Get the Balance Right (Part 2):

Interviews with Two California Experts on Integrating Behavioral Health Into Primary Care

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Context

The work of integrating care for behavioral health needs into primary care services is complex. In California, separate regulations and bifurcated funding between physical health care and behavioral health care make the work of integrating care challenging. Progress has been fueled by grant-funded innovations, a necessarily opportunistic approach to maximizing multiple funding streams, and quite recently through the growing industry agreement on the value of the Collaborative Care Model (CoCM). Provider organizations continue to make headway and provide care that is more integrated, making behavioral health both more available and more accessible.

The 2021 resources in CQC's Behavioral Health Integration Curriculum supporting behavioral health – primary care integration, of which this is one, employ the Collaborative Care Model (or a variation) as the goal. CoCM has been validated by research, with "more than 90 randomized controlled trials and several meta-analyses … (showing it) to be more effective than usual care for patients with depression, anxiety, and other behavioral health conditions. CoCM is also shown to be highly effective in treating co-morbid mental health and physical conditions such as cancer, diabetes, and HIV," per the CoCM "Evidence Base" webpage.

CoCM is the integrated care model with the most current potential for sustained funding, given the relatively new billing codes (CPT 99492, 99493, 99494; HCPCS G2214) and the fact that some managed care companies have begun to reimburse providers through these codes. (See advice from the American Psychiatric Association on these codes here.)

The conventional wisdom about what constitutes best practices in integrated behavioral health is changing, as a result of both the COVID-19 pandemic and marketplace innovation, as well as new opportunities from statewide policy. CQC identified three questions that are guiding organizations' current planning for sustainable integrated behavioral health services. These questions became the topics of discussion for CQC's interviews with two California experts.

1. **Treatment modality:** What is the ideal mix of in-person visits and virtual care by phone or video call? The leading models that direct the development of integrated care hold that the ideal scenario is in-person visits for patients, with an integrated care team who work in the same site. The rise of virtual care during the COVID-19 pandemic, particularly for behavioral health services, demonstrates the potential of a mixed modality for many patients and clinicians.

2. **In-house or external clinicians:** What is the ideal mix of **in-house behavioral health clinicians and external clinician partners?** External clinicians (who work for contracted behavioral health vendors or community partners) are an option for some provider organizations, particularly when an integrated care program is small and growing. This question led to the wider discussion of workforce, the roles on the integrated team.

3. **Funding beyond per-member-per-month and fee-for-service:** Will alternative payment models soon make it possible to build a sustainable integrated care team to deliver an effective continuum of integrated services? How can a provider organization prepare for these long-anticipated changes?

The two experts interviewed were Brenda Goldstein, Chief of Integrated Services, LifeLong Medical Care, a large Federally Qualified Health Center in Oakland, Berkeley, and other Bay Area locations in Northern California; and Julie Fortune, MFT, Executive Director of the Mental Health Institute / Southern California region of Providence Health. CQC is grateful for their time and generous contributions of expertise from their journeys with their organizations in achieving more integrated care for their patients.

The interviews with these two experts were conducted separately. They are presented here together, to make the similarities and differences in their experience, and their synergistic advice, easy to identify.

Julie Fortune's statements are in blue throughout, and Brenda Goldstein's are in green to make it easier to distinguish the two experts' statements.

In addition to the experiences and recommendations from these interviews, CQC recommends two other resources for leaders of behavioral health integration:

