Whole Person Care: Integrating Primary Care into Behavioral Health Agencies Including Support for Clients with Severe and Persistent Mental Illness and Substance Use Disorders

Milestones Checklist to Evaluate Your Team's Readiness for Integrating Primary Care

The questions and links below can help you to determine if your behavioral health agency is ready to launch transformative changes in your integrated practice or update your current integrated care strategies to meet approaches based on emerging evidence for integrated primary care in a behavioral health setting and incorporate core principles of the Collaborative Care Model described in Project 2A of Washington's Medicaid Transformation Demonstration.

1. Do you have the involvement and organized support of key senior leadership and clinic leadership?

2. Are clinical directors, clinical supervisors, and behavioral health clinicians well-informed and involved? Do you have a senior level whole person care champion involved in planning and training? Do your program lead(s) and/or clinical supervisor(s) have enough time and resources to adequately support practice change and implementation?

3. Is a staffing plan for care managers and/or coordinators and other providers in place? Are these staff hired or under contract? Is there dedicated space for integrated staff to meet with patients?

4. Is a primary care practitioner or consultant hired or under contract for consultation and/or direct patient care? Does your organization have a plan for how you will you provide or access these services on-site or virtually (i.e., through telemedicine)? Does your primary care practitioner or consultant have access to your electronic health record and your physical health registry?

5. Do you have a registry in place with the functions you need to track patients and make sure no one falls through the cracks? Many integrated programs in Washington have launched with simple registry tools like a patient tracking spreadsheet for critical health metrics (e.g., BMI, blood pressure, HbA1c) or the AIMS Depression Tracker, while they evaluate other IT options.

6. Does leadership have a preliminary plan in place to finance and sustain your model over time, including plans to generate revenue to support integrated staffing resources?

7. Have you piloted or implemented workflows for physical health screening? Is your screening workflow described in writing/diagram or otherwise reflected in clinic protocols and staff training materials?

8. Is there a plan in place to offer evidence-based approaches for monitoring and ensuring improvement in your patients' chronic physical health conditions?

9. Do you have a written protocol in place to ensure that all patients are linked with a primary care provider (on-site or with partner agency)? Do you have established communication mechanisms for care coordination?