

Core Elements

of Integrated Behavioral Health



The Montana Integrated Behavioral Health Steering Committee, comprised of stakeholders from the state health department, behavioral and primary care providers, and state and national associations reached consensus on the following elements to support statewide integrated care.



Intentional choice of level of integration

The program has made the intentional choice to coordinate, co-locate or integrate mental health, substance use, and primary care services based on the available resources in the community.



Team based care

There is clear identification of team members (virtual or on-site) which includes primary care, behavioral health care, and care coordination staff along with practices in place to support team communication, coordination and functioning, team roles, and interdisciplinary planning.



Evidence based clinical models

The practice chooses an approach that fits their setting and educates staff in brief, evidence based interventions like motivational interviewing, problem solving therapy, and behavioral activation.



Data driven systems

Practices put in place that focus on population health and universal screening (with appropriate clinical exceptions). Workflows established for patient identification through screening and clinical pathways to guide intervention and planning. Outcomes and quality measures are defined, tracked, reported, and used to modify care. Patient registries are maintained and staff are accountable for work and patient improvement.



Clear leadership

Clear leadership that sees behavioral health as a key element of health care. Articulates a clear vision on how to improve patient care, develops policy and procedures supporting integrated behavioral health, and supports performance management strategies that focus on integrated behavioral health.



Stepped care

A system of delivering and monitoring treatments so the most effective and least resource intensive treatment is delivered to patients first; only 'stepping up' to intensive/specialist services as clinically required. Primary care is the clinical home, everyone in the practice is trained to manage health as a combination of physical and behavioral health, all staff "work at the top of their license."



Defined continuum of care

Each provider in the practice knows when to treat, when to consult, and when to refer. Agreements are in place with external partners for specialty care referrals and communication.



Care coordination

There is a plan in place for how to insure smooth movement of patients from one provider or one level of care to another. This plan takes into account social determinants and community resources and is based on a data tracking system.



Psychiatric consultation

Each practice has a plan for consultation with psychiatric prescribers. Consultation may be face to face, through telehealth, or through embedded psychiatrists. The plan includes easy transition back to primary care for people who reach a point of stability. Practices work on developing the consultative psychiatry role where psychiatry consults with primary care providers for most patients and only sees clients directly with the most complex needs. This model grows as payment for it advances.

