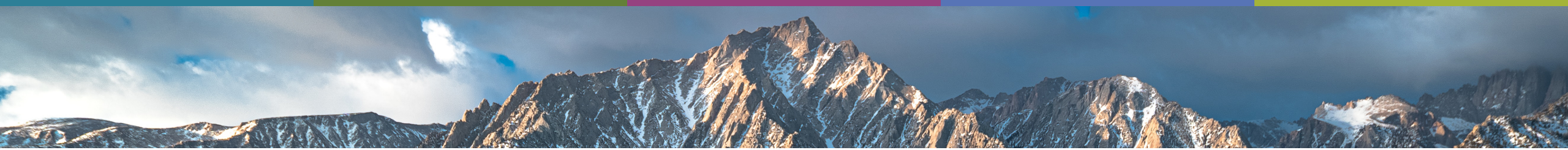**EXECUTIVE SUMMARY:**

People with Behavioral Health Conditions Guide

Populations of Focus Guide Series

This guide is part of a series focused on improving quality of care and equitable outcomes for five high-priority populations:

- Children
- Pregnant People
- Adults with Preventive Care Needs
- Adults Living with Chronic Conditions
- People with Behavioral Health Conditions

This guide provides step-by-step guidance for improving population-based care for **people with behavioral health conditions** with the goal of supporting substantive cultural, technological and process changes. It focuses on **increasing depression screening and follow-up for adolescents and adults, and depression remission or response for adolescents and adults.**

Population Health Management Initiative (PHMI) Overview

These guides were produced by PHMI, a **California collaboration of the Department of Health Care Services (DHCS), Kaiser Permanente and Community Health Centers (CHCs)**.

We're building on existing capacity of CHCs to employ **evidence-based models of care to improve quality of care and equitable health outcomes** for key populations of focus: children, pregnant people, adults with preventive care needs and adults living with chronic conditions, and people with behavioral health conditions.

Together, we are **empowering CHCs to successfully transition to the structural transformation** brought about by California Advancing and Innovating Medi-Cal (CalAIM) and new payment models through Alternative Payment Methodology (APM) 2.0.

As part of the capacity-building process, **CHCs can assess their existing population health management capacity** with the Population Health Management Capabilities Assessment Tool (PhmCAT). This self-administered tool can help organizations identify strengths and opportunities for improvement.

