



Working together to improve health care quality, outcomes, and affordability in Washington State.

Behavioral Health Integration Report and Recommendations

TBD 2017

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Executive Summary

The Robert Bree Collaborative was established in 2011 to provide a forum in which public and private health care stakeholders can work together to improve quality, health outcomes, and cost-effectiveness of care in Washington State. Mental illness and substance use disorders, together called behavioral health, are common and often go untreated due to stigma, lack of screening, and lack of access to appropriate care. Integrating behavioral health care into primary care, and primary care into behavioral health care has been proposed as a solution, but integration has been variable and inconsistent. The Bree Collaborative elected to address this topic and convened a workgroup to develop recommendations from April 2016 to January 2017 focusing on common elements across different integrated models as outlined in **Table 1**, below, and detailed later.

Table 1: Elements and Minimum Standards for Integrated Care

	Element	Specifications
1	Integrated Care Team	Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, understand their roles and participate in typical practice activities in-person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.
2	Patient Access to Behavioral Health as a Routine Part of Care	Access to behavioral health and primary care services are available on the same day as much as feasible. At a minimum, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
3	Accessibility and Sharing of Patient Information	The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. Clinicians work together via regularly scheduled consultation and coordination to jointly address the patient’s shared care plan.
4	Practice Access to Psychiatry Services	Access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan. For patients with more severe or complex symptoms and diagnoses, specialty behavioral health services are readily available and are well coordinated with primary care.
5	Operational Systems and Workflows to Support Population-Based Care	A structured method is in place for proactive identification and stratification of patients for targeted conditions. The practice uses systematic clinical protocols based on screening results and other patient data, like ER use, that help to characterize patient risk and complexity of needs. Practices track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.
6	Evidence-Based Treatments	Age-appropriate measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving. The goal of treatment is to provide strategies

		that include the patient’s goals of care and appropriate self-management support .
7	Patient Involvement in Care	Patient goals are incorporated into the care plan. The practice communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning.
8	Data for Quality Improvement	System-level data regarding access to behavioral care, the patients’ experience, and patient outcomes is tracked. If system goals are not met, quality improvement efforts are employed to achieve patient access goals and outcome standards.

Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a pioneer in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice evidence-based approaches that build upon existing efforts and quality improvement activities aimed at decreasing variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Mental illness and substance use disorders, together called behavioral health, are common, and often go untreated due to stigma, lack of screening, and lack of access to appropriate care. Integrating behavioral health care into primary care has been proposed as a solution, but integration has been variable and inconsistent. The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from April 2016 to January 2017.

See **Appendix B** for the Behavioral Health Integration workgroup charter and a list of members.

Problem Statement

Mental illness and substance use disorders, together called behavioral health, are common, with an estimated 46% of adults experiencing mental illness or a substance abuse disorder at some point in their lifetime, 25% in a year.¹ Depression is by far the most well-researched behavioral health diagnosis, approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period.^{2,3,4} Episodes of major depressive disorder typically last 16 weeks, almost all being clinically significant.³ Somatic symptoms, including fatigue and pain, are associated with depression and anxiety, leading to high use of medical care.⁵ Approximately 8.4% of Americans have a substance use disorder, 20.2 million adults; 7.9 million also had a co-occurring mental disorder.⁶

Patients with chronic medical conditions and behavioral health issues have an estimated two to three times higher health care costs.⁷ Depression is especially common among those with a chronic illness, such as diabetes, resulting in lower adherence to clinical recommendations, worse physical functioning, and higher cost.⁸ Behavioral health disorders also lead to higher rates of early mortality, contributing to approximately eight million deaths annually across the world (14.3%) and a median of 10 years of lost life.⁹

High Unmet Need

There is far greater stigma attached to mental health and substance abuse diagnoses than for other conditions; a less developed state and national infrastructure for measuring and improving care quality; the need for connecting a greater variety and number of siloed clinicians, specialists, and organizations; lower use of health information technology; and barriers in the health insurance marketplace.¹⁰ Partially due to these barriers and to a lack of education and training among clinicians, screening for and comprehensive access to treatment for depression occur infrequently.¹¹ This is especially true in Washington State which has been ranked 48th on measures of need for mental health services compared to access.¹² Measurement-based medical care is routine practice throughout primary care medical treatment such as from blood pressure cuffs to A1c tests for diabetes. Yet few practices routinely administer simple proven measurement tools, such as symptom rating scales, to monitor their patients' symptoms and progress toward behavioral health treatment goals. Best practice care management processes are used less often for depression and other behavioral health diagnoses than for asthma, diabetes, or congestive heart failure in primary care, showing a gap both in comprehensive assessment and evidence-based, supportive treatment.¹³

The Case for Integration

This high unmet need and siloed nature of behavioral health and physical health care were identified in the 2006 Institute of Medicine Crossing the Quality Chasm series as contributing to low-quality care.¹⁴ On average, 80 million Americans visit an ambulatory care center with major depressive disorder as their primary diagnosis, indicating potential to impact patient outcomes through treatment within the context of primary care.¹⁵ Primary care providers have reported preferring integrated care, reporting more effective communication and lower stigma about mental health and substance use for patients.¹⁶

Research has consistently shown healthier patients and populations including decreased depression, anxiety, and positive impacts on medical conditions including diabetes, increases in quality of life, and higher patient satisfaction.^{17,18} It is clear that screening without adequate treatment, referral to specialty care without close coordination or follow-up, and co-located behavioral health specialists without systematic tracking of outcomes or evidence-based treatments do not work.

Addressing behavioral health needs within primary care for the majority of patients is cost-saving. The Institute for Clinical and Economic Review estimates that behavioral health integration using the Collaborative Care Model represents a valuable improvement.¹⁹ Primary care settings are the natural home for behavioral health services for the majority of a population, enhancing access to behavioral health care, reducing stigma, and increasing physical and behavioral health in a cost-effective manner.²⁰ Additionally, those with severe and persistent mental illness often lack access to primary care and may be more comfortable receiving services within a behavioral health practice. Integrating behavioral health into primary care, and providing physical health care services within the walls of behavioral health clinics, has been clearly called out as a means to achieve whole-person, patient-centered care.

Background: Towards an Integrated System

Integrating behavioral and physical health or primary care, or integrated care, is an evolving field. Traditionally, patients receive the majority of their medical or physical care within the context of primary care with both mental health services and substance use disorder treatment as specialty services typically located in separate facilities and reimbursed through separate mechanisms.

The Institute of Medicine adapted their 2001 strategy for overall health care improvement to mental and substance use conditions with the goals that:²¹

- *“Individual patient preferences, needs, and values prevail in the face of residual stigma, discrimination, and coercion into treatment.*
- *The necessary infrastructure exists to produce scientific evidence more quickly and promote its application in patient care.*
- *Multiple providers' care of the same patient is coordinated.*
- *Emerging information technology related to health care benefits people with mental or substance-use problems and illnesses.*
- *The health care workforce has the education, training, and capacity to deliver high-quality care for mental and substance-use conditions.*
- *Government programs, employers, and other group purchasers of health care for mental and substance-use conditions use their dollars in ways that support the delivery of high-quality care.*
- *Research funds are used to support studies that have direct clinical and policy relevance and that are focused on discovering and testing therapeutic advances.”*

Many integrated models are conceptually based on the Chronic Care Model developed by Wagner and colleagues in 2001; an integrated system of interventions focused on patients with chronic illness (e.g., diabetes, asthma) moving along a continuum from minimal integration to fully integrated care.^{22,23}

Wagner's Chronic Care Framework includes delivery system redesign linked to community resources, patient self-management support and education, evidence-based decision support integrated into the practice, and standardized patient data collection including disease registries (e.g., clinical information systems).