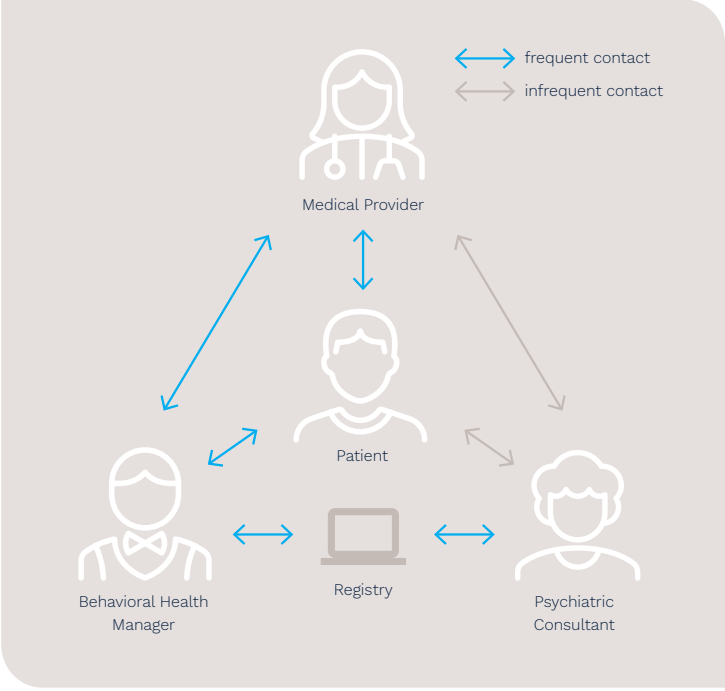
- CQC's *Business case considerations for evolving models for integration of behavioral health services into primary care: A California-focused outline to support the spread of the Collaborative Care Model* (link). This is the partner resource to this report, that lists the many variables to consider in the complex work of developing a sustainable program. Among other goals, the guide seeks to help a planning team decide how to use the next resource …
- The Financial Modeling Workbook from the AIMS Center at the University of Washington and the American Psychiatric Association. This Excel tool supports planning of budget and staffing for a CoCM model of care. Clinician capacity numbers are calculated against the CoCM CPT billing codes and the HSPCS G-code as the main payment mechanism, to establish the number of patients the program could serve, and the income an organization can expect from one or more payers using CoCM billing codes.

Collaborative Care Model: The basics

The Collaborative Care Model (CoCM) is a program design for delivering behavioral health services within the primary care team. As its originators at The AIMS Center (Advancing Integrated Mental Health Solutions) at the University of Washington point out, "Primary care is the de facto treatment location for most patients with common mental health conditions like depression and anxiety, with 70% of all antidepressant prescriptions in the United States written by a primary care provider."

The main principles of the CoCM include a specific care team where each professional has a defined role relative to the patient and the other team members. (See diagram below.) One of CoCM's "core principles" is "Measurement-Based Treat to Target," requiring regular monitoring of behavioral health symptoms to understand the patient's level of acuity and the care's effectiveness in helping manage symptoms.

The two experts interviewed for this guide each have at least one clinical site running the CoCM with high fidelity to the CoCM structure. Each also have clinical sites where the care model for behavioral health has been modified, e.g., the care team does not have the exact staff roles or ratios as CoCM recommends.



The Collaborative Care Model team structure. Adapted with permission from the University of Washington AIMS Center.

About the experts

Julie Fortune, LMFT, is the Executive Director of the Mental Health Institute / Southern California region of Providence Health, based out of Anaheim. Providence has 120,000 caregivers serving in 52 hospitals, 1,085 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington, making it the third largest not-for-profit health system in the United States.

Brenda Goldstein, MPH, is chief of integrated services at LifeLong Medical Care, based in Berkeley. Starting with one clinic site in 1976, LifeLong Medical Care now operates 14 primary care health centers, four dental centers and two dental vans, an adult day health center, four school-based health centers, a supportive housing and street medicine program, and urgent care centers in Alameda and Contra Costa Counties. LifeLong provides services to more than 61,000 underserved individuals annually.

Current model of integrated care at Providence St. Joseph

Julie Fortune: In 2018, we rolled out a primary care integration program using the Collaborative Care Model at Providence St Joseph in our Orange County and High Desert regions, in six sites utilizing grant funding. At the time, Providence did not have ambulatory behavioral health services in those regions. When our patients needed behavioral health services, they were referred to community providers or to their insurance for referrals. We gravitated toward the Collaborative Care Model (CoCM), supported by an engaged and willing executive, physician and practice leadership. Our providers were strong advocates and supporters for implementing this innovated program in their practices. When we launched the program, the behavioral health specialists (LMFT/LCSW) were all physically embedded in the primary care practices full time, five days a week. We had one therapist for each practice, with about 12 to 15 primary care providers at each practice. With support and partnership with from Blue Shield, we scaled the program to more primary care practices. Currently, our program has expanded to serve 13 primary care sites with plans for 3 additional sites in 2022.

Current model of integrated care at LifeLong

Brenda Goldstein: LifeLong provides integrated medical and behavioral health services at all of our primary care sites, school-based clinics and in our homeless services programs. Teams of primary care providers, licensed mental health counselors, psychiatrists, psychiatric nurse practitioners, associate social workers, behavioral health community health workers, and recovery counselors work together to provide an array of services including routine behavioral health screening and assessment, short-term and long-term counseling, psychiatric medication prescribing and management, substance use recovery counseling, and linkages to community-based support services and resources. Our electronic health record (EHR) includes a behavioral health registry. We use the EHR to communicate and to support data driven interventions.

