**Domain 3***: Clinical Improvement Projects*
**Project ID***: 3.a.i*
**Project Title***: Integration of Primary Care and Behavioral Health Services*

**Objective:**

Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

**Description:**

Integration of behavioral health and primary care services can serve 1) to identify behavioral health diagnoses early, allowing rapid treatment, 2) to ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) to de-stigmatize treatment for behavioral health diagnoses. Care for all conditions delivered under one roof by known healthcare providers is the goal of this project.

**Target Patient Population:**

Patients aged 12 years old and over who visit a project-participating primary care provider or behavioral health professional in our PPS network, with particular attention to patients living in neighborhoods with the highest rates of residents reporting psychological distress.

**Actively Engaged Patients for DSRIP Reporting Purposes:**

The total of number of patients engaged per each of the three models in this project, including:

a) PCMH Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SU.
b) Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site.
c) IMPACT: Number of patients screened (PHQ-2 / SBIRT)

**Providers Expected to Participate:**

Primary care physicians, non-PCP practitioners, clinics, behavioral health providers, substance abuse treatment providers, community based organizations, and others.

| Project Milestones |
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| **Model 1: Behavioral Health Services Co-located at Primary Care Practices Sites** |
| Co-locate behavioral health services at primary care practice sites.  Primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY3. |
| Develop collaborative evidence-based standards of care including medication management and care engagement process. |
| Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. |
| Use EHRs or other technical platforms to track all patients engaged in this project. |
| **Model 2: Primary Care Services Co-located at Behavioral Health Sites** |
| Co-locate primary care services at behavioral health sites. |
| Develop collaborative evidence-based standards of care including medication management and care engagement process. |
| Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. |
| Use EHRs or other technical platforms to track all patients engaged in this project. |
| **Model 3: IMPACT Model** |
| Implement IMPACT Model at Primary Care Sites. |

| Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement. |
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| Employ a trained Depression Care Manager meeting requirements of the IMPACT model. |
| Designate a Psychiatrist meeting requirements of the IMPACT Model. |
| Measure outcomes as required in the IMPACT Model. |
| Provide "stepped care" as required by the IMPACT Model. |
| Use EHRs or other technical platforms to track all patients engaged in this project. |