For more information about PHMI, visit www.phminitiative.com.
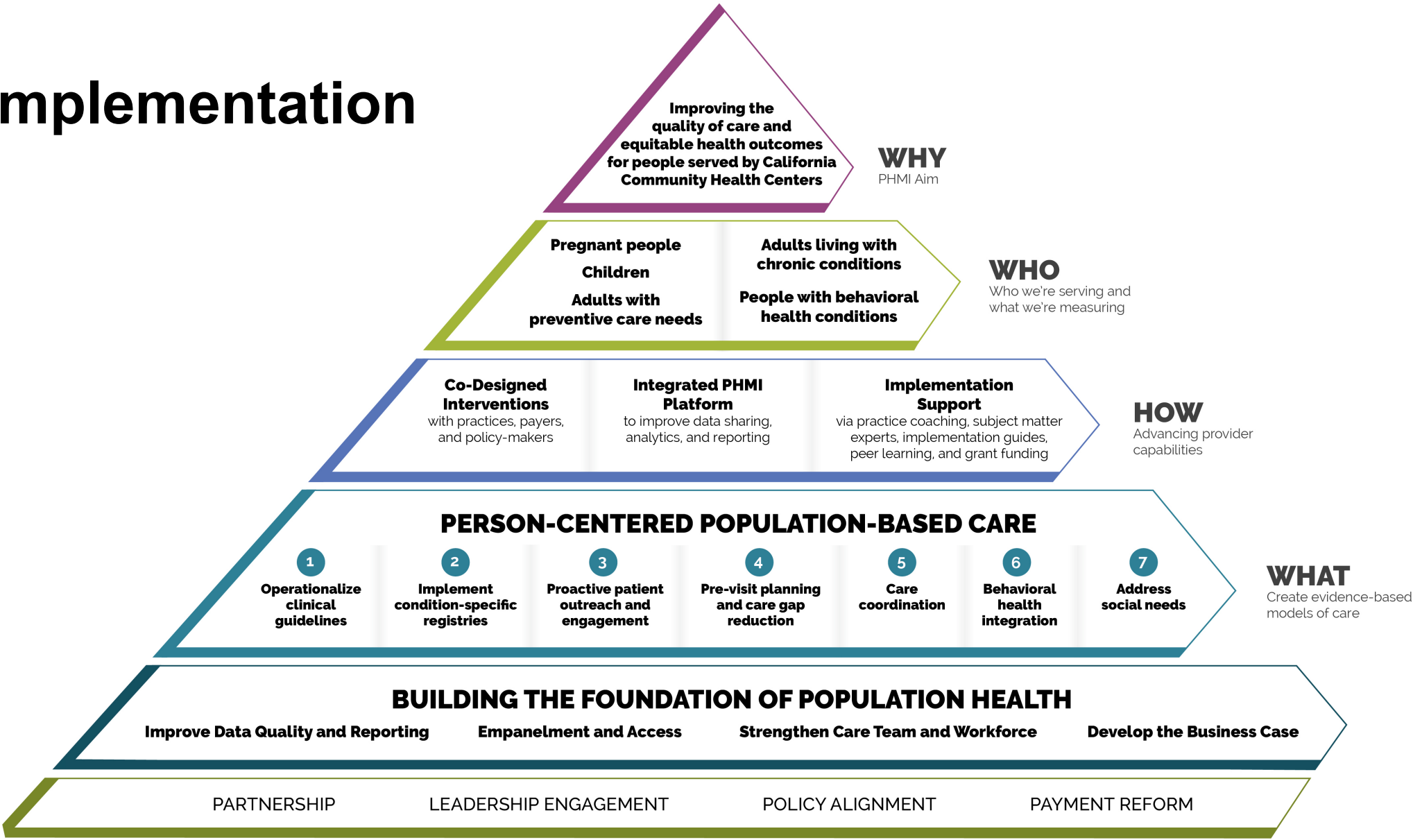
Why This is Important

Depression is a major contributor to mortality, morbidity and disability in the United States.

- An estimated 40% of the Medicaid population has a mental health and/or substance use disorder.
- Psychosocial problems drive 70% of all medical visits.

Primary care is the de facto mental health system in the United States.

- More than 60% of psychotropics are prescribed by primary care providers.
- Approximately 60% of patients prefer to discuss behavioral health issues at their primary care facility.

Most practices are understaffed making it challenging to meet patients' behavioral health needs.

Multi-disciplinary, team-based care can increase equitable access to behavioral health care, improve patient health outcomes, enhance quality of life, and improve job satisfaction of medical providers and staff.

How This Guide Is Organized

The guide uses existing evidence and bright spot examples from the field to offer practical guidance on improving care.

The key activities are organized into three categories, and we recommend that practices consider planning and attempting to implement the activities in the same order:

1. **Foundational activities:** Activities that all practices should implement.
2. **Going deeper activities:** More advanced activities that build off the foundational activities and help ensure your practice can achieve equitable improvement.
3. **On the horizon activities:** Additional activities, including "ideas worthy of testing" that include the latest ideas and thinking.

For each activity, we provide:

- **Guidance** on how to plan, test and implement the activity.
- **Links** to other resources, technology considerations and examples.
- **Tips** for periodically reviewing and making improvements to key workflows.

This guide also includes sections on measurement, equity, social health and behavioral health integration.

How To Use This Guide

The guide is designed to be part of an organized quality improvement strategy, with the goal of supporting substantive cultural, technological and process changes.

- **Sequencing activities:** We recommend implementing the activities in the sequence provided in this guide, but recognize that different practices may prioritize differently.

- **Testing and implementing:** Consider testing different versions of the action steps and roles on a small scale before scaling throughout your practice.

- **Maintaining the progress:** Ongoing review and continual improvement is important for your practice to maintain your progress and adapt to changes in patient demographics, clinical best practices, payment policies and workforce.