We have the formal Collaborative Care Model, with systematic psychiatric consultation for primary care providers, at one clinic site. There, the licensed social worker identifies the patients who are not making progress in behavioral health treatment for depression or anxiety, and where either a) the introduction of medication has been discussed as an option with the patient, or b) existing medication prescribed by the primary care provider have not working well. A psychiatrist provided by the county system will do a case review with the social worker and make a treatment recommendation to the primary care provider. The psychiatrist then monitors and supports the patient's progress during her one day per week working with that site.

At our other LifeLong sites, staff psychiatrists and psychiatric nurse practitioners are available to the counseling and primary care provider staff for consultation, but the model is not as formal as it is at the one CoCM site. The psychiatrists at the non-CoCM sites provide direct services to patients (which generate reimbursement). They are available to primary care providers and counseling staff for a quick conversation between patient visits, or through a note through the electronic health record, but these psychiatrists do not do routine, formal consultation for primary care patients as they would if using the full CoCM.

Question 1

What is the ideal mix of **in-person visits and virtual care** by phone or video call?

Treatment modality

Use virtual visits to provide options for patients and optimize patient experience

> "When you offer opportunities to patients and they are voting with their feet, or their phone, you are doing patient-centered care. We want to provide a hybrid model where patients have choice and staff are happy. I want to focus on patient choice."

Brenda Goldstein: We pivoted exclusively to remote care for behavioral health services at the start of the pandemic. Even now (mid-2021), we are doing mostly telephonic visits and some video visits. Patients tell us they really like it. They don't have to take a half day off from work, or find someone to watch their kids while they are traveling to and from a visit at the clinic. Giving patients the option to do what works for them reduces no show rates and improves patient satisfaction.

After switching to virtual visits during the past year we have come to realize that the best approach is to give our patients choices. Some people prefer tele-visits while for others prefer in person visits or have health issues that are best treated in the clinic. Our behavioral health clinicians also want to have the choice to see patients either remotely or in person.

At some of our clinic sites, we have a space set up with a computer and phone for patients to log on and meet with their behavioral health provider who is working remotely. This works for patients who don't have the technology or privacy where they are living to connect virtually. Using telehealth exclusively has highlighted the digital divide for low-income communities – most of our patients are not ready to use video for visits yet. Some patients don't have data plans that support long video visits; others need training and support on using the technology. We would love to add more texting into our communication, especially for young people, as a quick check-in. It's a great way to communicate.

Julie Fortune: When COVID hit, we converted all therapy services to virtual visits, and physically removed the therapists from the clinic practices. All of a sudden, telehealth was the new way of delivering services. With this transition, we e saw improvement in access to care because the therapists' schedules became more open, without the daily huddles, regular staff meetings, and other clinic activities. [The experts discuss developing virtual team collaboration below.]

We used program metrics and data such as numbers of referrals, visits volumes, patient satisfaction scores to keep a pulse on how well sites were adapting to these changes. We flexed our operations based on what we saw in the data. These operational changes were made based on each individual site. We decided not to make the same blanket changes for everyone.

We saw no indicators that this transition to virtual care hurt patients' clinical experience. Our PHQ9 depression treatment response remained positive and consistent year over year: 2019, 2020, 2021 Also, our Press Ganey behavioral health patient satisfaction "top box" results remained consistent 2019 to 2020 when we went virtual for the pandemic.

We tried to stay like water, fluid and flexible.

BG: Our decisions on how we serve our patients are led by who our patients are and what they need. Communities served by LifeLong are disproportionately impacted by racism, inequities and trauma. We offer opportunities for patients to engage in culturally affirming behavioral health services. For example, two groups for African American patients offer a safe space to discuss the experience and impact of racial trauma and stress and to build a supportive community.

Virtual visits require careful monitoring and management of clinical operations and team connections

> At some practices, when the staff went virtual, the referrals to the behavioral health team decreased as a result of the 'out of sight out of mind' challenge. This required our behavioral health therapists and mangers to become more engaged and active in marketing and promoting the program

JF: We realized if we are able to maintain active engagement in the team, between medical providers and behavioral health providers, this virtual model could continue to be implemented and successful. As we switched back to more in-person visits for patients in primary care, we continued to offer virtual behavioral health visits based on what works best for the patients and clinic providers and staff. We are constantly assessing this program, clinic by clinic, therapist by therapist.

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As a result, we now have all three models working well: We moved some sites to hybrid (onsite/virtual) schedules, and other sites went back to 100% in-person because of a decrease in referrals and engagement from the treatment teams when the behavioral health services were all virtual. And where communication and referrals stayed strong, we kept the behavioral health specialists 100% virtual.

