GROW Pathway Planning Worksheet: Completed Example

Anytown FQHC GROW Integrated Behavioral Health Plan

Goal: **Which populations of patients are we targeting?**	
	Do we serve this population now? How do we want to serve this population better?
Patients in crisis and distress	*We need to be able to see several patients per day to support PCPs. Right now a social worker helps with this challenge.*
Patients with common chronic mental illnesses such as depression and anxiety	*We have a large older adult population with co-morbid depression and diabetes that we would like to serve better.*
Patients needing support to manage serious, chronic and persistent mental illness	*This is not currently a big challenge for our clinic, and we have a good relationship with our community mental health center next door.*
Other populations	*We have a small OB practice and would like to be able to serve these patients with better post-partum depression care.*

Resources: **What are the resources available to us? What resource challenges need to be addressed?**	
	What resources does our organization have?
Geography	*We are an urban clinic located near a community mental health center.*
Physical space	*We have a fairly new space. The social workers currently sit in an office that is in the back of the clinic and the PCPs sit in the front of the clinic in their workroom. We may need to think about how to integrate their workflow more.*
Support of leadership	*We have a strong leadership team of administrative and medical direct staff leading our PCMH effort.*
Care team and workforce development	*We could shift some of the social worker's time to BHP time to provide new functions to support a mental health effort if we made her full time. We have a psychiatrist that is 0.2 FTE who is always fully booked, but with many no shows.*
Shared workflows	*We have not traditionally shared mental health and medical notes or had formal huddles. We are interested in exploring these options.*
Available technology/HIT	*We have a new EHR and providers like the system now that they are used to it. We have some capacity to create registry functions in this system.*
Financial Resources	*We have a small grant to start the transformation but then need to work toward financial sustainability. This will be a change because we have never charged for mental health visits.*

Options:

What capacities do we have now and how can we create capacity to integrate behavioral health?

		Do we do this?	How can we do this?
Access	Facilitated referral	*Yes*	*We might need to improve our tracking system.*
	Onsite behavioral health provider	*Yes*	*We might need to increase BHP FTE. We may need to contract for additional psychiatric consultation. We need to address the rate of patient no-shows to maximize existing psychiatric consultant's time.*
Accountability	Measurement-based treatment-to-target for individuals	*No*	*Some providers have used a screener since getting the new EHR; but this is not routine in the clinic.*
	Commitment to population outcome improvement	*No*	*We have moved to tracking a population for diabetes so the providers are familiar with the idea but we have not done this for depression.*

Workflow:

What changes will need to be in place for us to deliver integrated behavioral health?

Does staff need to be hired? What types of staff? Do existing or new staff need to be trained?	*We will need to hire our social worker BHP full time to provide support to a population of patients with diabetes and depression. We will try splitting the psychiatric consultant time to 0.1 FTE caseload consultant to work with the BHP and 0.1 FTE to see patients. Our caseload team will need training in Collaborative Care. All staff will need training in integrating the PHQ-9 into clinical workflow, and measurement-based treatment to target.*
What facilities, HIT, and other resources are required to implement the integrated workflow?	*We will need funding to support increased staff time. We will need office space for the increased staff time, including computers. We will need the ability to track PHQ-9 scores in our EHR. We will need to create a registry to support the caseload functions for our depressed patients with diabetes and/or post-partum depression.*
What internal communication materials and protocols, and practice-specific guidelines and protocols for psychiatric emergencies do we need?	*We will develop a clear plan about team communication. We will use the phone for psychiatric consultation scheduled weekly with the care manager and as needed for the PCPs. We will use messaging in patient notes for most communication and a weekly huddle with the diabetic team to coordinate care for patients. We have a safety protocol, but will need to confirm all staff have had training related to this protocol.*
How will our physical space foster collaboration? Should providers share a pod?	*Since we are a small clinic we have the care manger office close to the PCP workspace. We will ask the psychiatric consultant to work in the main pod while writing notes to facilitate access for curbside questions.*
What materials do we need to introduce the new care delivery pathway to patients and practice clinicians and staff?	*We will create a team flyer to promote and celebrate our new care effort. We need good depression care information to share with patients and family. We can promote this effort in the waiting room bulletin, our clinic newsletter and at all staff meetings.*

How will we schedule visits? Will we schedule follow-ups interspersed with open access appointments to facilitate time for just-in-time consultations and warm handoffs?	*We will schedule patients for two contacts per month. At least one of these will be in person. Our care manager will need some open spaces to allow her to see patients urgently so we will keep some same day slots in her template for warm handoffs. The psychiatric consultant can have four slots: two for patients in the general population and two reserved for patients off the registry.*
When and how will we evaluate our progress? What would be the next step if we don't reach our goal? How will we know we are not just going through the motions?	*We expect that more patients in our diabetic population would be identified and treated for depression. We will measure the number and proportion of diabetic patients screened for depression. We will measure the number and proportion of patients with clinically significant decreases in PHQ-9 depression scores out of the whole population and the target population. We will evaluate the access to care appointment times for behavioral health visits. We will survey patients about their experience with behavioral health care after six weeks of treatment. We will survey the providers at the start and after six months of this effort around their satisfaction. Our clinic manager will be responsible for gathering this data and presenting it monthly for six months and quarterly thereafter to the project team. If we are not meeting our goals we will revisit this process.*

Safety Net Medical Home Initiative

The Organized, Evidence-Based Care Supplement: Behavioral Health Integration is a component of the *Safety Net Medical Home Initiative Implementation Guide Series*.

The goal of the Safety Net Medical Home Initiative (2008-2013) was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon, and Pittsburgh), representing 65 safety net practices across the U.S. The partner sites and Regional Coordinating Centers that participated in the SNMHI were members of a learning community working toward the shared goal of PCMH transformation. The *SNMHI Implementation Guide Series* was informed by their work and knowledge, and that of many organizations that partnered to support their efforts.

The SNMHI was supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The Initiative also received support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center.

For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

For more information about The Commonwealth Fund, refer to www.cmwf.org.

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