Integration Framework and Associated Core Measures

This table is a printable summary of the Integration Framework and associated core measures found in the *Atlas of Integrated Behavioral Health Care Quality Measures (IBHC Measures Atlas)*. The table includes the "Core Measures" of integrated care only. For a full listing of the "Core Measures", "Additional Measures", and details about the developer, purpose, development and testing, past or validated applications, full citation, and copyright information for each measure, please visit the *IBHC Measures Atlas* website, available at: http://integrationacademy.ahrq.gov/atlas.

Table. Integration framework and core measures for assessing integrated behavioral health care

What is "Integrated Behavioral Health Care"?

Integrated behavioral health care is the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective 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 health care utilization.

FUNCTIONAL DOMAINS		MEASUREMENT CONSTRUCTS		MEASURES
Functional Domains divide and organize the Integration Framework into functions or actions.		**Measurement constructs** describe specific characteristics (i.e., structures), actions (i.e., processes), and outcomes that can be observed during Integrated Behavioral Health Care.		**Measures** provide details for how to define and assess measurement constructs and their sub-components.
1) Care Team Expertise: The team is tailored to the needs of particular patients and populations – with a suitable range of expertise and roles.		**Structure:** • Health care professionals with a range of expertise and roles are available and can be tailored into a team to meet the needs of specific patients and populations. **Process:** • Conduct an individualized needs assessment for a specific patient and family • Develop a unified care plan that builds a team - with necessary members and functions - to care for a given patient. • Train the care team to function in collaborative practice and respond as a team to an individual patient's unique needs. • If desired, select a sub-population of clinic patients with similar needs, such as geriatric care, children with special needs, or chronic illnesses and make available a range of team expertise generally needed to care for the selected sub-population.		C1. Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C3. Competency Assessment Instrument Measures C4. Consumer Assessment of Healthcare Providers and Systems – Clinician & Group Measures C6. Level of Integration Measure C7. Mental Health Integration Programs C8. Site Self-Assessment Evaluation Tool

Source: *Atlas of Integrated Behavioral Health Care Quality Measures*. June 2013. Agency for Healthcare Research and Quality, Rockville, MD. AHRQ Publication No. 13-IP002-EF. Available at: http://integrationacademy.ahrq.gov/atlas.

FUNCTIONAL DOMAINS		MEASUREMENT CONSTRUCTS		MEASURES

2) Clinical Workflow: The team uses shared operations, workflows, and protocols to facilitate collaboration.		**Structure**
		• Clinical protocols and workflows are clearly documented. This implies that the protocols and workflows specify:
		  ○ the roles, functions, and activities of all team members within the shared workflows;
		  ○ the types of information that need to be shared; and
		  ○ the standard way to manage the addition of team members, transitions (or "handoffs").
		
		Process
		• Consistently implement specific shared workflows rather than informal processes.
		• Collaborate toward shared goals using shared workflows.
		• Maximize team roles so that team members can do the highest-level tasks permitted by their credentials and licenses.
		• Build workflows that are coordinated, convenient, timely, and efficient from the patient's perspective.
				C1: Assessment of Chronic Illness Care
				C2. Behavioral Health Integration Checklist
				C4. Consumer Assessment of Healthcare Providers and Systems – Clinician & Group Measures
				C5. Consumer Assessment of Healthcare Providers and Systems – Health Plan Measures
				C6. Level of Integration Measure
				C7. Mental Health Integration Programs
				C8. Site Self-Assessment Evaluation Tool

3) Patient Identification: The team employs systematic methods to identify and prioritize individuals in need of integrated care.		**Structure** • Systematic methods to identify and prioritize individuals for integrated behavioral health care are present in the agreed-upon workflow. **Process** • Screening or other case identification processes are used to identify and prioritize people who need integrated behavioral health care in a timely manner.		C1: Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C3. Competency Assessment Instrument Measures C4. Consumer Assessment of Healthcare Providers and Systems – Clinician & Group Measures C5. Consumer Assessment of Healthcare Providers and Systems – Health Plan Measures C6. Level of Integration Measure C8. Site Self-Assessment Evaluation Tool C9. Young Adult Health Care Survey Measures

FUNCTIONAL DOMAINS		MEASUREMENT CONSTRUCTS		MEASURES
4) Patient and Family Engagement: The team engages patients and family (as appropriate) as active members in the integrated care team and in shared care plans.		**Structure** • Protocols or workflows for patient and family engagement are documented for care teams and in care plans. **Process** • Consistently use agreed-upon workflows for patient and family engagement.		C1: Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C3. Competency Assessment Instrument Measures C4. Consumer Assessment of Healthcare Providers and Systems – Clinician & Group Measures C5. Consumer Assessment of Healthcare Providers and Systems – Health Plan Measures C8. Site Self-Assessment Evaluation Tool
5) Treatment Monitoring: The team systematically measures patient outcomes over time and adjusts treatment as needed.		**Structure** • Clinical information, such as registry, outreach, and other information, is readily available for the purpose of monitoring and adjusting treatment. • A follow-up system (with detail on components) and workflows to use the system are documented. **Process** • Consistently use follow-up systems on a regular basis. • Adjust treatments if patients do not achieve the desired outcomes.		C1: Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C3. Competency Assessment Instrument Measures C4. Consumer Assessment of Healthcare Providers and Systems – Clinician & Group Measures C6. Level of Integration Measure C7. Mental Health Integration Programs C8. Site Self-Assessment Evaluation Tool
6) Leadership Alignment: The team is supported by leadership and administrative alignment.		**Structure** • Explicit, shared values with a visible leadership commitment to establish and maintain collaborative integrated behavioral health care exist. **Process** • Allocate resources, including money, time, and leader attention, in a manner that is consistent with stated priorities for integrated care. • Identify and address practical conflicts with other organizational priorities, incentives, and habits.		C1: Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C6. Level of Integration Measure C7. Mental Health Integration Programs C8. Site Self-Assessment Evaluation Tool