Another consideration during this transition was the therapist's preference for their clinical practice. Some therapists just prefer to be in the office. They want the connection to the practice; therefore, we supported the therapist's preference. An example of this situation occurred with one therapist. She was able to maintain good productivity metrics during this transition to virtual; however, she felt she just did better in person, and requested to go back to work onsite.

With another therapist who did very well working in a virtual space, we were able to increase access to care by keeping her virtual where she was succeeding. We were able to add another clinic to that therapist's caseload because she had more clinical time available with no commute and fewer regular meetings.

BG: Most staff prefer to see at least some of their patients in-person. There are perceived benefits to the patient-clinician relationship and it can be important for optimal management of certain kinds of symptoms or when using specific treatment approaches, e.g., EMDR (Eye Movement Desensitization and Reprocessing, a psychotherapy for trauma and related conditions that has a distinct visual component).

With virtual appointments, wait times are reduced and we can offer appointments sooner. No-show slots can be filled with a phone appointment for a different patient. Virtual appointments can also be location-neutral: we developed a behavioral health pool system to allow patients to access care regardless of whether the clinician is associated with their specific home clinic. For example, patients who live in Richmond normally would not be willing to travel to East Oakland. It's too far. With virtual visits, they can have an appointment with an East Oakland provider because it doesn't matter where the clinician is. Virtual care allowed us to pool appointments, so we have better appointment access.

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We have behavioral health community health workers (BH-CHWs) at each clinic site who handle warm handoffs and referrals. [Find more about this new role of BH-CHW in "Workforce" section below.] They were the first of the behavioral health staff to come back on site. The primary care providers really missed the BH-CHWs and wanted them back to see patients in person. Going forward, we will see the benefit of having the CHW back and not the clinicians. Eventually we will have a minimum in-person expectation for clinicians in the clinic for in-person care, warm handoffs of new patients to the behavioral health clinicians, team case conferences, meetings, and other team connections.

JF: We figured out how to keep effective communication with the physicians, staff, and practice managers. It took more intentional effort, marketing (of behavioral health services to the primary care providers), monthly touch-base meetings, and showing up at provider huddles virtually. These team activities help everyone stay connected when the therapist is not onsite.

One success factor that directly corelated to being successful in this new virtual environment was the amount of time that the program had been established pre-pandemic, and that level of rapport and teamwork between behavioral health clinicians and the practices before going virtual. At one clinic, the practice and therapist had been working together in the program for one year before the change to virtual care. For another therapist whose referrals dipped when she went virtual, she had been in practice a few months when COVID hit, so she was not as ingrained in the team yet. So now, at clinics where behavioral health services are newer, we have chosen to get the therapists back in office to establish rapport, to build that relationship and teamwork.

Another important piece: Know your data. Know your therapists and practice managers. Understand the therapist demeanor and preferences, and the individual practice culture. This information will help you make the best operational decisions for successful implementation of this model.

BG: Space has been an issue for growth. Behavioral health clinicians take up an office. With virtual care, we can hire more staff and offer more appointments because we don't need more space.

Virtual Group Visits for Behavioral Health, LifeLong Medical Care

"We have done some successful groups online. It is always a lot of work to run a group, and tough to keep no-shows low. That is made easier with virtual groups, because they are run from one facility, and open to patients across LifeLong. Some groups lend themselves better to virtual. I would like to see a combination of in-person and virtual. Clinicians are figuring it out still."

— Brenda Goldstein

Question 2

What is the ideal mix of **in-house behavioral health clinicians and external clinician partners?**

Workforce: In-house or external clinicians, team roles and billing

Psychiatry services may be the most common and cost-effective care team role to contract out, if any

Brenda Goldstein: For the vast majority of Federally Qualified Health Centers (FQHCs) I work with around the state, most do not contract out for members of the care team. Those that do, primarily contract for psychiatrists because they are so hard to recruit. The strongest model for true integrated care is to have people on staff and working together in the clinic. We want to bring our staff into our own culture and mission and on board with how we do care. You want people to communicate through a shared electronic records system. Can we keep the care holistic for our patients if we refer them out for primary psychiatry or other services we could provide? We do refer patients out to community resources for needs beyond what we provide, specialty services like day treatment or long-term therapy.

At one of our clinic sites our county provides a psychiatrist one day a week to one of our sites to provide consultation, as part of county-wide CoCM efforts. She comes to the clinic, meets with our staff, and uses our electronic health record to document and collaborate. We might consider contracting for psychiatric consultation services, but we're challenged currently because those services don't generate any billable revenue.