Foundational Competencies

If you implement the activities in this guide, you should be able to perform these foundational competencies:

1. Engage patients served by your practice to validate any of your proposed process improvements and to propose alternative methods to improve quality in your focus area.

2. Analyze core quality measures to identify disparities and improvement opportunities for achieving universal depression screening among all attributed adolescents and adults.

3. Integrate behavioral health follow-up services as needed (e.g., for positive depression screens).

4. Identify and engage behavioral health partners.

5. Create a health-related social needs screening process that informs patients' treatment plans.

6. Assess current capabilities and develop a plan for ongoing improvement in data utilization, care team workflows and efficiency that includes sustainable health information technology (HIT) strategies and continuous staff training in technology.

Who Should Use This Guide

Improving the health of a population impacts everyone in a practice. Critical roles needed to engage in the work outlined in this guide and support practice change, include:

- Chief behavioral health officers (CBHOs), chief medical officers (CMOs) and other clinical leaders.

- Operation leaders, such as chief operating officers (COOs) and practice managers.

- Quality improvement leadership, like a director of quality improvement (QI), to support cultural changes.

- Coaches or practice facilitators who are partnered with teams to help identify areas for improvement and support change through change management strategies.

Advancing Equity and Social Health

Many key activities in this guide include considerations for:

- Using the intervention to improve equitable health outcomes and reduce the effects of racism, bias and discrimination.
- Social needs at the individual or population level, such as expanding referral networks.

The following activities dive into these more deeply:

- Key Activity #10. Develop a Social Needs Screening Process that Informs Patient Treatment Plans
- Key Activity #11. Use a Systematic Approach to Address Inequities within the Population of Focus
- Key Activity #19. Strengthen a Culture of Equity

For more in-depth understanding of these topics, please see:

- PHMI Equity Framework & Approach
- PHMI Social Health Framework & Approach

Supported Quality Measures

This guide provides detailed guidance to improve your practice's results on the following HEDIS quality measures. These measures were chosen by PHMI to help CHCs improve their population health management capabilities and prepare for APM and CalAIM.

People with Behavioral Health Conditions Care HEDIS Measures for PHMI	
Core Measures	**Depression Screening and Follow-Up for Adolescents and Adults** Percentage of people aged 12 and older who were screened for depression using a standard screening tool and, if positive, received follow-up care within 30 days
Supplemental Measures	**Depression Remission or Response for Adolescents and Adults** Percentage of people 12 years and older with a diagnosis of depression, and an elevated PHQ-9 score who had evidence of response or remission within four to eight months of the elevated score.

Key Activity Summaries

Overview of Key Activities

Foundational Activities

1. Convene an IBH Implementation Team
2. Enhance the Culture of Integrated Behavioral Healthcare
3. Enhance Operational Integration of Behavioral Health
4. Develop Strategies to Maximize Capacity of IBH Services
5. Enhance Inreach and Outreach to Engage People in Behavioral Healthcare
6. Expand Access to Integrated Care
   b. Incorporate Preventive Activities into Acute Visits
7. Use Care Gap Reports or Registries to Identify all Patients Eligible and Due for Behavioral Health Screening and Follow-Up
8. Develop or Refine and Implement a Pre-Visit Planning Process
9. Adopt Universal Screening of All Adults for a Range of Behavioral Health Needs
   a. Screen Adults for Depression, Including Suicidality
   b. Implement Suicide Risk Assessment and Response Protocol
   c. Screen Adults for Anxiety
   d. Screen Adults for Unhealthy Substance Use
10. Develop a Social Needs Screening Process that Informs Patient Treatment Plans
11. Use a Systematic Approach to Address Inequities within the Population of Focus
12. Manage Treatment of Behavioral Health in Integrated, Evidence-based and Person-Centered Ways
    a. Foster Collaborative Teamwork with a Focus on Power Sharing Among Disciplines
    b. Embed Evidence-Based Care Practices
    c. Embed Develop and Implement Standing Orders
13. Optimize Patient Engagement and Activation
14. Coordinate Care

