(Draft) Community Care for Depression
Integration of Behavioral Health and Primary Care

	Bifurcated, Split, at Odds	Parallel-in the same building, paths cross but limited teamwork.	Getting together…getting there…getting to know you!	Integrated-team works together seamlessly.
EMR/Medical Records	PCP's don't read behavioral health notes or actively seek behavioral health information about patients. Social Workers don't read provider notes or seek medical information. EMRs are set up so that interdisciplinary access to notes is difficult or impractical.	PCP's and Social workers are aware that the information is available to them but not at the point where they find it necessary to review.	PCP's and Social Workers begin to look further into the EMR and take all notes into consideration when seeing the patient.	EMR system is utilized regularly in a way that consistently tracks both the medical and behavioral health of each patient. (pop-ups etc.) Both disciplines read notes and respond accordingly. The EMR is set up so that interdisciplinary access is seamless. Any acute or emergent information is easily communicated to relevant staff.
Space	Medical and behavioral health disciplines rarely "cross paths" formally or informally because of office structures/separate floors etc. Behavioral health is rigid about the 50 min hour, no interruptions etc. PCP's lack understanding of time necessary for counselors to deal with behavioral health complexities.	Medical and behavioral health providers try to check in with one another but it is difficult because they are not able to track each other down.	PCP's and Social Workers make it a point to check in with one another regularly on particular patients. Offices are located as near as possible to one another. Each discipline welcomes "visits" from the other	Counseling and exam rooms are situated so that Social Workers and PCP's can easily check in and compare patient information during the day. Administration supports colocation of offices and disciplines.
Materials	Primary care and behavioral health information doesn't cross disciplines; is not shared across lines. Disciplines don't see each other's information as relevant to what they do.	PCP's occasionally give out behavioral health brochures if they happen to have them available.	PCP's and behavioral health providers have a variety of materials to hand out to patients, stressing the importance of both fields of treatment.	PCP's and Social Workers embrace the need to look at patients from a "whole person" perspective and encourage patients to see their health in the same manner by distributing materials to that effect.

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Processes/ Protocols	Behavioral health protocols are not understood/applied by providers. Primary care protocols aren't understood by behavioral health. There are no inter-disciplinary meetings. Case review doesn't happen, or happens separately..	PCP's and Social Workers occasionally chat about extremely complicated patients	PCP's and Social Workers make an effort to spend more time comparing notes and looking for ways to work together for the benefit of the patient.	Social Workers and PCP's understand that they are both integral parts of a patient's "whole" care. They meet regularly as a team in order to discuss patients and handle issues as a joint intervention.
Personal	Behavioral Health and Medical staff don't know one another. Team members are unaware of each other's disciplines, stressors and why they entered their chosen profession. Burn out can be a significant factor for both disciplines, particularly so when because of bifurcation there is limited teamwork.	Behavioral and medical staff has a limited knowledge of other staff, and occasionally cross paths, but don't have time to go beyond initial pleasantries and introductions..	Behavioral Health and medical staff make an effort to meet occasionally to get to know one another.	Social Workers and PCP's attend a regular roundtable meeting. They get to know each other on a personal level and begin to understand the motivating factors of the other's professions. This knowledge translates to more teamwork and mutual support.
Attitudes towards patients	PCP's not always aware or interested in the stressors that affect the lives of the underprivileged." The providers' schedules are tight and patients are expected to keep their appointments. When stressed, staff and all disciplines may blame the patient when problems arise.	PCP's are aware that there may be non-compliant patients but tend to blame "no-shows" on the social workers.	PCP's understand that it can be difficult for a patient to keep an appointment if they don't have a vehicle or are unable to miss a day of work. Accommodations are made.	PCP's have a deeper understanding of the issues facing the under-privileged: homelessness, lack of transportation, socioeconomic factors, language barriers and cultural differences. All disciplines are trained to do brief motivational assessments before suggesting interventions to patients.

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Focus of Treatment	Since Behavioral Health does not generate as much revenue as medical care, it is not considered as important. Behavioral Health is perceived as "adjunct to" primary care rather than complimentary.	The accent is on the "medical model" for PCP, patients are referred to Behavioral Health, and behavioral health focuses on related issues except where there is a clear medical issue.	Each discipline recognizes the value of integration to health outcomes. Interest in learning from one another increases and teamwork becomes more common.	A patient is seen as a "whole person" and care of the mind and body are equally important. Interventions are responded to jointly, rather than seen as the responsibility of one discipline or another. There is consistency. All disciplines are valued and seen as vital to the care of the patient.
Quality vs. quantity of care	Number and length of visits is driven by reimbursement concerns.	A few patients are given more than 15-30 minute visits but this occurs only rarely.	It is recognized that some clients need extra time so modifications are made for complex needs (e.g. mental illness and language barriers).	Primary care and behavioral health visits are of sufficient length to reasonably respond to patients needs.
Understanding of our Mission	Organizational mission statements are either unknown to staff or are viewed as an abstraction; words that aren't relevant to patient care.	Mission statements are known but not well understood or not viewed as applicable to patient care and the performance of duties.	Mission statements are known and understood. Staff has an increasing awareness that integration relates to the overall mission of the CHC because it improves quality of care.	Mission statements are known and understood as relevant to patient care. Staff understands that integration of PC and BH is in the best interest of the clients as it improves health outcomes. Administration supports integration and regularly stresses its importance to all staff and new hires.