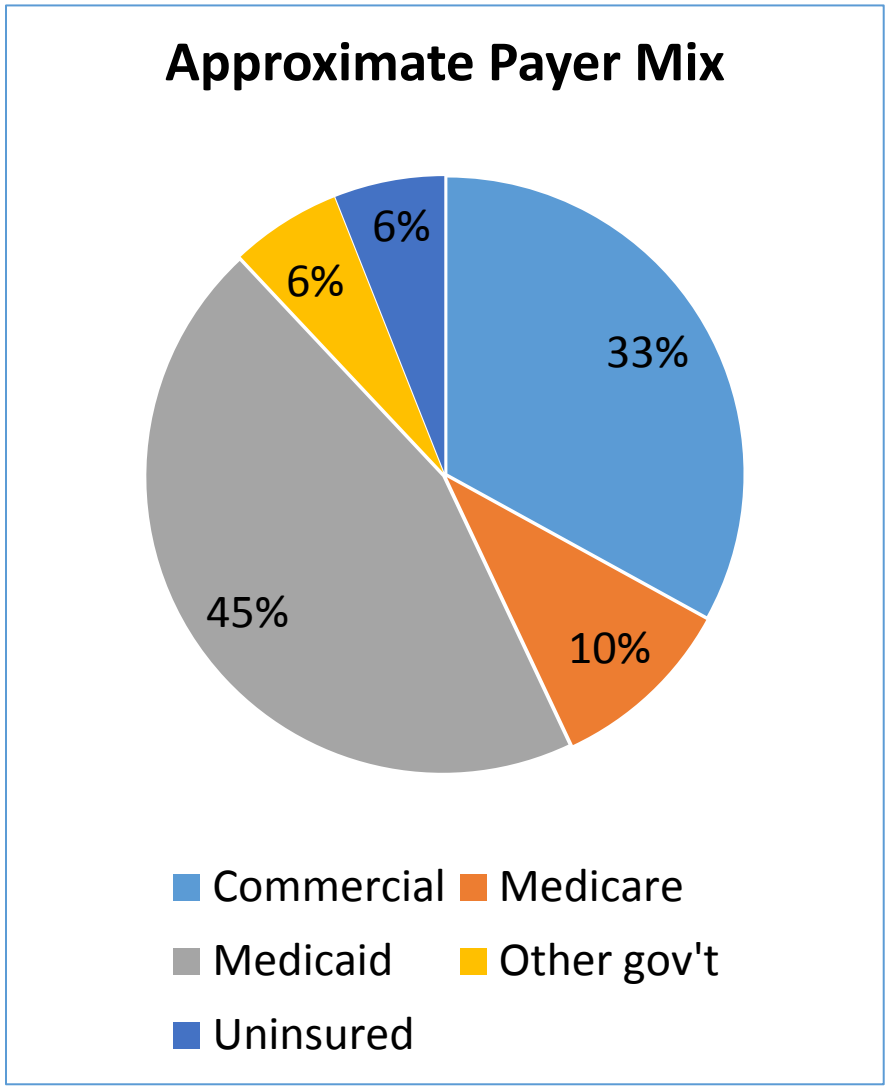
InteGREAT!
Building Capacity for Integrated Behavioral Health & Primary Care

Participating Practices at Baseline

Practice Type/Specialty	Providers & Staff N (FTE)				# of Patients Seen in Practice/ Week	PCPCH
	Primary Care Providers	Behavioral Health Providers	Medical Assistants	Nurses, Care Managers, Case Managers		
Owned by Hospital/Family Medicine	3 (3.0)	–	4 (3.5)	2 (1.6)	144	Tier III
Independent Practice Association/ Family Medicine	9 (7.0)	–	14 (11)	–	600	Tier III
Owned by Hospital/Family Medicine + Behavioral Health	11 (8.9)	4(3.0)	12 (10.6)	4 (3.8)	540	Tier III
Community Health Center/Family Medicine	13 (11.3)	–	17 (17.0)	10 (10.0)	513	Tier III
Community Health Center/Behavioral Health	0	31	0	17	550	NA



Note: The 4 primary care practices represent more than 75% of the CCO Medicaid population

Project Goals (June 2014 – May 2015)

To assist community practices in the PacificSource Community Solutions Columbia Gorge CCO in development of capacity for sustained integration of behavioral health and primary care:

1. Build partnerships among practices that are interested in integration.
2. Collaborate with practices to create the foundation for integration (clinically, operationally, and financially).
3. Provide technical assistance as practices initiate their integrated initiatives.

Work to Date

Build Partnerships

1. Engage 4 primary care clinics and 1 behavioral health agency (e.g., sign memorandum of understanding, identify project champions at each practice)
2. Established practice level cross-functional implementation teams

Foster development of learning ecosystem within practices and across the CCO

1. Practice teams meet monthly with practice facilitator, supplemented by phone and email support
2. Active participation in Integrated Clinical Work Team monthly meetings
3. Practice facilitator spreads ideas and insights across participating sites

Collect baseline data to assess current capacity for integration and identify needs for workflow development, quality improvement, and training

1. Practice Information Form
2. Comprehensive Primary Care/Health Home Monitor
3. Ability to generate “Minimal Data Set” of selected quality metrics from EHR (e.g., Diabetes, Hypertension, Depression, Anxiety, Substance Use/Abuse, BMI)

Comprehensive Primary Care Monitor

Baseline Responses to Behavioral Health Integration Section (includes 4 primary care practices)	Average Score (Self Report)				
	0 Not at All	1	2	3	4 Completely
Our practice has a shared vision for behavioral health integration that everyone understands		X			
Our practice has identified behavioral health conditions for focused quality improvement		X			
A system has been implemented to screen for patient behavioral health issues				X	
We have reliable registry data to identify and manage specific populations of patients with behavioral health concerns			X		
Our patients have easy access to comprehensive, coordinated behavioral health services in our own clinic or with community partners		X			
Protocols and work flows have been implemented for effective handoffs to and standardized follow up with our behavioral health providers		X			
A behavioral health professional has been fully integrated into patient care in our practice		X			
Our practice's business model supports the consistent delivery of integrated behavioral and medical services		X			
Personalized patient care plans are shared between behavioral health and primary care providers		X			

Next steps

1. Continue monthly meetings
2. Develop and refine workflows for delivery of integrated care
3. Complete CoACH Cost Tool to document integrated care costs
4. Implement monthly reporting of minimal data set indicators/quality metrics to ICWT/CCO
5. Share progress at quarterly ICWT meetings
6. Share progress and solicit feedback from Community Advisory Council
7. Collect follow-up data using CPC/Home Health Monitor

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