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Phase I Development of a Patient Perspective Measurement of Behavioral Health Integration in Primary Care: The Patient-Centered Integration Profile

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Phase I Development of a Patient Perspective Measurement of Behavioral Health Integration in Primary Care: The Patient-Centered Integration Profile

Brennen Caveney

Advised by Rodger Kessler Ph. D, ABPP, and John Green, Ph. D

The University of Vermont

April 18th, 2017
Abstract:

Health care is currently experiencing a significant amount of reform in order to improve multiple aspects of care. These reforms can be summed up as the Triple Aim. The Triple Aim is a widely accepted model for improving health care in three main areas including patient experience, clinical practice, and cost effectiveness. This current work strives to contribute to the patient experience level of the Triple Aim. In recent years medicine has seen an expanded importance of behavioral health care within primary care. A research group in UVM’s College of Medicine has created a measure to assess the level of behavioral health integration within primary care from a practice level perspective called the Practice Integration Profile (PIP). Working with this group, a decision was made to develop a tool to assess the patient perception of integrated behavioral health, and this work began that process. A literature review identified key patient preferences in integrated care. These preferences were contrasted with the PIP domains and reviewed by the PIP development team. A focus group of interested patients evaluated the identified patient preferences within relevant PIP domains. Questions for a patient experience survey of integration were drafted and reviewed by the research team for relevance to the identified patient preferences and the PIP domains. A pilot patient experience survey was developed using REDcap. A sample of patients reviewed the survey for readability and clarity of questions and identified a core group of 26 questions. Future work in this project involves further development of the measure and piloting the survey in practices who have taken the PIP survey. This data may allow practices to compare their own evaluation of integration efforts to their patient’s perceptions of integrated behavioral care.

Introduction

Primary health care is rapidly growing in the United States. An aging population requires an increased amount of primary care that strains capacity. A conceptual framework that is frequently endorsed for accomplishing efficiencies in a transformation of primary care is the
Triple Aim. The Triple Aim suggests a focus on increasing the quality of care, patient satisfaction, and decreased costs (Berwick et al., 2008). To achieve each of these goals, many different aspects of medical services are beginning to coordinate or co-locate to increase the collaboration between a broader range of care providers and their patients. Areas that are co-locating include behavioral health practice becoming part of primary care delivery. These activities have been defined as behavioral health integration. Behavioral health integration as stated by the AHRQ Integration Academy ( Peek et al., 2013): includes tightly integrated onsite teamwork with unified care planning including the patient as a standard approach to care for designated populations (of patients). There is organizational integration involving social and other services including integrated treatment, program structure, operational systems and integrated payments.

Early clinical targets for such integration have included primary care practices, and patient centered medical homes. A focus of these efforts is to optimize care outcomes for patients with both medical and behavioral comorbidities, who often require care from several providers (Singer et al., 2013). Having several care providers can become confusing and may have a negative impact on overall health. However, if care is coordinated and providers work together towards a common health goal, patients may experience a higher level of care (Singer et al., 2013). It has been suggested that chronic illness management coordination should include behavioral health.

Behavioral health care can encompass counseling for mental disorders, treatment for conditions such as depression, and substance misuse, or influencing health behaviors such as smoking, activity, and food consumption (Krist et al., 2016). Chronic illness often has behavioral
components (Cohen et al., 2015). Therefore, as populations with chronic illnesses become a larger focus of primary care, behavioral health care may have an increased importance. Kathol et al. reported that nearly 40% of patients seen in primary care have behavioral health issues, and two-thirds of those patients receive no behavioral care (Kathol et al., 2014). It is estimated that patients with behavioral comorbidity are responsible for $350 billion per year in unnecessary medical interventions, while behavioral conditions remain poorly treated (Kathol et al., 2014). The responsibility of effectively identifying and treating behavioral health needs may be beyond the capacity of a traditional primary care setting. In integrated settings, primary care includes greater access to behavioral clinicians, providing physicians with resources to arrange behavioral care for their patients (Ward et al., 2016).

Behavioral care is increasingly becoming a part of primary care, but to what degree isn’t clear in the literature. Massa et al. noted that in a survey of NCQA Patient Centered Medical Homes, about 40% of the respondents suggested that there was some form of behavioral clinician in their practice (Massa et al., 2012). The problem is exacerbated by reports that significantly less individuals who are referred to outside resources for their behavioral care actually receive appropriate behavioral care when compared to those who receive behavioral care onsite (Auxier et al., 2012). Kathol et al. observed that most patients with behavioral needs receive care solely from primary care (Kathol et al., 2014). It has been observed for 40 years, primary care is the de facto mental health care delivery system (Kessler & Stafford, 2008).

Integrating behavioral health into primary care requires processes and infrastructure to accomplish the task. To gain a better understanding of infrastructure development of behavioral care integration in primary care settings, a national research team headed by UVM
researchers, developed the Practice Integration Profile (PIP). The PIP focuses on assessing behavioral care interventions from the administrative and provider perspective. It is a 30 item web-based survey designed to allow behavioral health and primary care providers, staff, and managers to assess their own practices’ status along a continuum of progress from total absence of integration toward an idealized goal of “fully integrated behavioral health services.” (Macchi et al., 2016). It assesses the degree of processes that support integrated behavioral care. The PIP has collected over 800 responses in nearly 400 different primary care practices and has been initially effective in assisting behavioral care integration research and quality improvement (Kessler et al., 2016). The tool’s ability to compare different types of care delivery provides a holistic view of behavioral integration (Kessler et al., 2016). The PIP may continue to be a useful tool in future integration efforts and aid practices in their integration improvement.