Going Deeper Activities

15. Optimize Telehealth
16. Provide Tailored Outreach, Screening and Treatment Management for Adolescent Behavioral Health
    a. Provide Proactive Inreach and Outreach to Help Adolescents Engage in Behavioral Healthcare
    b. Screen Adolescents for a Range of Behavioral Health Needs
    c. Manage Treatment of Adolescents' Behavioral Health Needs in Integrated Person-Centered Ways
17. Continue to Develop Referral Relationships and Pathways
18. Strengthen Community Partnerships
19. Strengthen a Culture of Equity

On the Horizon Activities

20. Improve Care of People with More Severely Impacting Conditions

1. **Convene an IBH Implementation Team**
    The IBH implementation team within your practice should be responsible for planning and implementing the foundational key activities in this guide and overseeing related quality improvement and equity efforts.
    Senior leadership commitment to centering, implementing and refining integrated behavioral health is crucial in fostering effective integration practices.

2. **Enhance the Culture of Integrated Behavioral Health Care**
    Promoting a culture of integrated care delivery begins by establishing a clear vision of whole-person care and its implications. This helps ensure that all clinic staff understand their respective roles in supporting care of the whole person, addressing the physical, social, and behavioral needs of the clinic's patient population. This includes ensuring parity of behavioral and physical health care within the organization, universal training in screening and response to behavioral health needs and an ongoing commitment to fostering effective collaboration among multidisciplinary care teams.

3. **Enhance Operational Integration of Behavioral Health**
    Integrated care delivery needs a foundation of integrated operations, including practice management, scheduling appointments, team-wide access to patient data in the EHR, integrated consent forms and more.

4. **Develop Strategies to Maximize Capacity of IBH Services**
    This key activity involves conducting a gap analysis to determine the scope of needed behavioral health support and developing site-specific strategies to provide such support.

5. **Enhance Inreach and Outreach to Engage People in Behavioral Health Care**
    Clearly communicating to patients within the organization about behavioral health conditions, and the availability of behavioral health services, can help connect patients to needed treatment. Successful inreach uses language and media that reflects the preferences of different populations served by the practice. As capacity grows, practices can work with partner organizations to expand outreach activities.

6. **Expand Access to Integrated Care**
    Expand access to integrated care by offering connection to behavioral health services in the primary care setting. Encouraging 'no wrong door' to behavioral health, enhancing the effectiveness of warm hand-offs, promoting equitable access to care, and leveraging peer support and community resources combine to expand access to integrated care.

a. **Incorporate Preventive Activities into Acute Visits**
   Ensuring that prevention activities are incorporated into acute visit appointments expands access to care. This creates opportunities to build interventions that are responsive to patients and families' needs and preferences for engaging in the health system. Pre-visit planning allows the team to identify patients in need of screenings, while a practice culture that honors the prime importance of patients' own priorities helps to ensure that care is delivered in ways that supports patients' dignity of choice.

7. **Use Care Gap Reports or Registries to Identify all Patients Eligible and Due for Behavioral Health Screening and Follow-Up**
   This foundational activity provides detailed guidance on how to develop and use a regularly updated list of all patients eligible for recommended or standard screenings or interventions (e.g., behavioral health screening and documentation of follow-up) through a care gap report or registry reliably and efficiently.

8. **Develop or Refine and Implement a Pre-Visit Planning Process**
   This activity provides guidance for how the care team can effectively and efficiently embed behavioral health screenings and considerations into the practice's pre-visit planning process (PVP).

9. **Adopt Universal Screening of All Adults for a Range of Behavioral Health Needs**
   This activity provides guidance on screening for depression for adults (those 18 years and older). Treatment response guidelines are outlined, including same-day follow-up for identified suicide risk and an array of follow-up options for non-urgent indications of depression.

   a. **Screen Adults for Depression, Including Suicidality**
      This activity provides guidance on screening for depression for adults including selecting a screening tool, general action steps and other considerations.

   b. **Implement Suicide Risk Assessment and Response Protocol**
      Implementing a suicide risk assessment plan/protocol to respond to patient reports of suicidal ideation.

   c. **Screen Adults for Anxiety**
      This activity provides guidance on screening for anxiety for adults, including brief notes on follow-up options.

   d. **Screen Adults for Unhealthy Substance Use**
      This activity highlights the importance of screening for substance use disorders, along with recommendations for infrastructure that should be developed to support equitable screening.