Other influential models were developed to target patient needs for behavioral health or physical health care services based on specific care setting. Barbara Mauer developed four quadrants to describe clinical integration based on identified patient need for either physical health intervention or behavioral health intervention, see **Figure 2** on the following page.²⁴ In Mauer's model, primary care serves patients with low or high physical health and low behavioral health needs, while specialty mental health is meant to serve those with higher behavioral health needs.

Figure 2: Four Quadrant Model for Behavioral Health Integration ²⁴

	Low -----Physical Health Complexity-----High	
High	II: High behavioral health need Low physical health need Setting: Specialty Mental Health and Primary Care Example: Schizophrenia	IV: High behavioral health need High physical health need Setting: Specialty Mental Health and Primary Care Example: Schizophrenia and uncontrolled diabetes
Behavioral Health Complexity		
Low	I: Low behavioral health need Low physical health need Setting: Primary Care Example: Moderate alcohol use	III: Low behavioral health need High physical health need Setting: Primary Care Example: Uncontrolled diabetes

Integrating Behavioral Health into Physical Health

Since this initial work to develop conceptual models for integrated care, research into the effect of specific components on patient outcomes, most notably on depression remission, has grown rapidly. The Agency for Healthcare Research and Quality (AHRQ) and others including the Millbank Memorial fund have regularly conducted systematic literature reviews, from which this Report and Recommendations heavily draws. AHRQ first published their report *Integration of Mental Health/Substance Abuse and Primary Care* in 2008 to describe the current state of integration in various practice settings, barriers to that integration, and other factors affecting feasibility of the models such as health information technology and reimbursement structures.²⁵ The review found 33 trials, 26 of which addressed depression, and the majority of which used the Wagner Chronic Care Model described above but that differed greatly in level of provider integration and in specific processes. While the individual studies tended to demonstrate positive patient outcomes (e.g., depression or anxiety remission), researchers did not find an association between level of integration (e.g., presence of care processes including screening, coordinated care, clinical monitoring, medication adherence among others) and greater improvement in outcomes.²⁵

Medical homes, while not specifically focused on integrated behavioral health, meet many of the requirements of supporting a patient’s behavioral and physical health needs. The National Committee for Quality Assurance (NCQA) has defined criteria for medical homes (also called patient-centered medical homes) that include tracking patients with a registry, case management using allied health professionals, adherence to evidence-based guidelines, self-management support, universal screening, and supported referrals to specialty care.²⁶ Health homes, defined by the 2010 Affordable Care Act, are centered on patients with mental health and substance use disorders and other chronic conditions.²⁷

See **Figure 3: Current Models of Behavioral Health System Integration Continuum** on the following page.

Behavioral Health Integration Workgroup

Updated: January 9, 2017

The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington has developed the Collaborative Care Model (CCM), *“a specific type of integrated care...that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature...[focused] on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.”*²⁸ A systematic literature review of Collaborative Care for patients with anxiety or depression found 79 randomized controlled trials showing significantly greater improvement in depression and anxiety symptoms in the short and long-term and benefits for patient satisfaction.²⁹ Patients with depression choosing Collaborative Care over usual care had median time to readmission of 86 days compared to 614 days.³⁰

Primary care behavioral health (PCBH) is a population-based approach to mental health care that is simultaneously co-located, collaborative, and integrated within a primary care clinic. In this model behavioral health consultants (BHCs) work side by side with members of the clinical care team, including primary care providers, nursing/medical staff, dietitians, and others, to provide behavioral assessment and focused intervention at the point of care. An essential component of the PCBH model is the use of “warm hand-offs” whereby patients are immediately referred by care team members and met by BHCs in the context of their original medical visit. These “warm hand-offs” provide two key benefits: 1) allow for real-time communication between medical and behavioral personnel to facilitate a collaborative, whole-person care plan for patients and 2) increase patient access to behavioral care by removing common barriers that impede patients from seeking mental health services (e.g., stigma, shame, transportation limitations, childcare issues). Typical visits by BHCs are brief in nature (lasting 10-30 minutes), are solution-focused, and aim to provide patients tangible behavioral skills to improve daily functional abilities. BHCs are flexible members of the care and possess a generalist, well-rounded skillset to match the wide array of patient needs that enter the clinic. On any given day, a BHC may be asked to assist to intervene with issues of depression, anxiety, substance abuse, sleep hygiene, smoking cessation, marital discord, grief, parenting, or situational stress.

Research supports PCBH in enhancing outcomes for depression,^{31,32} PTSD³³ generalized anxiety disorder,³⁴ general mental health functioning for adults^{35,36} and common symptoms present in the pediatric population. The model’s flexibility of meeting individuals in the context of a medical visit as well as allowing them to return quickly as mental health issues arise leads to decreased stigma³⁷ and enhanced satisfaction for both patients and for medical providers alike.^{38,39,40} Despite PCBH’s brief nature, outcomes are generally sustained over time-- sometimes as long as two years from the last visit.³⁶

Millbank Memorial fund has published two comprehensive literature reviews, *Evolving Models of Behavioral Health Integration in Primary Care* in 2010 and an update *Evolving Models of Behavioral*

Health Integration: Evidence Update 2010-2015 in 2016. The 2010 review identified eight models in use across the United States: improved collaboration, medically provided behavioral health care, co-location, disease management, reverse co-location, unified primary care and behavioral health, primary care behavioral health, and collaborative system of care.⁴¹ Millbank categorized these eight models based on shared elements as coordinated, colocated, or integrated. Millbank's 2016 evidence update found a marked increase in the number of studies of integrated health, an expanded focus on diagnoses outside of depression, the majority focused on enhanced collaboration and coordination of care (88%) and a much smaller number (12%) focused on colocated care.⁴² Many of the studies found integration of care managers providing systematic follow-up, communication with providers, and some psychological intervention. However, research has been limited in focusing on specific populations and diseases, rather than the multiple chronic conditions affecting real patients and across multiple practice settings.

The reviews helped inform the Substance Abuse and Mental Health Services Administration's 2013 continuum of models that are detailed below:⁴³

- **Coordinated**
 - **Level 1:** Minimal Collaboration – Separate facilities and systems, little to no communication
 - **Level 2:** Basic Collaboration at a Distance – Separate facilities and systems, communication based on specific issues or patients
- **Co-Located**
 - **Level 3:** Basic Collaboration Onsite – Behavioral and physical health providers located at the same site, separate systems, referral process to behavioral health
 - **Level 4:** Close Collaboration with Some System Integration – Providers located at same site, some shared systems and records, some face-to-face communication
- **Integrated**
 - **Level 5:** Close Collaboration Approaching an Integrated Practice – Providers work as a team, frequent communication, may have separate medical records
 - **Level 6:** Full Collaboration in a Transformed/Merged Practice – Providers work as a team, patients have a single treatment plan, all patients are treated as a whole person

Figure 3: Current Models of Behavioral Health System Integration Continuum



Screening, Brief Intervention, and Referral to Treatment

SBIRT is an evidence-based paradigm seeking to encourage health care providers to systematically “identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.”⁴⁴

The Bree Collaborative developed recommendations around integrating the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model into primary care, prenatal, and emergency room settings in January 2014. The Report outlines the impact of drug and alcohol misuse in Washington State and proposes the SBIRT model to provide early motivational conversations with people prior to alcohol and other drug misuse overly impacting their lives. SBIRT has been endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) that support an SBIRT model that:⁴⁵

- Is brief
- Universally screens all patients for a specific issue (e.g., alcohol and other drug misuse)
- Occurs in a non-chemical dependency treatment setting (e.g., primary care, hospital)
- Includes a seamless transition between screening, brief intervention, brief treatment, and referral to specialty chemical dependency treatment
- Demonstrates success

This preventative approach to screening has been endorsed by the United States Preventive Services Task Force (USPSTF) that have recommended “clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse” giving the recommendation a B rating meaning that, “there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.”⁴⁶ However, the USPSTF does not recommend screening for alcohol and drug

use or for depression if there is no pathway to treat the patient within the practice or refer a patient to appropriate treatment. Screening alone is not recommended.