As the research team continued development of the PIP, it became clear that it is necessary to determine the patient perspective about how behavioral care is, and should be implemented. The PIP assesses preliminary integrated behavioral care from a practice level perspective (Macchi et al., 2016). It was determined a patient respondent PIP should be developed to focus on what is of value to the patients who will be receiving this care. It is hoped that measuring integrated care patient values will assist the evolution of integrated behavioral and primary care. If physicians and health care administrators are made aware of what is important to their patients, they can make decisions about how to structure their practices and coordination efforts that include patient voice. A patient perspective of integrated care could provide better patient experience, health outcomes, and perhaps impact health care costs, the three aspects of the Triple Aim.
Methods

In collaboration with the PIP development team and a patient expert, existing domains for behavioral health integration present in the PIP (Appendix I) were assessed for their level of relevance to patients. A literature review was done to identify patient preferences of integration present in the primary care setting. Literature reviewed included a collection of more than thirty articles provided by Dr. Kessler regarding chronic illness integration and behavioral health care within primary care and results of a search by the UVM reference librarian.

After reviewing the literature, patient preferences with regards to integration were identified. The initial list of patient preferences is presented in Table 1a. We then reviewed the PIP questions and determined those that could have patient reported analogs. Additional preferences that pertain to patients considering this type of care were identified from CJ Peek’s Lexicon for Integrated Behavioral Health Care (Peek et al., 2013). Using an iterative process each of these lists were reviewed by Dr. Kessler, members of the PIP team, and a patient expert. Subsequently a list of all preferences under the PIP domains was created (Table 1b).

Concurrently with the development and review of potential questions we began creating a survey. Questions were assessed for the perceived level of importance and organized within the PIP domains. Review by the UVM IRB determined the project was “not research”. Seven patient preferences that represented a sample of the larger list were identified for presentation to an interested volunteer patient focus group (Figure 1). Focus group participants
were recruited from UVM’s Jeffords Institute of Quality and Operational Effectiveness, and some other experienced patients who were referred by an expert patient volunteer.

The focus group consisted of five patient volunteers. Volunteers were asked to share positive and negative experiences related to each of the care domains to highlight areas of importance. Identified patient values were discussed and participants rated them on a scale of 1-5, with 5 being the most important. Volunteers were shown six integrated care domains that encompassed all of the questions regarding their positive and negative experiences. Each individual was asked to choose the most important three out of the six domains. Distribution of choices was discussed with the entire group.

Values identified from the focus group were used to eliminate questions from the list of patient preferences. The resulting patient endorsed questions are summarized in Table 1c. These questions were continuously reviewed by the larger PIP development team. Concurrently, the PIP development team correlated patient approved questions to PIP questions for valid convergence. Upon approval from PIP development team, survey development began.

Revised questions were organized under the six domains of the PIP. The survey was created using REDCap electronic data capture tools hosted at UVM College of Medicine. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies (Harris et al., 2009). Apart from the questions, demographic information such as practice location and an email address were included. The
survey was reviewed by Dr. Kessler and members of the PIP research team for final adjustments in question structure and clarity.

Interested patient participants were recruited from the focus group and those who had contacted Dr. Kessler regarding a patient experience survey. Five participants were emailed a link to the survey through REDCap. These five patients were asked to fill out the survey online while on the phone to discuss the structure, relevance, and readability of each question. Patient interview feedback was used to make any necessary edits to survey questions to improve these areas. The current survey represents those results.

Results

Patient preferences identified in the literature (Table 1a) were organized with reference to the PIP domains (Table 1b). The PIP development team reviewed this list of domains for face validity. This included an itemized review of each preference and its associated domain in a group setting. Findings were presented via poster at 2016 UVM student research conference. Reviews of Peek’s lexicon for behavioral health integration and analysis of PIP questions with a volunteer patient expert led to identification of more areas relevant to patients such as consistent care between providers, and a treatment strategy that fits a patients’ lifestyle ( Peek et al., 2013). To improve patient understanding, workspace, workflow, and shared care integration domains in the PIP were changed to clinical environment, care coordination, and integration methods respectively in the Patient-Centered Integration Profile (PCIP) (Table 1b, c).

Based on focus group discussion, the original list of 27 patient preferences from the literature review was reduced to 15 patient values (Table 1c). Further reviews with the PIP
development team helped target values to specific questions corresponding to the PIP domains. These edits included separating ideas into two separate entities, the presence of an integration aspect and its importance, and this process resulted in removing and adding questions. 24 questions remained, 14 of which that were correlated with PIP questions (Appendix III). Once the questions were uploaded into REDCap, editing and restructuring of the questions with the PIP team brought the total to 28 questions (Table 1d). Patient interviews further changed questions and generated the current list of 26 questions. A final draft of the PCIP survey can be found in Appendix IV.

**Discussion:**

Starting with a review of the literature, 27 patient preferences were generated. A review of these items with the PIP development team allowed parallels to be drawn with questions in the PIP. Patient feedback optimized the list of questions to 15 of the most valuable patient preferences. Additional review of the preferences with the PIP development team resulted in 28 questions. Patient interviews to assess the clarity and relevance of each question yielded a total of 26 questions for this stage of survey development.

As integrated behavioral health care evolves, at least three areas need continued focus. The first is a definition of key aspects of integrated behavioral health care. CJ Peek’s Lexicon of Collaborative Care identifies a core set of elements (Peek et al., 2013). Second such a definition needs to be operationalized so that it can be measured by individual practices to compare their level of process integration to similar practices and to be able to use the measurement to evaluate and adjust their efforts. The PIP has shown preliminary success in evaluating practice
level of behavioral integration using a measure derived from Peek’s Lexicon. Third, key patient stakeholder assessment of integration efforts needs to be generated, and the convergence between practice and patient perception evaluated (Kessler et al., 2016 Macchi et al., 2016). This initial effort to generate stakeholder patient perspective is the focus of the Patient-Centered Integration Profile (PCIP).

