician
5. Notifies patients/families of normal and abnormal lab and imaging test results
6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (N/A for adults)

7. More than 30 percent of laboratory orders are electronically recorded in the patient record+
8. More than 30 percent of radiology orders are electronically recorded in the patient record+
9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record+
10. More than 10 percent of scans and tests that result in an image are accessible electronically++

+ Stage 2 Core Meaningful Use Requirement

++ Stage 2 Menu Meaningful Use Requirement

This element is not specific to BHI. Not included in the Factors, but implied in BHI, is the existence of adequate health information exchange to permit the sharing of lab test and procedural results across providers, including behavioral health and primary care providers. Psychiatrists and primary care providers may order laboratory tests, such as prolactin, thyroid tests, and glucose to monitor adverse effects related to behavioral health medications and/ or provide information about the status of adverse effects. Sharing this information among providers should reduce test duplication and coordinate management of adverse effects.

Element 5B: Referral Tracking and Follow-Up

Must Pass

6 points

FACTORS:

1. Considers available performance information on consultants/specialists when making referral recommendations
2. Maintains formal and informal agreements with a subset of specialists based on established criteria
3. Maintains agreements with behavioral healthcare providers
4. Integrates behavioral healthcare providers within the practice site
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral
6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan
7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals+
8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports CRITICAL FACTOR
9. Documents co-management arrangements in the patient's medical record
10. Asks patients/families about self-referrals and requesting reports from clinicians

+ Stage 2 Core Meaningful Use Requirement

The 2014 standards have added several Factors to this Element that focus on behavioral health integration, specifically Factors 3 and 4. Also, Factors 1 and 2 are particularly relevant to BHI. Factor 3,"maintains agreements with behavioral health providers," incorporates Factors 1 and 2, and makes these Factors specific to behavioral health.

In coordinated models of BHI and with non-co-located specialty mental health care, practices will need to identify behavioral health care providers with whom they intend to develop formalized agreements. Identifying partners may be based on factors such as geographic location, prior positive experiences with particular providers - from both the patient and provider perspectives- and availability/accessibility of care from these providers.

MOUs or other formalized agreements between primary care and behavioral health providers should include access, communication and coordination expectations. Communication should include both electronic and/or non-electronic sharing of medical records, team communication for care planning and for management of inter-current problems/changes in clinical status. Other components of these agreements might include cross-training, reviewing cases together, and each practice's leadership engagement in advancing BHI. See MOU and contracting resources in the Center for Integrated Health Solutions website: www.integration.samhsa.gov/operations-administration/contracts-mous

In a co-located or in an integrated model, the practice's policies and procedures for coordinating and integrating care are required documentation for Factor 3. In the co-located model, the policy/procedure might include the appointment process and sharing information of completed referrals or no-shows; sharing medical records, the approach to provider-provider consultations, and team

meetings. In an integrated model, an approach might include the roles and responsibilities of the embedded generalist behavioral health provider and the other team members, the systematic approach to identifying patients for integrated behavioral health care, and the approach to communication across the team, including team meetings.

Factor 4 is a description of the approach taken by the practice to integrating behavioral and physical health care. As noted above, there is a continuum of approaches that might be taken, beginning with coordinated, and progressing to co-located and integrated, with 6 levels of integration across these three approaches.[5] Specialty mental health and/or substance abuse treatment facilities/ provider organizations may be added to these models by referral, or in some larger practices, may also be co-located or integrated.