FUNCTIONAL DOMAINS		MEASUREMENT CONSTRUCTS		MEASURES
7) Operational Reliability: The team is supported by reliable and robust office processes.		**Structure** • Office workflows, processes, and quality control processes that support integrated behavioral health care are specified and documented. These structures and office systems may involve clinicians, clinic and office staff, and office processes. **Process** • Consistently use specified structures, office workflows, processes, and standards for integrated behavioral health to support highly reliable operations. • Employ quality improvement approaches, such as Lean or other process improvement methods, to improve office workflows, processes and standards.		C1: Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C6. Level of Integration Measure C7. Mental Health Integration Programs C8. Site Self-Assessment Evaluation Tool C9. Young Adult Health Care Survey Measures
8) Business Model Sustainability: The team is supported by a sustainable business model.[i]		**Structure** • A business model that is sustainable for the practice, its providers, and its patients is in place. Sustainability for patients includes copays, time off work required for appointments, driving and transportation costs in time and money—as well as health care premiums. **Process** • Monitor and modify financial performance of the integrated behavioral health aspect of the practice over time to ensure or improve sustainability, e.g., monitoring revenues, productivity, and outcomes that are rewarded financially in different ways within existing or newly emerging business models in health care.[i]		C1: Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C6. Level of Integration Measure C8. Site Self-Assessment Evaluation Tool

FUNCTIONAL DOMAINS		MEASUREMENT CONSTRUCTS		MEASURES
9) Data Collection and Use: The team is supported by the collection and use of practice-level data to achieve high quality, high value care.		**Structure** • Practice-wide systems to collect and use data for data-driven quality improvement are expected and present. **Process** • Collect practice-based data on key processes (e.g., percentage of patients with a shared care plan, percentage of patients with follow-up monitoring and treatment adjustment or outcomes of care (see outcome measures below). • Use the data to inform decisions that improve quality, effectiveness, and value. **Note:** Some quality or process improvement methods (described in #7) may yield practice data that can be incorporated as part of the practice data set used to make decisions to improve quality and value		C1: Assessment of Chronic Illness Care C2. Behavioral Health Integration Checklist C7. Mental Health Integration Programs C8. Site Self-Assessment Evaluation Tool
10) Desired Outcomes[ii] –Patient experience:		Outcomes include: • Individual patient experience with integrated behavioral health care. • Aggregate patient experience for the panel of patients who receive health care. • Aggregate patient experience (for a particular population denominator(s) defined by the practice).		C2. Behavioral Health Integration Checklist C4. Consumer Assessment of Healthcare Providers and Systems – Clinician & Group Measures C5. Consumer Assessment of Healthcare Providers and Systems – Health Plan Measures C7. Mental Health Integration Programs C9. Young Adult Health Care Survey Measures

FUNCTIONAL DOMAINS		MEASUREMENT CONSTRUCTS		MEASURES
The following outcomes are beyond the scope of the current IBHC Atlas; however, these domains and constructs are in the long-term plan for IBHC Atlas development.				
11) Desired Outcomes **a. Provider Experience**		Outcomes include: • Provider experience with integrated behavioral health care.		
b. Clinical Outcomes		• Individual patient clinical improvements due to integrated behavioral health care (may include self-care). • Individual functional improvements due to integrated behavioral health care. • Aggregate clinical outcomes for the panel of patients who receive integrated behavioral health care. • Aggregate population health (for a population denominator(s) defined by the practice).		
c. Financial Outcomes		• Aggregate total cost of care (or affordability) for the population (for a population denominator(s) defined by the practice).		
d. System Experience		• Health system administrator, leader, or institutional experience with integrated behavioral health care as an aspect of the overall system of care.		

[i] The functional domain of "Business Model Sustainability" includes measurement constructs and measures, which are within the control of a practice(s) implementing integrated behavioral health care. Broader, system-wide changes, such as reimbursement reform, are acknowledged as highly influential on a practice's business model; however, measurement of system-wide structures and processes is beyond the scope of the current Atlas.

[ii] The outcomes shown here are evaluative—the degree to which desired effects are seen. It may also be useful for this emerging field to include descriptive measures such as the proportion of patients receiving integrated behavioral health care; the proportion who need it and are actually receiving it (and who they are in terms of conditions, age, demographics, etc.); and the actual patient groups involved in integrated behavioral health care.