In quality assurance research it is important to recognize the needs of your target demographic. Health care is no exception to this rule. Health care is ultimately a service, and patients can be viewed as consumers of a product. When evaluating what is of value to consumers, internal deliberations, focus groups, and product testing are all vital steps in achieving a successful final product. In this instance, the final product is successful behavioral health integration within primary care.

The PCIP assists furthering behavioral integration efforts by responding to the needs of the target population. It assesses what is of value to patients receiving this type of integrated care. The PCIP familiarizes the patient with the concept of integration and provides them a platform for evaluating their perception of their practice’s efforts. Perhaps most importantly, the PCIP allows comparison with the PIP, by evaluating the correspondence of patient with practice view. This association will inform further evolution of the integration of behavioral health into primary care practices.

Measurement tools like the PIP and PCIP are important preliminary steps in improving behavioral integration. They are first steps to clearly defining parameters of integration from two perspectives in health care. The PCIP engages patients by familiarizing them with necessary
aspects of behavioral health integration and provides a platform to communicate a valuable perspective to health care decision makers. This feedback loop is necessary to ensure practice level efforts are relevant to patients. An open line of communication with patients validates their opinions and gives the practice insight to their own successes and failures.

The PCIP may highlight practice integration limitations, but when combined with results from a PIP, key local aspects of integration will be much easier to identify. PCIP domains were adapted from the PIP, so at its core, the PCIP is related to the PIP. This unique relationship will present a broad integration profile of a practice. A combination of practice and patient data assessing the same domains of behavioral integration may be valuable in highlighting necessary areas of improvement within a practice. It is reasonable to postulate that correlated PIP and PCIP scores are an indication that integration efforts parallel. Results that are unrelated may suggest a lower level of integration than perceived by the practice. Essentially if a practice with a high overall PIP score receives a significantly lower PCIP score, integration efforts by the practice are not being effectively received by the patients.

**Limitations:**

A difference in PCIP and PIP scores could be a result of theorized integration efforts by the practice that fail to be recognized by the patients. However, we cannot currently interpret that. The scoring model for the PCIP still needs to be developed with the research team to correlate with the PIP methodology.

We cannot completely correlate all the questions in the PIP to the PCIP. Certain items in the PIP, such as shared medical record, are invisible to the patient and impossible to measure.
from the patient perspective. A method of comparing these non-precisely correlating scores between PIP and PCIP scores is to be developed. The PIP by design, assesses practices that are at least partially integrated under the definition from AHRQ (Peek et al., 2013). Therefore, the PCIP respondents must come from practices that adhere to the same parameters of those sampled in the PIP. We do not know how such an expectation will fit into practice flow, nor, what is the most expedient method to identify and collect such patient reported data. At this point in the development of the PCIP, we have not yet tested in a broad sample of patients, and do not know whether different patient sub groups will respond similarly.

Patient samples that were recruited for both the focus group and the patient reviews of the survey were small, with only five participants. Nine out of the ten total patients recruited were women. The nine women were all from the northern Vermont region and the one male participant was from New Hampshire. This demographic information is limiting and representative sampling will need to be done.

**Future Efforts:**

Work to date has produced a set of questions that appear to have face validity to the research team and a small group of patients. Next steps need to include development of a scoring method, patient testing of the scoring method, then piloting and evaluating the PCIP in appropriate settings to develop an administration method. Once a data set of patient and practice response is generated we need to analyze and interpret PCIP and PIP convergence. The research team will have to conduct validation studies with a larger, diverse sample. Further review of questions and scoring methodology, defining a piloting sequence and related efforts
by the larger PIP development team, could produce a workable model of the PCIP ready for initial distribution to practices by the end of 2017.

The PCIP provides a different perspective of measuring behavioral health integration than has been created before. It can be a helpful tool in assessing overall behavioral integration within primary care practices. Incorporating patient feedback is a necessary step in health care research. A comparison of patient and practice responses will ultimately expedite the process of successful behavioral integration. Integration is a proposed theory to improve health care under the Triple Aim (Berwick et al., 2008). It is likely that with the continued adaptation of tools such as the PIP and the PCIP, health care integration can continue to grow and provide patients with an improved level of access to care and hopefully improve outcomes.
Tables and Figures:

Table 1: Chronological ordering of question development. A) Patient preferences identified in the literature. B) Patient preferences organized within the PIP domains. C) Patient preferences remaining after the patient focus group. D) List of questions for survey prior to patient interviews.