Resources for learning more about models of integration include:

- *SAMHSA/HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/*
- *Heath, B., Wise Romero, P., & Reynolds, K. A Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013 http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf*
- *AHRQ Academy for Integrating Behavioral Health and Primary care http://integrationacademy.ahrq.gov/*
- *AHRQ Lexicon for Behavioral Health and Primary Care Integration http://integrationacademy.ahrq.gov/lexicon*
- *MA Patient Centered Medical Home Initiative Behavioral Health Integration Online Toolkit http://pcmhlearning.ehs.state.ma.us/atutor/login.php*
- *Evolving Models of Behavioral Health Integration in Primary Care (Millbank Memorial Fund), (Referenced in NCQA 2014 PCMH guidelines) http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf*

The other factors represent general good practice for making referrals and ensuring that information is received and exchanged about the reason for referral, important background information, and the final consultation assessment and plan. In BHI, issues related to patient privacy expectations and regulations may impede full health information exchange. A minimum expectation of information sharing includes diagnoses, clinical status, and medication lists. MOUs or other formalized agreements should delineate communication and information-sharing expectations and processes, and the approach to ensure patient privacy, including the approach to obtaining patients' consented release of information. Patients should be informed of the information-sharing policies and procedures and how their privacy is protected.

Element 5C: Coordinate Care Transitions — 6 points

FACTORS:

1. Proactively identifies patients with unplanned hospital admissions and emergency department visits
2. Shares clinical information with admitting hospitals and emergency departments
3. Consistently obtains patient discharge summaries from the hospital and other facilities
4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit
5. Exchanges patient information with the hospital during a patient's hospitalization
6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners
7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+

+Stage 2 Core Meaningful Use Requirement

This Element is not specific to BHI. In BHI, this Element would apply to transitions in care related to behavioral health ED and inpatient visits, residential and partial treatment facility stays, and stays at substance abuse treatment facilities. However, according to NCQA, practices do not require documenting the care transitions process specifically related to behavioral health.

Information sharing related to behavioral health and in particular, substance abuse, is often impeded by real and perceived privacy regulations and patients' expectations for privacy, making this element more difficult to achieve for behavioral health transitions in care. See comments above.

PCMH 6: Performance Measurement and Quality Improvement — 20 points

Element 6A: Measure Clinical Quality Performance — 3 points

At least annually, the practice measures or receives data on:

FACTORS:

1. At least two immunization measures
2. At least two other preventive care measures
3. At least three chronic or acute care clinical measures
4. Performance data stratified for vulnerable populations (to assess disparities in care).

This element is not specific to BHI and NCQA does not require that measures of behavioral health care, behavioral health screening, or BHI are used, although in NCQA's PCMH 2014 guidelines, screening for depression was included as an example of a measure for preventive care.

Practices that have set a goal to integrate behavioral health and primary care throughout the lifespan should include measures of BHI in their practice-specific quality improvement monitoring. This may include nationally validated measures of depression screening for adults, adults with diabetes, or screening for alcohol and tobacco use in adolescents. It may also include measures of chronic disease management and intermediate chronic disease clinical outcomes, such as blood pressure or diabetes control for patients with severe and persistent mental illness. BHI measures should also focus on care coordination and care management. Monitoring the implementation of BHI processes, such as the development of a MOU with non-co-located behavioral health providers, and having a systematic approach to identify patients for integrated behavioral health care, are helpful to assess progress towards implementing BHI. Resources for measures are provided in NCQA's 2014 guidelines. An additional resource specific to BHI is the Atlas of Integrated Behavioral Health Care Quality Measures from the AHRQ Academy for Integrating Behavioral Health and Primary care – http://integrationacademy.ahrq.gov/atlas

Element 6B: Measure Resource Use and Care Coordination — 3 points

At least annually, the practice measures or receives quantitative data on:

FACTORS:

1. At least two measures related to care coordination
2. At least two measures affecting health care costs

This element is not specific to BHI, nor does NCQA require quantitative data on care coordination across behavioral health and primary care, or behavioral health resource use measures.

However, practices that have a goal to integrate behavioral health and primary care should include measures specific to behavioral health care coordination and resource use in their practice-specific quality improvement measures set. See comments above on Element 6A. Measures of resource use specific to BHI might include behavioral health ER visits, potentially avoidable behavioral health inpatient stays and re-admissions, redundant lab tests, prescribing generic medications vs. brand name medications for behavioral health medications, etc.

