Practice self-assessment checklist based on the AHRQ lexicon for integrated behavioral health:

http://integrationacademy.ahrq.gov/lexicon

The Academy’s Lexicon is a set of concepts and definitions developed by expert consensus for what is meant by behavioral health and primary care integration—a functional definition—what is achieved in practice.

Implementing Behavioral Health Integration: A self-assessment checklist

**Behavioral health integration:** Primary care and behavioral health clinicians, working together with patients, using a systematic approach to mental health and substance abuse conditions, health behavior change, life crises, and stress-related physical symptoms.  
(Adapted from AHQR lexicon, along with the questions below)

This checklist helps your practice self-assess for how fully key functions of integrated behavioral health have been implemented in your practice so far, knowing that this is only a snapshot of the present state.

Mark along the line the point that best reflects your present state of implementation.

### Section 1: A practice team tailored to the needs of each patient and situation

1. Behavioral health expertise and functions are readily at hand—available to the practice, with practice relationships in place—ready to be part of the care team at any time for any particular patient or population.

   ![1-5 scale](image)

   - 1: Uncertain who to call, and likely not available at the time.
   - 2: Familiar face ready to join in on a moment’s notice.

2. The behavioral health expertise is brought in to the care team in the ways needed for each individual patient or in general for each target population.

   ![1-5 scale](image)

   - 1: Team composition not yet defined at the level of each individual or population.
   - 5: Team composition and roles tailored to each individual patient or target population.

3. The workflows and protocols are in place and used to actually operationalize the behavioral health participation and role in the team.

   ![1-5 scale](image)

   - 1: Workflows and protocols not yet specified or used consistently.
   - 5: In place and used by everyone all the time to get things done.
### Section 2: Patient identification and care planning

**4.** A method is in place and routinely used to identify patients who need or may benefit from integrated BH

1. An explicit method not yet in place or used; non-systematic—“gut feeling”
2. Systematic data or observations routinely used to identify individuals

**5.** Patients are engaged with clinicians in the creation of their care plan and making important decisions within it

1. Now, clinicians usually plan and decide things pretty much on their own.
2. Patients routinely part of creating plans and making decisions—couldn’t do it without them

**6.** Primary care and BH clinicians work from shared care plans developed for each shared patient, located in a single medical record that they both access.

1. Now, separate clinical plans in separate places—rarely shared
2. One clinical plan shared by all clinicians in one place they all go to

### Section 3: Systematic monitoring and adjustment of treatment plans if patients are not improving as expected

**7.** A system including a registry or patient list is in use for monitoring participation in treatment and treatment response (for individual patients and to monitor the status of selected populations).

1. So far, informal monitoring without systems—mostly via return visits or patient calls to clinic
2. Treatment and response monitored using a data-based registry system

**8.** Outreach is made to patients who do not follow up

1. If patients don’t call or come in, we don’t yet have systems or tech to reach out
2. Routine calls, emails, or letters to anyone who “falls off the radar”

**9.** The team quickly adjusts the care plan for patients who are not improving.

1. Usually takes a while to notice a need for change and then make it.
2. Need for change quickly detected, with adjustment made right away

**10.** Plans to build patient understanding of setbacks and what to do about them are established for patients who are substantially improved and no longer in active treatment

1. Active planning to prevent setbacks or “relapse” not yet in place—if patients get worse, they’re expected to call in
2. Every patient is shown what to watch for to prevent setbacks, what to do, and when to call back
Section 4: Organizational functions that support integrated behavioral health

11. A vision for integrating behavioral health in primary care is shared across the organization—along with supporting strategies, resource allocations, and leadership alignment.

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<tbody>
<tr>
<td>Right now up to each person—little shared picture or alignment</td>
<td>Clear shared vision, with incentives, resources, and leaders aligned</td>
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12. The practice team has been trained to work together across disciplines to integrate care

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<td>Little training yet—we figure out problems as we bump into them</td>
<td>We’re all trained in programs or systematically “on-the-job”</td>
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13. Clinic operational systems—office processes and workflows—reliably support daily functions of integrated behavioral health

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<tr>
<td>So far, still ambiguous, clunky, undependable</td>
<td>Clear consistent “standard work” you can depend on</td>
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14. Financial support for the functions of integrated behavioral health is reliably in place

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<tr>
<td>Constantly begging, borrowing, temporary grants, doing for free or doing without</td>
<td>Sustainable financing in place for all necessary functions</td>
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15. The practice routinely collects, uses, and internally reports practice-based data to improve outcomes and quickly learn from experience. (e.g. a locally meaningful combination of quality, patient experience, provider experience, cost, cost of care, operational reliability)

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<tr>
<td>Not more than anecdote or occasional QI so far—not much “score” reported out</td>
<td>Routine data helps us make course corrections quickly and “call out the score”</td>
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16. Our practice takes advantage of opportunities to demonstrate or educate patients and families about the value of integrated behavioral health for their own care and as a general standard of care.

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<td>We don’t try to show patients why integrated BH should be a standard of care—a few are aware</td>
<td>We take many opportunities to help patients see why this benefits them and is a standard of care—many patients aware of this</td>
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