| A) Patient Preferences identified from Literature Review | Planning stage, Patient understanding of care plan, Consistent communication between patient and physician, Problem solving, Proactive care, Goal setting, Transfers in health care, Access to GP, Location of care, Out of pocket cost, Trust and respect between patient and physician, Comprehensive care, Shared decision making between patient (and family) and physician, Feeling a connection between patient and physician, Coordination of care, Consistent communication, Physicians understanding of outside circumstances such as home life and lifestyle etc., Treatment plan, Follow-up assessment appointments, Smooth handoffs between care providers, Patient convenience |
| B) Patient Preferences organized within the PIP domains | **Workflow:** Patient choice of care, Transfers in health care, Appointment with behavioral health clinician same day as primary care visit,  
**Clinical Services:** Planning stage, Proactive care, Treatment plan, Behavioral care options presented in such a way that is not demoralizing or confusing to patient,  
**Workspace:** Location of care, Access to general physician, Patient convenience,  
**Shared Care and Integration:** Medication Reviews, Trust and respect between patient and physician, Comprehensive care, Feeling a connection between patient and physician, Coordination of care, Consistency in care, Smooth handoffs between care providers,  
**Case Identification:** Physician understands outside circumstances such as home life and lifestyle, Follow-up assessment appointments scheduled,  
**Patient Engagement:** Goal Setting, Patient understanding of care plan, Consistent communication between patient and physician, Shared decision making, Method of self-monitoring care |
| C) Patient Preferences | **Care Coordination:** Primary care doctor provides information regarding different options for BH treatment including multiple clinicians and community based resources, Follow up appointments are outlined and scheduled by the office on the same day, Primary care practice connects patient with necessary BH resources and remains involved in patient’s BH care |
| remaining after the patient focus group | Patient Engagement: Decisions regarding care are made between care team, patient, and care giver/family. Practice follows up with patients who have been recommended to BH care and checks in on their current involvement with BH services.  
Integration Methods: Primary care doctor and BH clinician coordinate their treatments and communicate with one another outside of my office visit. There is regular, clear communication between patient and care team. There is a shared care plan that is agreed upon by the care team, patient, and care giver/family, and is consistent at each individual office visit.  
Case Identification: Care providers take into consideration lifestyle aspects when designing a care plan. Follow up appointments are outlined and scheduled by the office on the same day. There is a regular screening procedure for BH conditions and the data is presented to the clinician at the time of a medical office visit.  
Clinical Services: There are treatment options for a wide variety of BH conditions, including counseling, prescriptions, and specialized health therapies. There is a clear planning stage between patient, primary care, and BH clinician where care plan is explained in detail.  
Clinical Environment: Convenient location between your primary care facility and your BH clinician. Timely access to your care providers. |
|---|---|
| D) Initial PCIP survey questions | My primary care practice provides information regarding different options for Behavioral Health (BH) care, including behavioral clinicians and community-based resources.  
My primary care practice arranges follow-up visits with more than one care team member during my same single office visit.  
My primary care practice connects me with necessary BH resources and remains involved in my BH care.  
My primary care practice refers to common treatment goals that are shared among my medical and BH team members.  
My primary care practice involves myself, my family, and caregivers in decisions about my care.  
My primary care practice follows up with me after a BH care recommendation and asks about my current involvement with BH services. |
<table>
<thead>
<tr>
<th>My primary care practice...</th>
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<tbody>
<tr>
<td>Provides me with opportunities to work with BH team members when necessary</td>
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<tr>
<td>My primary care practice...</td>
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<tr>
<td>Coordinates the care I get from my medical and behavioral providers</td>
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<tr>
<td>My primary care practice...</td>
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<tr>
<td>Makes references to the BH provider’s work with me</td>
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<tr>
<td>My primary care practice...</td>
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<tr>
<td>Clearly explains my care plan to me</td>
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<tr>
<td>My primary care practice...</td>
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<tr>
<td>And BH provider both appear to be aware of my care plan</td>
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<td>My primary care practice...</td>
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<tr>
<td>Developed a care plan with me, my family and caregivers, my medical provider and behavioral provider</td>
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<td>My primary care practice...</td>
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<tr>
<td>Follows my shared care plan at each office visit</td>
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<td>My primary care practice...</td>
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<tr>
<td>And BH providers take into consideration my lifestyle issues when designing a care plan</td>
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<td>My primary care practice...</td>
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<tr>
<td>Screens for BH conditions such as depression, anxiety, smoking, drinking and lifestyle issues at least annually</td>
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<td>My primary care practice...</td>
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<tr>
<td>Presents screening data to me and clinician at the time of a medical office visit</td>
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<td>My primary care practice...</td>
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<tr>
<td>References my screening data when making treatment recommendations</td>
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<td>My primary care practice...</td>
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<tr>
<td>Offers or recommends treatment options for a wide variety of BH conditions, including counseling, prescriptions and specialized health therapies</td>
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<td>My primary care practice...</td>
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<tr>
<td>Helped me with a substance abuse issue</td>
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<td>My primary care practice...</td>
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<tr>
<td>Has a behavioral provider onsite whom I saw by appointment or during a crisis</td>
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<td>My primary care practice....</td>
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<td>-----------------------------</td>
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<tr>
<td>Clearly explains care plan when myself, medical provider, and BH clinician are present</td>
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<tr>
<td>My primary care practice....</td>
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<tr>
<td>Sets up meetings with medical and BH providers within their office</td>
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<tr>
<td>My primary care practice....</td>
</tr>
<tr>
<td>Offers timely access to each care provider of my medical team</td>
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Figure 1. Critical questions from each integration domain in the PIP that were presented to the focus group participants.

**References:**

As per Department of Psychology requirements, references cited in APA format.


Appendices

Appendix I: Practice Integration Profile  pp. 22-34
Appendix II: PIP Development Team Members  pp. 35
Appendix III: Correlation between sample Patient Preferences and PIP Questions  pp. 35-37
Appendix IV: Patient Centered Integration Profile  pp. 38-42
Appendix I: Practice Integration Profile

Confidential

**PIP Practice Integration Profile V1.0**

The Practice Integration Profile is an organizational self-assessment survey operationalizing the ideas in AHRQ developed Lexicon of Collaborative Care (2013)

The lexicon defines integration as:

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic 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 healthcare utilization.

The PIP takes about 10 minutes to complete and has two purposes. First, it is meant to help you and your practice to assess where you are with your integration efforts. Second, we will use the results to improve the survey itself. All information will be analyzed and reported in a form that does not identify you or your practice. Responding to all questions is extremely important.