Our model of integrated behavioral health builds on the proven SBIRT model and expands the protocol to beyond that of screening for alcohol and other drug misuse and offering brief intervention or referral to treatment as needed.

Integrating Primary Care into Behavioral Health

While the potential for improved patient outcomes and increased access to care is greater for those with more severe mental illness and substance abuse, research into outcomes of integrating primary care services into behavioral health settings are more limited. Focusing on both types of integration is often called bi-directional integration and is a focus within Washington State. The 2008 AHRQ review found three trials of this type of integration, all of which used the Collaborative Care Model.²² All found increased positive patient health outcomes and two were cost-neutral due to declines in hospital and emergency room use.

Millbank Memorial Fund expanded their focus on integrated care with a 2016 update *Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness* and found 12 randomized controlled trials for patients with bipolar disorder, other serious mental illness, and chemical dependency.⁴⁷ Most of the studies took place in large integrated health systems (e.g., Kaiser-Permanente, Group Health Cooperative) and used care management to facilitate care coordination around the patient and patient education on self-management. All the interventions met the four components of the Wagner Chronic Care Model (delivery system redesign, patient self-management support, guideline- and specialist-based decision support, and supportive clinical information systems).³⁶ In four of the studies, a primary care provider was fully integrated into the mental health or chemical dependency facility, with full access to shared medical records, and participation in team meetings for joint care planning. The other studies either had onsite enhanced collaboration with an initial evaluation followed by arrangements for primary care near the facility or off-site primary care with care managers facilitating collaboration. Results from the systematic review grouped by patient population are:³⁶

- Four of the studies were focused on patients with bipolar disorder (in mental health clinics or at Group Health Cooperative), in general finding a decrease in length of mania episodes and symptoms, increased mental health-related quality of life, better access to care but lower quality evidence for better blood pressure control and better physical health-related quality of life compared to usual care.
- Three studies focused on patients with other serious mental illness (in mental health clinics or an acute inpatient psychiatric ward) finding greater use of preventative services, improvements in mental health-related quality of life, and variable improvement in health-related quality of life, lower emergency department use, and variable costs compared to usual care.

- Five of the studies were focused on patients with a substance use disorder (in a residential detoxification unit, Veterans Administration, Kaiser Permanente chemical dependency treatment, or hospital-based methadone maintenance clinic) and found that on-site medical care with team meetings and joint treatment planning may improve abstinence rates with uncertain impact on health care utilization and cost compared to usual care. Interestingly, the studies indicate that colocated primary care alone, without actual integration or enhanced collaboration, may not improve abstinence rates or health-related quality of life.
- Long-term outcomes are unknown due to short follow-up periods as well as well as robust data on cost or the effect of integrated care on patients with co-occurring mental health and substance use disorders.

Defining Integrated Care

Integration of behavioral and physical health care has been both facilitated and stymied by the availability and use of different models. Research into shared characteristics of practices that have successfully integrated the types of care suggest a need to move away from heuristics and toward functions or approaches to integration that unify the various models.⁴⁸ Our Integration workgroup found it necessary to focus on functions or minimum standards that could be used across settings for which clinics would not have to hire additional on-site staff. It is clear that screening without adequate treatment, referral to specialty care without close coordination or follow-up, and co-located behavioral health specialists without systematic tracking of outcomes or evidence-based treatments do not work.

Like the field in general, our workgroup first started by focused on integrating depression screening, brief intervention, and referral to higher levels of treatment into primary care. Our workgroup's goal is that much like using a blood pressure cuff to track treatment outcomes in hypertension, practices monitor behavioral health outcomes with a symptom rating scale to determine efficacy. We heavily drew from AHRQ's 2013 [Lexicon for Behavioral Health and Primary Care Integration](#), the work of the AIMS Center in Washington State, and the work of CCO Oregon. The AHRQ Lexicon *"is a set of concepts and definitions developed by expert consensus for what we mean by behavioral health and primary care integration—a functional definition—what things look like in practice."*⁴⁹ The AIMS Center uses five principles to define Collaborative Care:⁵⁰ Read more about these principles [here](#)

- *Patient-centered team care: Collaboration between primary and behavioral health care providers using a shared care plan*
- *Population-based care: Defined patient group tracked in a registry with consultation from specialists*
- *Measurement-based treatment to target: Treatment plans based on patient goals and evidence-based tools (e.g., PHQ-9)*
- *Evidence-based care: Use of therapeutic techniques shown to work in primary care (e.g., problem-solving treatment, cognitive behavioral therapy) and medication management*
- *Accountable care: Reimbursement for quality and outcomes*

The Maine Health Access Foundation (MeHAF) has developed a self-assessment for practices to assess level of integration. The assessment is divided into (1) integrated services and patient and family-centeredness and (2) practice/organization with 18 questions on a 10-point scale. The tool is available [here](#). We crosswalk our eight elements with the MeHAF questions in **Appendix C** (questions II-1. *Organizational leadership for integrated care* and II- 9. *Funding sources/resources* underlie all elements).

The Oregon Legislature established the Patient-Centered Primary Care Home Program in 2009, working with stakeholders to set standards for care within a medical home including behavioral health care.⁵¹ In 2014, the Oregon Health Authority developed Patient-Centered Primary Care Home Program Recognition Criteria. CCO Oregon, a non-profit member organization supporting delivery of quality care at lower cost, convened the Integrated Behavioral Health Alliance of Oregon that met to develop behavioral health quality incentive metrics and integration methods. The workgroup developed seven minimum standards based on the AHRQ lexicon and definitions.

- Read the recognition criteria [here](#)
- Read these minimum standards [here](#)

Our goal is that these eight elements will allow providers and clinics know when they have achieved integrated care, patients know when they are receiving integrated care, and purchasers and health plans know when they are buying integrated care. Our workgroup found it important to define integrated behavioral health care in order to create a common vocabulary. Behavioral and physical approaches must align for integrated behavioral health, see **Figure 3: Levels of Primary Care Integration**. We used this model, and the resources mentioned above, in the development of our seven key elements, outlined in the introduction and detailed in **Table 2** on the following page.

“Integrated Care” means team-based care provided to individuals of all ages, families, and their caregivers in a whole-person oriented setting by licensed primary care providers, behavioral health clinicians, and other care team members working together to address one or more of the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks/conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization.

"Behavioral Health Provider" means a licensed psychiatrist, a licensed psychologist, a licensed nurse practitioner or registered nurse with a specialty in psychiatric mental health, a licensed independent clinical social worker, a licensed mental health counselor, a licensed marriage and family therapist, a certified clinical social work associate, an intern or resident who is working under a state-approved supervisory contract in a clinical mental health field; or any other clinician whose authorized scope of practice includes mental health intervention.