10. Develop a Social Needs Screening Process that Informs Patient Treatment Plans
This activity provides guidance on screening patients for health-related social needs and how the information can begin to be used to inform patient treatment plans, including referral to community based services.

11. Use a Systematic Approach to Address Inequities within the Population of Focus
This activity provides guidance for a systematic, evidence-based approach for identifying and then reducing inequities for people with behavioral health conditions.

12. Manage Treatment of Behavioral Health in Integrated, Evidence-Based and Person-Centered Ways

   a. Foster Collaborative Teamwork with a Focus on Power Sharing Among Disciplines
   Integrated behavioral health care requires participation of all care team members through effective power sharing. Staffing, team structures and physical spaces should reflect this orientation to whole-person care.

   b. Embed Evidence-Based Care Practices
   Find evidence-based care practices for supporting patients with behavioral health needs, including screening and assessment, a range of person-centered treatment modalities, and a collaboratively designed treatment plan.

c. **Develop and Implement Standing Orders**
    Standing orders, in concert with other key activities, allow care team members to work to the full scope of their license and provide scaffolding to support care team members as they work to greater autonomy. Implementing standing orders for behavioral health treatment could support integrated care teams to provide holistic, effective and potentially life-saving care to every patient who experiences a behavioral health crisis.

13. **Optimize Patient Engagement and Activation**
    This activity focuses on partnering with patients to foster engagement in care and health-promoting behaviors. In integrated behavioral health settings, team-based approaches are essential to fostering patient engagement and self-management.

14. **Coordinate Care**
    This activity will help you provide care that is patient-centered and coordinated across all internal and external providers involved with the patient, including specialist referrals, behavioral health referrals and connections to community resources. Behavioral health clinicians and staff should be an integral part of care coordination activities as their skills and expertise are an asset to providing comprehensive and effective support to patients with complex medical needs.

15. **Optimize Telehealth**
    Telehealth is a preferred modality for many patients seeking behavioral health services, making it an important area of growth for most practices.

16. **Provide Tailored Outreach, Screening and Treatment Management for Adolescent Behavioral Health**
    These three activities provide considerations for supporting the behavioral health needs of your adolescent patients (ages 12 to 18 years).

    a. **Provide Proactive Inreach and Outreach to Help Adolescents Engage in Behavioral Healthcare**
       Outreach consists of identifying the behavioral health care needs of adolescents in the community, while inreach involves identifying the same among your practice's adolescent patients.

    b. **Screen Adolescents for a Range of Behavioral Health Needs**
       This activity provides general recommendations on screening for behavioral health needs for adolescents, starting with depression screening.

    c. **Manage Treatment of Adolescents' Behavioral Health Needs in Integrated, Person-Centered Ways**
       This activity provides general recommendations on treatment of adolescents' behavioral health needs in integrated and person-centered ways. Confidentiality considerations are outlined, with tips and resources specific to adolescent treatment.

17. **Continue to Develop Referral Relationships and Pathways**
Your practice can take steps to optimize both the referral pathways to providers and receipt of a referral outcome regardless of referral source. Behavioral health integration strategies and expanding your practice's capacity to provide behavioral health services can be paired with continuing to expand your network of off-site behavioral health providers.

18. **Strengthen Community Partnerships**
Establishing partnerships in the community can help address the most pressing social needs and leverage essential resources that support or assist patients. Deep engagement in this work can require significant resources from your practice.

17. **Strengthen a Culture of Equity**
Find strategies and resources to create a culture of equity in your practice. That means a transformational shift at the organizational level that is necessary for long term and sustainable improvement to health and racial equity.

20. Improve Care of People with More Severely Impacting Conditions
Each practice is likely already serving people with severely impacting behavioral health conditions. This activity notes a range of methods to enhance psychiatry resources, along with practical tips to boost staff capacity to serve people with more severely impacting conditions.

Thank you!