In return for answering all questions in the survey, you will receive a graph of your practice profile for each of the dimensions of this measure. There is no cost to you or your practice for participation. You can choose whether or not to participate. The Practice Integration Profile is still under development and we do not guarantee that your practice’s performance on the survey corresponds to evidence-based practice or improved patient outcomes. If you have any questions or concerns about the project, please feel free to contact Rodger Kessler, PhD, Associate Professor at the University of Vermont, at 802-656-4560 or Rodger.Kessler@med.uvm.edu.

Directions: We suggest that it be rated both by the Medical Director and a Senior Behavioral Health Clinician. First, please check that you have reviewed the terms and conditions. Then, read the statements in each of the eight dimensions and select the response that best reflects your organization. Most items ask for a rough approximation of how often your practice meets a particular criterion and with a numerator and denominator to guide your thinking. You don’t need to collect specific data - just provide your best estimate. Where we refer to “patients”, feel free to consider family, caregivers, surrogates and other stakeholders as appropriate. Some items are ordered such that each level implies that all the previous criteria are met. Please choose the highest level that applies based on current practice activities.

Created by: Rodger Kessler Ph.D. ABPP, Mark Kelly, Jon van Luling, Andrea Auxier Ph.D, Daniel Mullin Psy.D. MPH, C.R. Macchi Ph.D., Juvena Hitt, Benjamin Littenberg MD

Please review the attached Collaboration Agreement and once you have read and understood it, please let us know if you are willing to participate in our study below.

[Attachment: "PIPCollaborationAgreement2016.pdf"]

If you are willing to participate, Choose "YES" and thank you!  

| YES | NO |

Practice Name: ____________________________

Email Address: ____________________________

Practice Group:

- TPC&BH Workshop
- Lehigh Valley Health Network (LVHN)
- National Research Network (NRN)
- Practice group not listed or not applicable
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<td>Rural</td>
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Practice State/Territory

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
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- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- Washington D.C.
- West Virginia
- Wisconsin
- Wyoming
- American Samoa
- Guam
- Puerto Rico
- U.S. Virgin Islands

Practice Zip Code

Length of time integration effort has been active at your practice location.

- No Integration Effort
- Planning Integration but Not Executed
- Effort is 6 Months or Less
- Effort is More Than 6 Months and Less Than 1 Year
- Effort is More Than 1 Year
<table>
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<td>The behavioral health clinician(s) in your practice is</td>
<td>○ Employed by the practice or practice organization</td>
</tr>
<tr>
<td></td>
<td>○ Contracted with the clinician</td>
</tr>
<tr>
<td></td>
<td>○ Contracted for services with a different organization</td>
</tr>
<tr>
<td></td>
<td>○ We do not have a behavioral health clinician in our practice</td>
</tr>
<tr>
<td>How long has there been a behavioral health clinician as part of the</td>
<td>○ We do not have a behavioral health clinician in our practice</td>
</tr>
<tr>
<td>practice?</td>
<td>○ Less than 6 Months</td>
</tr>
<tr>
<td></td>
<td>○ 6 Months to 1 year</td>
</tr>
<tr>
<td></td>
<td>○ 1 - 2 years</td>
</tr>
<tr>
<td></td>
<td>○ More than 2 years</td>
</tr>
<tr>
<td></td>
<td>○ Do not know</td>
</tr>
<tr>
<td>May we contact you for follow up using the email you provided us above</td>
<td>○ Yes</td>
</tr>
<tr>
<td></td>
<td>○ No</td>
</tr>
</tbody>
</table>
Integration

Definition of Integration for this Measure:

"Primary care and behavioral health clinicians, working together with patients, using a systematic approach to mental health and substance abuse conditions, health behavior change, life crises, and stress-related physical symptoms." (condensed from the "Lexicon for Behavioral Health and Primary Care Integration" by CJ Peek & and the National Integration Academy Council, 2013)
PRACTICE WORKFLOW

In our practice...

...we use a standard protocol to identify, assess, treat, and follow up patients who need or can benefit from integrated Behavioral Health (BH).

Scoring Criteria:
Numerator = # of BH patients receiving protocol-based care
Denominator = # of patients in need of BH

...we use registry tracking to identify and follow patients with identified BH issues.

Scoring Criteria:
Numerator = # of patients in BH registries
Denominator = # of patients with BH needs

...we coordinate clinical care and or provide bidirectional communication for patients with BH issues who would benefit from specialty services (not primary care).

Scoring Criteria:
Numerator = # of BH patients receiving coordinated care
Denominator = # of BH patients needing coordinated care

...we connect patients with BH issues to non clinical community resources.

Scoring Criteria:
Numerator = # of BH patients receiving referral assistance to community resources
Denominator = # of BH patients needing referral to community resources

...we provide referral assistance to connect patients to specialty mental health resources.

Scoring Criteria:
Numerator = # of patients receiving referral assistance to specialty mental health resources
Denominator = # of patients needing referral to specialty mental health resources

Never for any aspects of care: 0%
Sometimes for some aspects of care: 1-33%
Often for some aspects of care: 34-66%
Frequently for most aspects of care: 67%-99%
Always for all aspects of care: 100%

(Example: Patients in need of BH services are identified, assessed, treated, and followed using a consistent set of processes)

None: 0%
Some: 1-33%
About half: 34-66%
Most: 67%-99%
All: 100%

(Example: Insomnia or depression registry)

None: 0%
Some: 1-33%
About half: 34-66%
Most: 67%-99%
All: 100%

(Example: We facilitate first appointments for and or provide ongoing bidirectional communication with specialty mental health services and specialty medical services.)

None: 0%
Some: 1-33%
About half: 34-66%
Most: 67%-99%
All: 100%

(Example: We provide with information to patients with BH issues regarding non-clinical community resources such as exercise programs, AA, disability advocates, SNAP(spell out) benefits, and support groups.)