Figure 3: Levels of Primary Care Integration

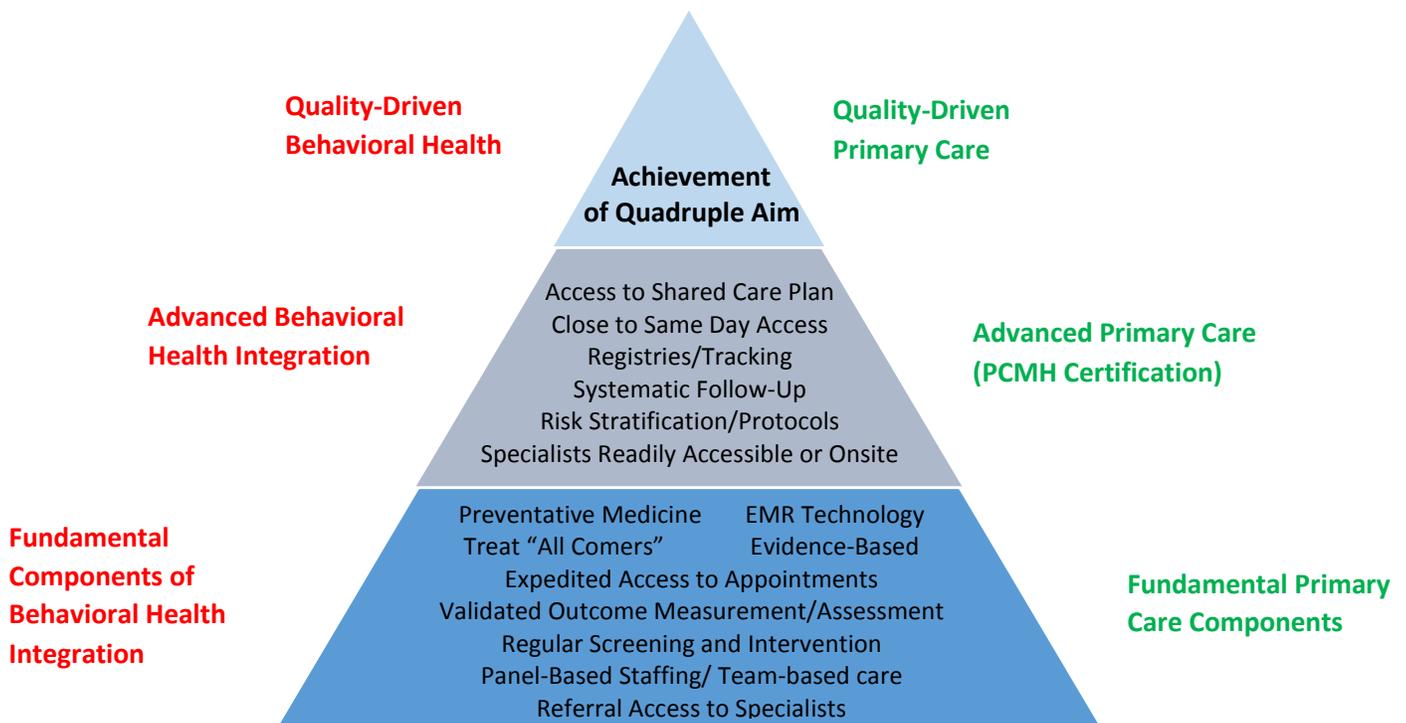


Table 2: Specifications for Integrated Care

	Element	Specifications	Patient Perspective	Operational Details for Integrating Behavioral Health Care into Primary Care
1	Integrated Care Team	Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, understand their roles and participate in typical practice activities in-person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.	<i>I can talk to members of my integrated care team about any of my concerns, including feeling low or depressed, or concerns about my drinking. The team will be able to answer my questions and help me get treatment if I choose to.</i>	<p>Usual Care: Behavioral health support is provided by the primary care provider, who may not feel adequately supported or adequately trained in managing all behavioral health conditions in his/her patient panel.</p> <p>Steps Toward Integration: Behavioral health professionals are onsite or available remotely but do not participate in clinic-level workflows and are not part of the usual patient care. Behavioral health may closely coordinate and follow up with the primary care provider on all patients that are referred to them for treatment.</p> <p>Integrated Care: Practices are committed to developing and maintaining a culture of integration and teamwork including engaging providers in integrated approaches to care proven to help patients get better and achieve their treatment goals. The integrated care team utilizes shared workflows to systematically screen and treat common behavioral health conditions and uses measurement-based behavioral health scales and tools to screen and track patient progress toward treatment goals. Behavioral health professionals - including psychologists, social workers, nurses and others with specialized training - participate in primary care workflows. Behavioral health professionals may be practice-based, (i.e., located in the same physical space as the integrated care team) or telemedicine-based (i.e., available to the practice onsite on a regular but not daily basis, and available by phone, pager or videoconference) to assist primary care providers and patients during practice hours when they are not onsite.</p>

<p>2</p>	<p>Patient Access to Behavioral Health as a Routine Part of Care</p>	<p>Access to behavioral health and primary care services are available on the same day as much as feasible. At a minimum, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.</p>	<p><i>I am offered the option to have an in-person visit, speak with a behavioral health care provider during my primary care visit, or have a follow-up phone call from a member of the integrated care team. I can elect to receive services in-person, by phone, or via other mechanisms that are most convenient for me.</i></p>	<p>Usual Care: Behavioral health services are available using a referral-based approach (internally or externally). Patients may not be able to see the provider to which they are referred in a timely way.</p> <p>Steps Toward Integration: Behavioral health services are not consistently scheduled and are occasionally available on the same day and in the same location, although this is not routine practice.</p> <p>Integrated Care: Appointment scheduling is managed and monitored for behavioral health providers in much the same way as it is managed for primary care providers. As much as possible, scheduling for practice-based behavioral health providers allows availability on the same day as patients’ medical visits in a coordinated way. Behavioral health providers are scheduled in such a way so as to allow sufficient time to engage patients in their treatment through frequent visits and phone contacts, especially in the first month of treatment. Patients have opportunities to access care easily and conveniently through face-to-face and virtual interactions with the care team.</p>
<p>3</p>	<p>Accessibility and Sharing of Patient Information</p>	<p>The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. Clinicians work together via regularly scheduled consultation and coordination to jointly address the patient’s shared care plan.</p>	<p><i>I have access to my own care plan if I want to see it. When I call the clinic, they always know who I am and what my needs are. My health care team communicates well, has access to the same information, and it feels like they are all on the “same page” about my health goals.</i></p>	<p>Usual Care: Behavioral or medical information is not readily or systematically available at the point of care; providers must rely on an “as needed” request. There may be separate treatment goals in the EHR and/or lack of coordination and communication in the pursuit of a shared treatment plan.</p> <p>Steps Toward Integration: Primary care and behavioral health providers have access to the same information through EHR or shared clinical care management systems, but there is limited coordination and/or little ability to track of patients’ status over time.</p> <p>Integrated Care: The integrated care team has an information system that supports population-based care, systematically shares patient information, and tracks patient outcomes over time. Patient information is incorporated into a shared care plan whereby critical medical,</p>

