IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care

IBHA

The Integrated Behavioral Health Alliance (IBHA) is a multi-stakeholder workgroup of healthcare payers, providers and policy developers.

IBHA promotes the full integration of behavioral and physical health services in primary care settings, as well as other physical health settings. In 2015, IBHA developed recommended standards for primary care practices providing integrated behavioral health. Those recommendations have been incorporated into the 2017 Patient Centered Primary Care Home (PCPCH) standards to illustrate what advanced integrated primary care looks like.

Throughout 2016-2018 IBHA focused its efforts around identifying a recommended set of measures to assess integrated care outcomes. It is important to note that measuring integrated care is a new and complicated endeavor, and there is a lack of existing measures that fully capture the impact of integrated behavioral health care. Despite these challenges, innovative organizations across Oregon are moving forward with developing measures to assess integrated care outcomes. IBHA encourages the lens of health equity to be applied when utilizing these measures.

The table below contains a consensus list of recommended measures; please note that IBHA encourages organizations to begin with process measures, building capacity over time to measure more complex intermediate and outcome measures. Child and adult specific measures are in development.

Health Systems, Health Plans, Accountable Care Organizations, CCOs

IBHA recommends that health systems, insurance plans, and others looking to measure progress toward integrating behavioral health in primary care use the 2017 PCPCH Standard 3.C.3 as the integration metric of choice. At the system level, IBHA concurs that measuring practice-level progress toward adopting excellent integrated care delivery models in the most meaningful way to affect system change.

The example below is a proposed method that health systems, health plans and CCOs can measure progress towards system integration:
Numerator: # of PCPCHs that have attested to meeting 2017 PCPCH measure 3.C.3
Denominator: # of PCPCHs in Oregon or in a health plan's network

IBHA recommends that primary care homes (and other medical settings) adopt an integration model that works best for their staff and patient population, and the IBHA standards provide a framework for practices looking to move beyond simply co-located behavioral health services.

The table below contains a consensus list of recommended measures; IBHA encourages organizations to begin with process measures, building capacity over time to measure more complex intermediate and outcome measures. Further detail on each recommended measure is provided in the Technical Specifications Guidelines for IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care.

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Integration Concepts	Process Measures →	Intermediate Outcome Measures →	Outcome Measures →
I. Access to Care	I. a. Percent of completed referrals to outside specialty behavioral health services	I. a. Population Penetration: Access to Integrated Behavioral Health Services: Percentage of unique patients receiving clinical services from a BHC.	I. a. Population penetration: Access to integrated behavioral health - reaching a benchmark population penetration
II. Quality of Care	II. a. Behavioral health screening rates (e.g., SBIRT, PHQ-9, CRAFFT, GAD7, ASQ, etc.)	Identification & Intervention with Target Sub-Populations: Percentage of a sub-population of patients who could benefit from BHC involvement that received a BHC intervention during the reporting period. (e.g., patients with positive BH screening, patients with new/poorly controlled chronic health condition diagnosis, diagnoses of ADHD or Functional Abdominal Pain)	II. a. Patient-Reported Outcomes (e.g., quality of life surveys) II. b. Demonstrated improvement in scores for behavioral health and/or physical health conditions. (e.g., decrease in PHQ-9 scores, lower HbA1c in patients with diabetes, etc.) for patients seen by a BHC.
III. System of Care	III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 III. b. Must meet some elements of IBHA recommended minimum standards and have a written plan to meet more elements within the next year	III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 III. b. Must meet 1st element and 3 of the remaining 6 and have a written plan to meet more elements within the next 12 months.	III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 III. b. Must meet all 7 elements

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Integration Concepts (continued)	**Process Measures →**	**Intermediate Outcome Measures →**	**Outcome Measures →**
IV. Utilization & Cost	IV. a. A fiscal sustainability plan has been established IV. b. Tracking rate of clinic patients receiving integrated behavioral health care for specific quality improvement metrics. Examples: Follow up after hospitalization for mental illness Avoidable emergency department visits ED utilization among patients with serious mental illness(es) Comprehensive Diabetes Care: HbA1c Poor Control Controlling high blood pressure	IV. a. Meet engagement benchmarks for the integrated behavioral health care for specific quality improvement metrics.	IV. a. Comparison of total cost of care for comparably risked patients for patients those receiving integrated care with patients receiving standard (non-integrated) care IV. b. Demonstrate clinical or system impact of integrated behavioral health program on quality metrics and health outcomes
V. Patient Experience of Care	V. a. Patient and family experience receiving integrated care (survey) Note: Preference for real-time data over dated information.)	V. a. Patient and family experience receiving integrated care, demonstrating aggregated improvement (survey data)	V. a. Patient and family experience receiving integrated care, demonstrating improvement and reaching a benchmark (survey data)
VI. PCP Engagement & Satisfaction	VI. a. Measurement of PCP satisfaction with integrated care at practice level (e.g., Likert scale 1-10)	VI. a. Measurement of PCP satisfaction with integrated care at practice (e.g., Likert scale 1-10) VI. b. Measurement of PCP's utilization of BHC	VI. a. Measurement of PCP satisfaction with integrated care at practice (e.g., Likert scale 1-10) VI. b. Measurement of PCP's utilization of BHC demonstrating improvement of benchmark over previous year's measures