None: 0%
Some: 1-33%
About half: 34-66%
Most: 67%-99%
All: 100%

(Example: We help schedule any appointments for psychiatry services for severe persistent mental illness.)
...we use a standard approach for documenting patients' self-management goals.

Scoring Criteria:
Numerator = # of BH patients with documented goals
Denominator = # of patients with BH needs

Total Percentage of PRACTICE WORKFLOW:

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-90%
- All: 100%
(Example: Goals are documented in a structured problem list or other well-defined place.)

(Out of 100%)
CLINICAL SERVICES for chronic/complex medical illnesses

In our practice...

...we have clinicians available on site who provide non-crisis focused BH services.

Scoring Criteria:
Numerator = # hours non-crisis BH services are available
Denominator = # of hours the clinic is open

...we have clinicians available on site to see patients in behavioral crisis.

Scoring Criteria:
Numerator = # hours crisis BH services are available
Denominator = # of hours the clinic is open

...we have BH clinicians who can see seriously mentally ill and substance-dependent patients.

Scoring Criteria:
Numerator = # hours BH services for seriously mentally ill and substance-dependent patients are available
Denominator = # of hours the clinic is open

...we offer behavioral interventions for patients with chronic/complex medical illnesses.

Scoring Criteria:
Numerator = # of patients offered BH interventions for chronic/complex medical illnesses
Denominator = # of patients needing such services

...we offer complex or specialized behavioral health therapies.

Scoring Criteria:
Numerator = # hours BH clinicians with training in specialized BH therapies are available
Denominator = # of hours the clinic is open

...we offer evidence-based substance abuse interventions.

Scoring Criteria:
Numerator = # of patients offered evidence-based substance abuse interventions
Denominator = # of patients needing such services

- Never: 0%
- Sometimes: 1-33%
- Often: 34-66%
- Frequently: 67%-99%
- Always: 100%
(Example: Scheduled care (assessment, counseling, referral, etc.) of behavioral issues)

- Never: 0%
- Sometimes: 1-33%
- Often: 34-66%
- Frequently: 67%-99%
- Always: 100%
(Example: BH provider able to see patients in behavioral crisis same day as requested.)

- Never: 0%
- Sometimes: 1-33%
- Often: 34-66%
- Frequently: 67%-99%
- Always: 100%
(Example: BH provider able to see patients with schizophrenia, problem drinking, etc.)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%
(Example: Assessment, counseling, coaching for BH needs of diabetes, cancer, heart disease, hypertension, etc.)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%
(Examples: Including but limited to: Exposure therapy for anxiety, DBT, or EMDR)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%
(Examples: Screening and brief intervention, relapse prevention focused therapy, and/or Motivational Interviewing)
...we offer prescription medications for routine mental health and substance abuse diagnoses.

Scoring Criteria:
Numerator = # of patients offered prescription medications for routine mental health or substance abuse diagnoses
Denominator = # of patients needing such services

...we offer prescription medications for serious complex co-occurring mental health and/or substance abuse diagnoses..

Scoring Criteria:
Numerator = # of patients offered prescription medications for serious mental health or substance abuse diagnoses
Denominator = # of patients needing such services

...we offer referral to non-clinical services outside of our practice.

Scoring Criteria: Numerator = # of patients offered referrals
Denominator = # of patients needing such services

Total Percentage of CLINICAL SERVICES for chronic/complex medical illnesses:

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%

(Examples: Moderate depression, anxiety, and/or opiate dependence)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%

(Examples: Major depression, bi-polar, schizophrenia)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%

(Examples: Spiritual advisors, schools, criminal justice (probation and parole, drug courts), or vocational rehabilitation)

(Out of 100%)
WORKSPACE ARRANGEMENT and Infrastructure

In our practice...

...BH and medical clinicians work in:

- Different Buildings
- Different Floors
- Different Office Suites
- Separate Parts of the Same Suite
- Fully Shared Space
  (Example: Shared building or unit)

Scoring Criteria:
Ordered - Please pick the best descriptor of your practice

...patient treatment/care plans are documented in a medical record accessible to both BH and medical clinicians

Scoring Criteria:
Numerator = # of BH patients with treatment/care plans in shared records
Denominator = # of patients receiving BH services in the practice

Total Percentage of WORKSPACE ARRANGEMENT and Infrastructure:

(Out of 100%)
INTEGRATION METHODS

In our practice...

...BH and Medical Clinicians regularly and actively exchange information about patient care.

Scoring Criteria:
Numerator = # of BH patients with regular active exchange of information
Denominator = # of patients receiving BH services

...there are regular educational activities including both BH and Medical Clinicians.

Scoring Criteria:
Ordered - Please pick the best descriptor of your practice

...BH and Medical Clinicians regularly spend time together collaborating on patient care.

Scoring Criteria:
Numerator = # of BH patients discussed in person
Denominator = # of patients receiving BH services

...patients with BH needs have shared care plans developed jointly by the patient, BH and Medical Clinicians and updated over time.

Scoring Criteria:
Numerator = # of BH patients with a jointly developed care plan
Denominator = # of patients receiving BH services

Total Percentage of INTEGRATION METHODS

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%

(Examples: "Active" includes "tasking" or both clinicians signing shared documentation. Does not include simply documenting in a place that is available to the other clinician)

- No structured educational activities
- Educational activities are provided to BH and medical clinicians separately
- Some activities with both medical and BH clinicians
- Frequent activities with both medical and BH clinicians
- Regularly scheduled activities with full participation by both medical and BH clinicians

(Examples: This includes but is not limited to sessions focused on specific conditions such as patients with chronic pain or depression. Includes case conferences, seminars, etc.)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%

(Examples: Face-to-face contact to discuss patient care)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%

(Examples: Joint visits with patient, caregivers, medical and BH clinicians for development of a problem list and action plan; iterative development of the problem list and plan by individual)

(Out of 100%)
PATIENT ENGAGEMENT

In our practice...