				behavioral, and social information is recorded and accessible. Shared information includes current and past medications, progress and visit notes, and relevant diagnoses. The integrated care team can easily track patients and work toward shared treatment goals that are documented in the patient record.
4	Practice Access to Psychiatry Services	Access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan. For patients with more severe or complex symptoms and diagnoses, specialty behavioral health services are readily available and are well coordinated with primary care.	<i>My integrated care team is able to consult with specialists to make sure that my treatment is going to help me. If I need higher levels of care, I am able to see a specialist directly as needed.</i>	<p>Usual Care: There is no agreement or staffing in place for psychiatry consultation, telemedicine, or direct clinical services. If there is an agreement or staffing in place, the services available are scarce and may not be organized in such a way so as to leverage services to meet the needs of as many patients as possible.</p> <p>Steps Toward Integration: Staff have inconsistent access to psychiatry consultation services, not regularly or systematically. Patient referrals to psychiatry care occur but may not always be incorporated into the patient’s care plan and must be requested individually per patient.</p> <p>Integrated Care: Access to psychiatry consultation services are available in a systematic manner so as assist the primary care provider and team to develop a treatment plan and adjust treatments for patients who are not improving as expected. Psychiatry services may be received virtually (via video conference or by phone) if this method is more efficient or there is limited access to face-to-face consultation. For patients with more severe or complex symptoms and diagnoses, specialty services are readily available and are well coordinated with primary care. Any referral includes shared bi-directional communication.</p>
5	Operational Systems and Workflows to Support Population-Based Care	A structured method is in place for proactive identification and stratification of patients for targeted conditions. The practice uses systematic clinical protocols based on	<i>I am asked about behavioral health concerns (e.g., depression, anxiety, alcohol, substance use) at my first visit and at least annually thereafter.</i>	<p>Usual Care: Behavioral health needs are not assessed or are occasionally assessed. There is no way to systematically track patients who do screen positive or this is done by individual providers patient by patient.</p> <p>Steps Toward Integration: Screening for behavioral health needs is incorporated as a pilot for selected group(s) of patients. Follow-up is a normal part of care but patients are not contacted if they miss appointments or if they do not show improvement.</p>

		<p>screening results and other patient data, like ER use, that help to characterize patient risk and complexity of needs. Practices track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.</p>	<p><i>If my screening results suggest that I may have behavioral health concerns or screen positive I am introduced to someone on the team that is trained to help me. I receive the type of treatment that is best suited to me.</i></p>	<p>Integrated Care: Patients are proactively screened using validated tools on regular intervals for target conditions such as alcohol use disorder, substance use disorder, and select mental health conditions (e.g., Alcohol Use Disorders Test (AUDIT), Drug Abuse Screening Test (DAST-10), the Patient Health Questionnaire (PHQ-2 or PHQ-9), and Generalized Anxiety Disorder (GAD-7), among others). The practice also has a plan for recording, tracking, and following-up based on screening results. For patients who do not improve or do not have a follow-up visit scheduled, the practice reaches out in an attempt to engage them, change the treatment approach, or connect them with appropriate services.</p>
6	Evidence-Based Treatments	<p>Age-appropriate measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving. The goal of treatment is to provide strategies that include the patient's goals of care and</p>	<p><i>My provider asks me about my symptoms and treatment goals and incorporates them into my individualized treatment plan. I can track my own progress over time in much the same way that I keep track of my blood pressure. My health care team helps me understand my choices about the type of treatment I elect to receive and</i></p>	<p>Usual Care: While measurement-based medical care is routine practice throughout the practice, (e.g., blood pressure cuffs, A1c tests for diabetes), use of behavioral health measurement tools, such as symptom rating scales, to monitor patients' symptoms and progress toward treatment goals are not used.</p> <p>Steps Toward Integration: Evidence-based guidelines including self-management support are available within the practice, but are not systematically integrated into care. Use of evidence-based best practice depends on the provider and is highly variable, not emphasizing self-management strategies, or not adhering to behavioral therapies that are amenable to a brief, episodic format.</p> <p>Integrated Care: The practice routinely delivers age-appropriate, evidence-based behavioral and physical health interventions that are adapted to the practice setting and are integrated across disciplines including health behavior change strategies, brief behavioral interventions, and appropriate medication management/medication assisted treatment. Integrated practice teams use behavioral health</p>

		appropriate self-management support.	<i>the reasons for the type of treatment.</i>	symptom rating scales in a systematic and quantifiable way to determine whether patients are improving using a symptom rating scale (e.g., as in using a blood pressure cuff to track treatment outcomes in hypertension).
7	Patient Involvement in Care	Patient goals are incorporated into the care plan. The practice communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning.	<i>My providers have talked to me about what integrated care means for me and have asked me what I think about access and quality. I am asked about my social support and other needs I may have.</i>	<p>Usual Care: Patients may be minimally engaged or not engaged in their own treatment care plan and not asked about their treatment goals or preferences.</p> <p>Steps to Integration: Patients are sometimes but not regularly involved in care decisions</p> <p>Integrated Care: Patients are involved in their own care and they are asked about potential barriers to care. Shared-decision aids are used whenever possible</p>
8	Data for Quality Improvement	System-level data regarding access to behavioral care, the patients' experience, and patient outcomes is tracked. If system goals are not met, quality improvement efforts are employed to achieve patient access goals and outcome standards.	<i>The practice asks for my feedback about my experience at the clinic. They frequently assess and reassess my health goals to track progress. It feels like the practice is getting better at serving my needs.</i>	<p>Usual Care: Patient health data points are paper-based and/or kept independently by providers.</p> <p>Steps Toward Integration: Practice has an EHR but information on patients is not systematically tracked and/or the data is not used for improvement in a meaningful way.</p> <p>Integrated Care: Practice systematically tracks physical and behavioral health screening results and outcomes for all patients receiving integrated care services. Practice collects data on program adherence and staffing needs for program evaluation. Practice systematically collects data for all identified patients that is focused on data points such as depression screening and follow up, patient clinical outcomes in behavioral health, timely access to services, utilization patterns, risk stratification, patient experience, or other meaningful measurements.</p>

Deeper Dive: The Patient Perspective

Primary Care Practice

I don't like going to doctors, and I've never really thought about talking about how I feel with my doctor. This time when I went to the practice I got a sheet of paper with the usual questions on it, like, how would I describe my health, if I eat vegetables, I expected those questions. But this one asked me if I have had any major changes in my life, good or bad. Well, I lost my job of 15 years about four months ago and although I've been doing a little work on the side, losing my job is rough all the way around. One question asked whether I have any interest in doing things, and whether I've been feeling down the last couple weeks. So I wrote I haven't been feeling like myself lately, which is an understatement. I also decided I would write that maybe I've been drinking a little too much lately.

When I went in to see my doctor she looked at my answers and asked me a couple more about how I was doing. She asked questions like it was part of what was going on with me and my health, how losing my job has really made me feel down and maybe that was impacting me more than I realized. She was so understanding, it was a relief for me to be able to talk about what was going on. She also said my blood pressure was up, and it might have something to do with how I was feeling, and the excess drinking I've been doing, plus not getting out and moving like I used to do in my work. So besides trying some blood pressure medication and encouraging me to exercise, my doctor asked me if I would be ok if she brought in a clinician who might be helpful to talk through my situation some more, to find some ways that might support me while I am dealing with all this. Five minutes later I'm talking to this other clinician about how I've been feeling and what might be helpful, so I can set some new goals for myself and make my life work better for me. I don't know how soon I am going to get a new job, but I do know it's going to be easier if I'm feeling good all around.

Behavioral Health Clinic

I don't always feel like I belong in Primary Care when I go to a Doctor's office and sometimes I think they don't even want me there. Plus I don't always trust doctors I don't know. So I just never went. But my Care Coordinator at the Mental Health Clinic really thought I should see a Doctor, and she helped me set up an appointment. She said she would go with me if I wanted her too, and that made me feel better about going.