Element 6C: Measure Patient/Family Experience — 4 points

At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care:

FACTORS:

1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:
   - Access
   - Communication
   - Coordination
   - Whole person care/self-management support
2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool
3. The practice obtains feedback on experiences of vulnerable patient groups
4. The practice obtains feedback from patients/families through qualitative means

This element is not specific to BHI, but NCQA specifies in its guidelines that patient/family experience surveys should include questions regarding the practice's provision of "whole person care/self-management support"... including "emphasizing the spectrum of care needs such as mental health; routine and urgent care; advice, assistance and support for making changes in health habits and making health care decisions."

Given that a whole person orientation is the general principle behind BHI, much of the standard patient experience survey questions will reflect on BHI. However, practices that have set a goal of integrating behavioral health and primary care may include questions more specific to BHI for their practice-specific quality improvement activities, such as perceived coordination and communication across behavioral health and primary care, respect for privacy concerns, and whether the practice routinely asks about behavioral health problems and concerns, etc.

Element 6D: Implement Continuous Quality Improvement — Must Pass — 4 points

The practice uses an ongoing quality improvement process to:

1. Set goals and analyze at least three clinical quality measures from Element A
2. Act to improve at least three clinical quality measures from Element A
3. Set goals and analyze at least one measure from Element B
4. Act to improve at least one measure from Element B
5. Set goals and analyze at least one patient experience measure from Element C
6. Act to improve at least one patient experience measure from Element C
7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations

This element is not specific to BHI, nor, as noted above, are measures related to behavioral health care, screening or BHI required in the QI plan and goal setting. However, for practices that have a set a goal of integrating behavioral health and primary care, quality improvement plans and processes should include goal setting and interventions to improve behavioral health care and BHI measures as described above.

Element 6E: Demonstrate Continuous Quality Improvement — 3 points

The practice demonstrates continuous quality improvement by:

FACTORS:

1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D
2. Achieving improved performance on at least two clinical quality measures
3. Achieving improved performance on one utilization or care coordination measure
4. Achieving improved performance on at least one patient experience measure

This element is not specific to BHI but practices that have set a goal to integrate behavioral health and primary care should include measures specific to BHI as noted above, set goals for improvement, develop and implement interventions to improve performance on these measures and document improvement. See comments on 6A-D.

Element 6F: Report Performance — 3 points

The practice produces performance data reports using measures from Elements A, B and C, and shares:

FACTORS:

1. Individual clinician performance results with the practice
2. Practice-level performance results with the practice
3. Individual clinician or practice-level performance results publicly
4. Individual clinician or practice-level performance results with patients

This element is not specific to BHI, but for those practices that have set a goal to integrate behavioral health and primary care, including measures specific to BHI, following the quality improvement steps summarized in 6E comments and providing reports on improvement at all of these levels, would apply.

Element 6G: Use Certified EHR Technology — Not Scored

The practice uses a certified EHR system:

FACTORS:

1. The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID+++
2. The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary, and corrects identified security deficiencies+
3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically++
4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically++
5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically ++
6. The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use+++
7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically +
8. The practice has access to a health information exchange
9. The practice has bidirectional exchange with a health information exchange
10. The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care+

+ Stage 2 Core Meaningful Use Requirement ++ Stage 2 Menu Meaningful Use Requirement +++ CMS Meaningful Use Requirement

This element is for data collection purposes only and will not be scored.

This element is not specific to BHI nor is it scored for PCMH recognition. For those practices that have a goal to integrate behavioral health and primary care, the ability to exchange information, ideally electronically, between primary care and behavioral health settings is an important element of behavioral health integration. See comments on Elements 4 and 5 B.

The ability to identify and generate lists of patients for proactive care can be an important component of BHI. As noted above in Element 4, identifying high-risk individuals for integrated care management would be facilitated by an electronic health record with comprehensive (PC and BH) functionality.

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