...we successfully engage identified patients in Behavioral Care.

Scoring Criteria:
**Numerator** = # initiating behavioral intervention  
**Denominator** = # of patients who are identified with a specific behavioral need

...we successfully retain patients in Behavioral Care.

Scoring Criteria:
**Numerator** = # completing behavioral intervention  
**Denominator** = # of patients who initiate behavioral intervention

...we have specific systems to identify and intervene on patients who did not initiate or maintain care.

Scoring Criteria:
**Numerator** = # receiving action to engage or retain  
**Denominator** = # of patients who do not initiate or complete BH care

...we have follow-up plans for all patients whose BH needs are resolved.

Scoring Criteria:
**Numerator** = # of patients with a specific follow-up plan  
**Denominator** = # of patients who complete a BH intervention

Total Percentage for PATIENT ENGAGEMENT:

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%
  (Examples: Patients who have an unmet BH need actually meet at least once with a BH provider)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%
  (Example: Patients who meet with a BH clinician collaboratively agree on treatment goals and reach one or more goals)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%
  (Example: Post-referral “tickler” files with practice staff follow-up)

- None: 0%
- Some: 1-33%
- About half: 34-66%
- Most: 67%-99%
- All: 100%
  (Example: Automatically scheduled visits with primary care provider)

(Out of 100%)
THANK YOU FOR YOUR PARTICIPATION.

A graphical representation of your results will be emailed to you within 48 hours.

If you would like to have a separate analysis of your data in comparison to a specific subset, please indicate the particular subset. An additional cost may be assessed for custom reports.

☐ Community Mental Health Center
☐ Community Health Center
☐ Pediatrics
☐ OB/Gyn
☐ Family Medicine
☐ Internal Medicine
☐ Other

If you chose "Other Specialty Medical Practice" please specify what type of practice to which you would like your practice compared.
Appendix II: PIP Development Team Members:

C.R. Macchi PhD, Rodger S. Kessler PhD, ABPP, Andrea Auxier, PhD, Juvena R. Hitt BS, Daniel Mullin PsyD, MPH, Constance van Eeghen DrPH, Benjamin Littenberg MD

Appendix III: Correlation between Sample Patient Preferences and PIP Questions

<table>
<thead>
<tr>
<th>Patient Preference Survey</th>
<th>PIP Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Coordination 1-4</strong></td>
<td><strong>Workflow</strong></td>
</tr>
<tr>
<td>My primary care practice....</td>
<td>In our practice....</td>
</tr>
<tr>
<td>Provides information regarding different options for Behavioral Health (BH) care, including behavioral clinicians and community based resources**</td>
<td>...we provide referral assistance to connect patients to specialty mental health resources.</td>
</tr>
<tr>
<td>My primary care practice....</td>
<td>In our practice....</td>
</tr>
<tr>
<td>Arranges follow-up visits with more than one care team member during my same single office visit</td>
<td>...we use a standard protocol for patients who need or can benefit from integrated Behavioral Health (BH).</td>
</tr>
<tr>
<td>My primary care practice....</td>
<td>In our practice....</td>
</tr>
<tr>
<td>Connects me with necessary BH resources and remains involved in my BH care **</td>
<td>...we provide coordination of care for patients with identified BH issues.</td>
</tr>
<tr>
<td>Refers to common treatment goals that are shared among my medical and BH team members</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Engagement 5-7</strong></td>
<td><strong>Patient Engagement</strong></td>
</tr>
<tr>
<td>My primary care practice....</td>
<td>In our practice....</td>
</tr>
<tr>
<td>Involves myself, my family and caregivers in decisions about my care.</td>
<td>...we have follow-up plans for all patients who complete BH interventions</td>
</tr>
<tr>
<td>My primary care practice....</td>
<td>In our practice....</td>
</tr>
<tr>
<td>Follows up with me after a BH care recommendation and asks about my current involvement with BH services**</td>
<td>...we successfully engage identified patients in Behavioral Care</td>
</tr>
<tr>
<td>Provides me with opportunities to work with BH team members when necessary</td>
<td></td>
</tr>
</tbody>
</table>
### Integration Methods 8-14

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinates the care I get from my medical providers and my Behavioral Providers**</td>
<td>&quot;BH and Medical Clinicians regularly exchange information about patient care&quot;</td>
</tr>
<tr>
<td>Makes references to the BH provider’s work with me</td>
<td>&quot;BH and Medical Clinicians regularly spend time together collaborating on patient care.&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearly explains my care plan to me</td>
<td>&quot;patients with BH needs have shared care plans developed jointly by the patient, BH and Medical clinicians.&quot;</td>
</tr>
<tr>
<td>And BH provider both appear to be aware of my care plan</td>
<td>&quot;patients with BH needs have shared care plans developed jointly by the patient, BH and Medical clinicians.&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed a care plan with me, my family and caregivers, my medical provider and behavioral provider</td>
<td>&quot;patients with BH needs have shared care plans developed jointly by the patient, BH and Medical clinicians.&quot;</td>
</tr>
<tr>
<td>Follows my shared care plan at each office visit</td>
<td>&quot;patients with BH needs have shared care plans developed jointly by the patient, BH and Medical clinicians.&quot;</td>
</tr>
</tbody>
</table>