I was nervous at first to see the Doctor because I hadn't had a check-up in forever, but it was right there at the Mental Health Clinic so I figured it might be ok. Everyone at the Clinic made me feel comfortable and I got through the check-up OK. The Doctor saw the spot on my face that has been bothering me, and he said he wanted to check it out and make sure it wasn't cancer. It was, but it was still easy to take off and that made me glad I went.

You know, I didn't know that people cared about my physical health, I thought they just cared about my mental health. Well, that, and whether I am drinking again. So I feel really good about that. When I was there, my Doctor took my blood too, to find out if everything is fine. I think my prescriptions make me overweight, and I don't get out much, so he wants to make sure I don't have diabetes or anything else. He seemed kind and respectful, and he treated me well, so I'll go back again when I need to. In fact, he said if something happened on the weekend, that I could call a number and if he couldn't help, another Doctor could, so I don't have to go to the Emergency Room now that I know that.

Measurement

Healthcare Effectiveness Data and Information Set

The Centers for Medicare and Medicaid Services adopted behavioral health measures for Accountable Care Organizations in 2016 focused on depression readmission or response at 12 months.⁵² The National Committee for Quality Assurance recently developed Healthcare Effectiveness Data and Information Set (HEDIS) measures for 2017 that include expectation of depression remission and/or response within 5-7 months. Studies have supported this shorter time to readmission using evidence-based collaborative care interventions. The Collaborative supports an expectation of depression remission and/or response within 5-7 months.

HEDIS 2017 includes two depression-specific measures:

- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- Depression Remission or Response for Adolescents and Adults

The HEDIS measure, *Depression Remission or Response for Adolescents and Adults*, allows health plans to assess and report the percentage of health plan members 12 years and older with a diagnosis of depression who had evidence of response or remission within 5 to 7 months of their initial diagnosis. Remission is documented by a PHQ-9 score less than 5 points and response is indicated by a 50% decrease over the initial PHQ-9 score. This is one of only two measures for which health plans have the option of using an Electronic Clinical Data System (ECDS) such as a registry or other clinical management tracking system in addition to their EHR to capture reporting data. More information can be found here: <http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017>

National Quality Forum

National Quality Forum measure 0418 (NQF 0418) Screening for clinical depression and follow-up plan *“Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.”* This measure is consistent with the need to impact and measure the impact of access to mental health treatment in Washington State. More information can be found here: http://www.aana.com/resources2/quality-reimbursement/Documents/2016_PQRS_Measure_134_11_17_2015.pdf

Washington State Common Measure Set on Health Care Quality and Cost

The Healthier Washington Common Measure Set on Health Care Quality and Cost was mandated through ESHB 2572 to set a foundation for measuring performance state-wide. The [most recent iteration](#), approved for 2017, includes six behavioral health-focused measures including:

- **Adult Mental Health Status**. Measured by the Department of Health through Washington State the Behavioral Risk Factor Surveillance System survey.
 - The percentage of adults ages 18 and older who answer “14 or more days” in response to the question, “Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?” on the BRFSS.
- **Mental Health Service Penetration (Broad Version)**. Measured by health plans and DSHS from claims data.
 - The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for age groups: 6-17 years and 18-64 years.
- **Substance Use Disorder Service Penetration**. Measured by DSHS from claims data.
 - The percentage of members with a substance use disorder treatment need who received a substance use disorder treatment in the measurement year. Reported for Medicaid only. Separate reporting for age groups: 6-17 years and 18-64 years.
 - This measure is reported for Medicaid only.
- **Antidepressant Medication Management**. Measured by the Washington Health Alliance from Claims data.
 - The percentage of members 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.
 - Two rates will be reported: Effective Acute Phase Treatment and Effective Continuation Phase Treatment.
- **Follow-up After Hospitalization for Mental Illness**. Measured by health plans from claims data.
 - The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge.
- **30-day Psychiatric Inpatient Readmissions**. Measured by DSHS from claims data.
 - For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days.
 - This measure is reported for Medicaid only.

Learn more about the Common Measure Set: www.hca.wa.gov/about-hca/healthier-washington/performance-measures and www.hca.wa.gov/sites/default/files/measures_fact%2520sheet.pdf

Current State of Integration

Both federally and at a state-level, the health care community is moving toward integrated care. The Centers for Medicare and Medicaid Services announced in November 2016 a final rule revising payment for primary care services for patients with multiple chronic conditions including behavioral health issues participating in an integrated care structure including Collaborative Care.⁵³ These codes allow the primary care provider to bill for “*behavioral health care manager activities, in consultation with a psychiatric consultant,*” and subsequent behavioral health care manager activities in increments of 60 and 30 minutes.⁵⁴ Find more information via the AIMS Center [here](#).

The Washington State health care community has shown a continued commitment to providing evidence-based treatment to improve both physical and behavioral health across the State. [Healthier Washington](#), the Health Care Authority-managed program to transform the health care system through encouraging value-based purchasing, community-directed health, and bi-directional behavioral and physical health integration, is facilitating further transformation

Integrated Funding in Washington State

The Washington Medicaid Integration Partnership, a voluntary managed care pilot was initiated in January 2005 in Snohomish County.⁵⁵ The pilot was administered by Molina Healthcare of Washington for disabled Medicaid clients 21 years or older by funding medical care, substance use treatment, mental health treatment, and long-term care services together. While the pilot did not demonstrate cost savings, clients enrolled in the program did show lower mortality rates and inpatient hospital admissions.

Senate Bill 6312, passed in 2014, directed the Department of Social and Health Services to “*integrate funding and oversight for behavioral health (mental health and substance use) treatment services...to better coordinate care for people with co-occurring disorders.*”⁵⁶ The effect of this was to move from state-purchased behavioral health through the previous Regional Support Networks and counties to “*Behavioral Health Organizations (BHOs) to purchase and administer public mental health and substance use disorder services under managed care.*”⁵⁷ BHOs are responsible for delivering short-term mental health treatment in the practice and through Apple Health and managing services for patients who need services not covered by Apple Health and substance abuse services. More information on patient benefits can be found [here](#).

By changing the reimbursement structure for mental health and substance use disorder services in the state Medicaid (Apple Health) program, physical and behavioral health needs “*will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.*”⁵⁸ The Health Care Authority piloted this integration starting April 1, 2016 in southwest Washington, Clark and Skamania counties, with Medicaid Managed Care Organizations Molina Healthcare of Washington or County Health Plan of Washington managing all

three types of previously siloed care. A report on the first 90 days of the program is available [here](#) and found:⁵⁹

- Better care coordination
- Reduced behavioral health administrative burdens
- Lower emergency department visits
- Necessary back-office changes so that behavioral health providers can bill the managed care organizations rather than the previously existing regional support networks

Washington Screening, Brief Intervention, and Referral to Treatment

As discussed earlier, the SBIRT model is a platform from which to develop truly integrated behavioral health, but alone is not sufficient to address mental health needs, substance use disorders, and physical health. The Washington Screening, Brief Intervention, and Referral to Treatment Primary Care Integration (WASBIRT) started as a five-year grant from SAMHSA from 2003 to 2008 to implement Screening, Brief Intervention, and Referral to Treatment in nine emergency departments across the state and a second grant on Primary Care Integration (WASBIRT-PCI) to expand to clinics from 2011 to 2016.⁶⁰ To date, 85,124 people have been screened in primary care clinics in Cowlitz, Clallam, King, Thurston, and Whitman Counties.