### Case Identification 15-18

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers take into consideration my lifestyle issues when designing a care plan</td>
<td>&quot;all eligible adults are screened for BH conditions using a standardized procedure&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screens for BH conditions such as depression, anxiety, smoking drinking and lifestyle issues at least annually</td>
<td>&quot;all patients are screened at least annually for lifestyle or behavioral risk factors&quot;</td>
</tr>
<tr>
<td>Presents screening data to me and clinician at the time of a medical office visit**</td>
<td>&quot;screening data are presented to clinicians with recommendations for patient care.&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
<tbody>
<tr>
<td>References my screening data when making treatment recommendations</td>
<td>&quot;screening data are presented to clinicians with recommendations for patient care.&quot;</td>
</tr>
</tbody>
</table>

### Clinical Services 19-22

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>My primary care practice...</th>
<th>In our practice...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offers or recommends treatment options for a wide variety of BH conditions, including counseling, prescriptions and specialized health therapies**</td>
<td>...we offer substance abuse interventions, including evidence-based Screening and Brief Intervention</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Helped me with a substance abuse issue</td>
<td>...we have clinicians available on site who provide non-crisis focused BH services.</td>
</tr>
<tr>
<td>Has a behavioral provider onsite whom I saw by appointment or during a crisis</td>
<td>...we have clinicians available on site to respond to patients in behavioral crisis.</td>
</tr>
<tr>
<td>...we offer referral to non-clinical services outside of our practice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My primary care practice....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearly explains care plan with me, medical provider, and BH clinician present</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Environment 23-24</th>
<th>Workspace Arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>My primary care practice....</td>
<td></td>
</tr>
<tr>
<td>Sets up meetings with medical and BH providers within their office</td>
<td></td>
</tr>
<tr>
<td>My primary care practice....</td>
<td></td>
</tr>
<tr>
<td>Offers timely access to each care provider of my medical team</td>
<td></td>
</tr>
</tbody>
</table>
Appendix IV: Patient-Centered Integration Profile

Confidential

Patient-Centered Integration Profile

Please complete this survey about your practice below.

*The survey will take about 15 minutes to complete, but may be saved at the bottom and returned to later.

Your responses will be kept confidential and will not be linked to your email in the practice report.

Thank you!

Type of Practice
- Community Mental Health Center
- Community Health Center
- Pediatrics
- OB/GYN
- Family Medicine
- Internal Medicine
- Other

Name of Practice Type selected above

If other, please describe

Zip Code of Practice

Personal Email Address

Useful Definitions:

Behavioral Health (BHI) is care for:
mental health problems, substance use disorders, health behavior change, and attention to family and other psychological and social factors.

BH is used for depression, anxiety, stress, insomnia, overeating, physical inactivity, smoking, problems taking medications regularly, chronic pain, problem drinking, addiction, and other common conditions.

A Behavioral Health Provider (BHP) is someone who is trained to treat and support patients with behavioral issues. They may be psychologists, social workers, or other professionals.

A shared care plan is a personalized treatment plan for a patient that is understood by the medical and behavioral providers, the patient, and their family and caregivers.

A caregiver provides regular personal support and service to the patient, often at home. This could be a family member, a home health aide, a nurse, or other professional.

Care providers make up a person's medical team and may include a primary care physician, physicians assistant, nurse practitioner, behavioral health provider, social worker, nurse, or other professionals.

Integration can be defined as highly coordinated or co-located care with shared care planning, treatment strategies, and payment systems.

1. My practice...

...provides information regarding different options for behavioral health care, including behavioral clinicians or community based resources

- Never (0%)  
- Sometimes (1-33%)  
- Often (33-66%)  
- Frequently (67-99%)  
- Always (100%)  
- Does not apply to me
2. My practice...
...arranges follow-up appointments at each office visit

3. My practice...
...connects me with necessary behavioral health care resources

4. My practice...
...remains involved in my behavioral health care

5. My practice...
...discusses common treatment goals with me that are shared among my medical and behavioral team members

6. My practice...
...involves me, and if desired, my family/caregivers in decisions about my care.

7. My practice...
...contacts me between visits to ask about my behavioral health care

8. My medical provider...
...asks about my current involvement with behavioral health care services

9. My behavioral provider...
...asks me about my current medical care

10. My practice...
...provides me with opportunities to work with behavioral health providers
11. My medical provider...
   ...asks me about the behavioral care provider's work
   with me

12. My behavioral provider...
   ...asks me about the medical provider's work with me

13. My practice...
   ...develops a care plan with me, my medical and
   behavioral providers, and if desired, my
   family/caregivers present

14. My care team members...
   ...are all aware of my care plan

15. My care team members...
   ...all clearly understand my care plan

16. My practice...
   ...follows my shared care plan at each visit

17. My care providers...
   ...consider my daily life when designing a care plan

18. My practice...
   ...screens for behavioral conditions such as
   depression, anxiety, smoking, drinking, and other
   lifestyle issues

19. My practice...
   ...goes over the screening results with me at the
time of a medical office visit
20. My practice...
...considers my screening results when making treatment recommendations

21. My practice...
...offers or recommends treatment options for behavioral conditions, including counseling, prescriptions and special health therapies

22. My practice...
...helps me with a substance abuse issue

23. My practice...
...has a behavioral provider onsite whom I can see by appointment

24. My practice...
...has a behavioral health provider onsite whom I can see during a crisis

25. My practice...
...sets up meetings for me and my care providers within their office

26. My practice...
...offers timely access to the care providers in my medical team

Please rate the overall behavioral integration at your practice from 1-10.

1 Poor, no behavioral integration
2
3
4
5 Some integration present
6
7
8
9
10 Great, practice is fully integrated with easy transition between medical and behavioral providers
May we contact you in future with another survey via the email address provided above?

- Yes
- No

Please provide any additional comments:

______________________________