Sustainability past 2016 is a primary goal of the program and the Health Care Authority has opened billing codes to reimburse for the brief intervention portion of SBIRT. In order to receive reimbursement for SBIRT under Medicaid, the Health Care Authority requires those billing to have at least four hours of training. Advanced registered nurse practitioners, mental health counselors, marriage and family therapists, independent and advanced social workers, physicians, psychologists, dentists, and dental hygienists can bill for SBIRT services and chemical dependency professionals, licensed practical nurses, physician assistants, and registered nurses can provide the services but cannot themselves bill. Protocol for the WASBIRT program includes:

1. **Prescreen:** Single-item alcohol and drug use asked to new patients, annually to all patients, and at triage in the emergency department
2. **Full Screen:** If patient screens positive for alcohol or drug use, patient is given a full AUDIT or DAST-10, as appropriate through written self-report or verbally asked by medical assistant or nurse
3. **Mental Health Screen:** If patient screens positive for alcohol or drug use on the AUDIT or DAST-10, they are also screened for depression with PHQ-9 and anxiety with GAD-7
 - Information about billing [here](#).
 - Information about brief interventions [here](#).
 - Information about training [here](#).

Mental Health Integration Program

The AIMS Center is leading a state-wide effort to integrate mental health screening and treatment into safety net settings using the principles of Collaborative Care called the Mental Health Integration Program (MHIP). Approximately 200 community health and mental health centers in Washington State have enrolled, funded by the State Legislature, Public Health – Seattle and King County, and the Community Health Plan of Washington so that 50,000 patients have received integrated care since January 2008.⁶¹

The PCBH model has expanded considerably over the last few years given its alignment with the patient centered medical home's whole-person orientation. One of major advantages of the PCBH model is its ability to reach a large segment of the population. On average, one full time BHC provides services to 1300-1700 unique patients annually depending on the setting and clinic volume.³⁴ With only 10 full-time behavioral health providers, the Yakima Valley Farm Workers Clinic was able to provide services to more than 13,000 patients in 2016. Many health centers in Washington State have also adopted the Primary Care Behavioral Health model to help provide increased access to behavioral care to vulnerable populations.

Integrating funding of behavioral and physical health is a necessary first step to a whole-person system, but not sufficient alone for true integration. Our goal is that our recommendations and specifically our eight elements will be used to build on these models and existing infrastructure to increase access to behavioral health services through primary care throughout Washington. We want providers and clinics to have a clear pathway to integrated care and patients to know that our entire state has a no-wrong-door approach to their needs.

Next Steps to Full Integration

Overcoming Barriers

Much of the research into integrating behavioral health is centered on strategies for overcoming barriers to integration. Supporting material to Qualis Health's Implementation Guide, [Common Barriers and Strategies to Support Effective Health Care Teams for Integrated Behavioral Health](#), identifies the methods of overcoming barriers based on principles of effective teams including: shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes.⁶²

While not a comprehensive list, steps to overcoming barriers to implementation include:

- **Knowing Where to Start:** There are many assessments and checklists to determine where to start. Our workgroup does not endorse any one assessment and recommends clinics use one to meet their own needs or those of a program in which they are enrolled.
 - AHRQ has developed a 37-question integration checklist available here: https://integrationacademy.ahrq.gov/sites/default/files/playbook/Self_Assessment_Checklist_1.6.16.pdf
 - Maine Health Access Foundation 21-question Site Self-Assessment available here: https://integrationacademy.ahrq.gov/sites/default/files/measures/8_MEHAF_SSA.pdf
 - Qualis Health's Safety Net Medical Home Initiative 36-question Patient-Centered Medical Home Assessment available here: <http://www.improvingchroniccare.org/downloads/pcmha.pdf>
- **Making the Case:** Facilitating buy-in is a key first step to integration.³⁵ AHRQ has developed a comprehensive website complete with videos to facilitate understanding as to they why for integrating behavioral health here: <https://integrationacademy.ahrq.gov/resources/videos>.
 - SAMHSA has developed a comprehensive toolkit to determine the financial business case for integrating behavioral health here: http://www.integration.samhsa.gov/integrated-care-models/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf with a corresponding Excel tool available for download here: http://integration.samhsa.gov/integrated-care-models/Business_Case_for_Behavioral_Health_Pro_Forma_Model.xlsx
- **Staffing:** Hiring the right staff, especially behavioral health clinicians who have the skills, experience, and are comfortable working in a primary care setting, is difficult for many clinics.⁶³ Pragmatic research has repeatedly found the importance of training behavioral health and primary care staff together to deliver patient-centered care as a team. Staffing, and especially scheduling ratios of behavioral health to primary care clinicians may need to be consistently revisited due to the complexity of a practice as an adaptive system and any local and national changes.³⁷ Higher ratios of behavioral health staff and flexible schedules are associated with warm handoffs that better support a patient rather than referrals that can result in patients

being lost in the system.⁶⁴ AHRQ outlines necessary staff competencies including therapeutic skills such as motivational interviewing but also skills necessary for working within primary care such as consultation skills.⁶⁵

- **Addressing Health Information Technology:** Electronic health records (EHRs) are a key component in multiple of our eight elements of behavioral health integration, most notably [accessing and sharing patient information](#) and [collecting data](#). However, EHRs are notoriously challenging especially with: documenting and tracking behavioral health information (e.g., due to lack of a relevant template and inability to track longitudinal data), supporting team-based communication and care coordination, and exchanging information with other EHRs.⁶⁶ Practices should assess their needs and capabilities early-on in the integration process and develop necessary workarounds.

Implementation Guides

There are many high-quality integration implementation guides including:

- **Agency for Healthcare Research and Quality:** Behavioral Health Implementation Guide Facilitates Integration <https://integrationacademy.ahrq.gov/resources/new-and-notables/behavioral-health-implementation-guide-facilitates-integration>
- **AIMS Center:** Collaborative Care Implementation Guide <https://aims.uw.edu/collaborative-care/implementation-guide>
- **SAMHSA-HRSA:** Center for Integrated Health Solutions developed a quick start guide to behavioral health integration for safety-net primary care providers: <https://www.thinglink.com/channel/622854013355819009/slideshow>
- **Qualis Health:** Implementation Guide to Behavioral Health Integration builds off previous framework to move a practice into a patient-centered medical home model and uses the AIMS Center's five principles of integrated care, detailed previously. Available here: <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Behavioral-Health-Integration.pdf>

Stakeholder Actions and Quality Improvement Strategies

Patients and Family Members

- Review **Table 2: Roadmap to Integrated Care**. You should be receiving care that addresses both physical and behavioral health needs. Read through the patient perspective on the eight elements.
- Talk to your primary care provider or other care team members about any concerns including feeling low or depressed, feeling anxious, concerns about drinking or drug use, or any other concerns about behavioral health.
- Ask to see your care plan if you would like.
- Talk to your providers about your concerns with accessing the type of care that you need.
- Track progress on treatment for behavioral health diagnosis in the same way that you would track something like blood pressure.
- Ask your care team about the reasons or evidence for the types of treatments that you receive.
- Give your feedback about your experience at the practice.

Primary Care Clinics and Systems

Review Table 2: Roadmap to Integrated Care. The following list includes key action items from the Roadmap.

- Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff.
- Structure typical practice activities to facilitate involvement by all members of the integrated care team (e.g., team meetings, daily huddles, pre-visit planning, quality improvement meetings).
- Facilitate patient access to behavioral health and primary care services on the same day as much as feasible.
- At a minimum, ensure that for each patient with an identified behavioral health need, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
- Ensure that the integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care.
- Ensure that clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.
- Facilitate access to psychiatry consultation services in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan.
- Coordinate specialty behavioral health services for patients with more severe or complex symptoms and diagnoses.
- Proactively identify and stratify patients for targeted conditions.
- Use systematic clinical protocols based on screening results and other patient data, like ER use, that help to characterize patient risk and complexity of needs.

- Track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.
- Use age-appropriate measurement-based interventions for physical and behavioral health interventions that are adapted to the specific needs of the practice setting.
- Use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether patients are improving.
- Include the patient's goals of care and appropriate self-management support in care.
- Incorporate patient goals into the care plan.
- Communicate effectively with the patient about their treatment options and ask for patient input and feedback into care planning.
- Track system-level data regarding access to behavioral care, the patients' experience, and patient outcomes. If system goals are not met, use quality improvement efforts to achieve patient access goals and outcome standards.

Health Plans

Partially adapted from SAMHSA's *ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers*⁶⁷

- Reimburse for primary care providers participating in a collaborative care program or receiving other integrated behavioral health services as outlined in CMS Federal Register Final Rule for Docket Number CMS-1654-F (e.g., G0502, G0503, G0504).
- Work with health care purchasers to identify and provide data on outcome measurements relevant to their population to better ensure treatment efficacy and patient access (e.g., NCQA behavioral health treatment within 14 days, NCAQ anti-depressant medication management).
- Develop and maintain strong, respectful relationships with practices including sharing information, decision making, costs, and savings as appropriate.
- Measure quality and outcomes including traditional clinical measures but also data beyond care delivery and claims: arrests/recidivism, housing status, employment, if possible
- Make changes to integrated programs as needed, whether prompted by outcome data or if necessary for the feasibility and functionality of a program.
- Try to ensure all practices use the same information system from the beginning, even if that requires implementing a second population-management system.

Washington State Health Care Authority

- Certify patient decision aids around treatment options for common behavioral health conditions (e.g., depression, anxiety, alcohol use, substance abuse).

Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade MS	Deputy Director	Washington Health Alliance
John Espinola MD, MPH	Executive Vice President, Health Care Services	Premera Blue Cross
Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed MD	Chief Medical Officer	Confluence Health
Richard Goss MD	Medical Director	Harborview Medical Center – University of Washington
Christopher Kodama MD	President, MultiCare Connected Care	MultiCare Health System
Daniel Lessler MD, MHA	Chief Medical Officer	Washington State Health Care Authority
Paula Lozano MD, MPH	Associate Medical Director, Research and Translation	Group Health Cooperative
Wm. Richard Ludwig MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O’Neill MD, MBA	Partner	Mercer
John Robinson MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers MD (Vice Chair)	Chief Executive Officer	Foundation for Health Care Quality
Jeanne Rupert DO, PhD	Medical Director, Community Health Services	Public Health – Seattle and King County
Kerry Schaefer	Strategic Planner for Employee Health	King County
Bruce Smith MD	Medical Director	Regence Blue Shield
Lani Spencer RN, MHA	Vice President, Health Care Management Services	Amerigroup
Hugh Straley MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Carol Wagner RN, MBA	Senior Vice President for Patient Safety	The Washington State Hospital Association
Shawn West MD	Family Physician	Edmonds Family Medicine

Appendix B: Behavioral Health Integration Workgroup Charter and Roster

Problem Statement

Untreated behavioral health disorders, including substance abuse, are debilitating and costly. Approximately 23% of Americans experience a major depressive episode in their lifetimes, however screening and comprehensive access to treatment happen infrequently.^{1,2} Untreated depression and anxiety are associated with poor health outcomes, increased health care costs, and a shorter life.³ Washington State has been ranked 48th on measures of need for mental health services compared to access.⁴ The integration of behavioral health and primary care has been shown to increase access to behavioral health services through decreased reliance on specialty care and be more patient-centered, cost-saving, and result in healthier patients and healthier populations.⁵

Aim

To improve the integration of behavioral health services and primary care across the State of Washington starting with screening and increased access to treatment for depression.

Purpose

To propose evidence-based recommendations to the full Bree Collaborative on:

- Screening for depression
- Defining integrated approaches focused on enhancing behavioral health access and outcomes
- Referring to treatment for depression
- Best practices for overcoming barriers to patient-centered behavioral health care (e.g., information technology, 42 CFR)
- Measuring improvements and access to behavioral health care
- Identifying additional areas for recommendations

Duties & Functions

The Behavioral Health Integration workgroup will:

- Research evidence-based guidelines and best practices (emerging and established).
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

¹ National Institutes of Mental Health. Major Depression Among Adults. Available: <http://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml>. Accessed: August 2015.

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Behavioral Health Integration Workgroup

Updated: January 9, 2017

Structure

The workgroup will consist of individuals appointed by the chair of the Bree Collaborative or the workgroup chair and confirmed by Bree Collaborative members.

The chair of the workgroup will be appointed by the chair of the Bree Collaborative.

The Bree Collaborative project director will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. The program director will conduct meetings along with the chair, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members to be added at the discretion of the chair.

Member	Title	Organization
Brad Berry	Executive Director	Consumer Voices Are Born
Regina Bonnevie, MD	Medical Director	Peninsula Community Health Services
Michelle Guerra, MD	Senior Clinician	Premera
Larry Marx, MD	Medical Director, Behavioral Health Support Services	Group Health Cooperative
Rose Ness, MA, LMHC, CDP	Behavioral Health Expert	Sound Integration for Behavioral Healthcare
Kim McDermott, MD	Physician	NeighborCare
Mary Kay O'Neill MD, MBA	Partner	Mercer
Joe Roszak	CEO	Kitsap Mental Health Services
Anna Ratzliff, MD, PhD/ Anne Shields, MHA, RN	Director of the UW Integrated Care Training Program, Associate Director for Education/Associate Director	AIMS Center, University of Washington
Jeff Reiter, PhD	Lead Psychologist	Swedish Medical Services
Julie Rickard, PhD	Program Director of Integrated Behavioral Services	Confluence Health
Brian Sandoval, PsyD	Behavioral Health Manager, Oregon and Washington Services	Yakima Valley Farm Workers Clinic
Lani Spencer, RN, MHA	Vice President	Health Care Management Services, Amerigroup – Washington
Emily Transue, MD, MHA	Senior Medical Director	Coordinated Care
Melet Whinston, MD	Medical Director	United Health Care

Appendix C: Crosswalk of Eight Elements with MeHAF

	Element	Link to MeHAF Question
1	<i>Integrated Care Team</i>	II-2. Patient care team for implementing integrated care II-3. Providers' engagement with integrated care ("buy-in") II-8. Physician, team and staff education and training for integrated care
2	<i>Patient Access to Behavioral Health as a Routine Part of Care</i>	I-1. Co-location of treatment for primary care and mental/behavioral health care I-12. Accessibility and efficiency of behavioral health practitioners
3	<i>Accessibility and Sharing of Patient Information</i>	I-3. Treatment plan(s) for primary care and behavioral/mental health care II-4. Continuity of care between primary care and behavioral/mental health
4	<i>Practice Access to Psychiatry Services</i>	II- 5. Coordination of referrals and specialists
5	Operational Systems and Workflows to Support Population-Based Care	I-2. Screening/Assessment of emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) I-7. Follow-up of assessments, tests, treatment, referrals and other services I-11. Tracking of vulnerable patient groups that require additional monitoring and intervention
6	<i>Evidence-Based Treatments</i>	I-4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care I-10. Patient care based on (or informed by) best practice for prescribing of psychotropic medications
7	<i>Patient Involvement in Care</i>	I-5. Patient/family involvement in care plan I-6. Communication with patients about integrated care II-7. Patient/family input to integration management
8	<i>Data for Quality Improvement</i>	II-6. Data systems/patient records

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