Julie Fortune: We would have preferred to have all staffing in-house. It did not work out this way for the consulting psychiatrist role (in the CoCM model). Hiring a full-time psychiatrist can be very expensive, and fair market value is increasing. In Southern California, the average annual base salary for a psychiatrist is $325,000. This led us to explore many different opportunities to fill the psychiatric consultant role for this model/program. Currently, we have a contract with a group to provide the psychiatric consultation support required for the collaborative care model.

We have tried different iterations of staffing this role for the Collaborative Care Model. Here are the models we have tried so far:

- **Contracted organization for psychiatry consultants (current model):** This group conducts the weekly case and registry review/consultation with each therapist, and provides psychiatry e-consults for our primary care providers, like virtual curbside consultations. This psychiatrist also hosts educational lunch-and-learns with our providers. We are 100% satisfied with this relationship. It has been helpful contracting with a group, because their group has access to multiple psychiatric specialties: adult, child, geriatric, substance use. One important thing: We onboarded the psychiatrist consultant as if they were hired at Providence, giving them direct access to our electronic records to do direct documentation and messaging. This has been very important to having transparent and fluid collaboration, and helped make them a natural part of the treatment team. We contract with this group on an hourly/per diem rate. This partnership started in January this year (i.e., seven months ago). It has been ideal so far.

- **Psychiatric nurse practitioner:** When we first implemented the program, we decided to utilize a board-certified psychiatric nurse practitioner as our psychiatric consultant. Utilizing a nurse practitioner for this role had its advantages. Not only could the NP provide the weekly case consultations and registry review for the therapists but they could also see patients for psychiatric services. We found that our NP was able to engaged with patients and collaborate more closely with the primary care providers. In addition, it was easier to recruit and hire a NP than a psychiatrist. A nurse practitioner does require a psychiatrist as their clinical supervisor, so we had to contract with a psychiatrist to provide about ten hours per month of clinical supervision for the NP. However, even with this added cost it was still the best financial option for filling the psychiatric consultant role.
- **Psychiatry residents:** Another staffing model we tried was partnering with psychiatry residents in an academic university program. One new benefit was the access to the teaching program's faculty by our primary care providers. However, in implementation this partnership did not prove to be the right fit for the program that we were developing, in large part because residents are so busy with their academic work and clinical rotations.

BG: As I said earlier, we do not use paid contractual relationships outside of LifeLong, but we do have many referral partnerships for specialized services our patients need.

Staffing our in-house team became easier recently. During the COVID Public Health Emergency, FQHCs were approved to bill for associate-level social workers and marriage and family therapists (ASWs and AMFTs). Previously, not being able to bill for these clinicians' services created a leak in the workforce pipeline, between the students we train and the licensed professionals.

We do modeling of revenue based on clinician productivity, in order to budget for support staff, administrative overhead, site expenses, and other operational expenses. Our goal is to use billing revenue to pay for behavioral health community health workers (BH-CHWs), to get a good ratio of these support staff to our behavioral health clinicians. We cannot bill directly for the work of the BH-CHW.

A support role for behavioral health is new. The BH-CHW role includes a range of patient and care team supports:

- Referrals management between primary care and behavioral health care
- Ensuring every billable visit is billed.
- Keep the clinicians' schedules full, and address no-shows.
- Connect patients to resources.
- Perform panel management a la AIMS Model, with outreach for patients who need to be seen and whose PHQ-9 score (or other clinical measures could be improved).

We are supplementing the funding for our case manager positions with Health Homes Program dollars, which will become CalAIM dollars. [CalAIM is the current multi-year delivery reform initiative for Medi-Cal, which has integrating care as a guiding principle. See a program summary by California Health Care Foundation here.] The anticipated Alternative Payment Model could also help with adding more services and flexibility our care model.

Productivity and billing

BG: We asked the behavioral health staff across our clinic sites: What percentage of your time do you spend in different activities? Clinical/billable services, improvement projects, administrative time and staff meetings. For the behavioral health clinician, the LCSW or MFT, is the rule of thumb is that 75% of their time is spent on direct service and 25% on other activities. We use this to calculate productivity goals which are communicated with each clinician. They can manage their schedules to meet these goals, which contributes to promoting a flexible work culture and staff ownership of their work.

JF: We don't get all the money we charge. We need to be careful in predicting reimbursement for Collaborative Care. We can send out a large number of charges, but we will not get that amount back. What we get back is a lot lower. Everyone needs to know: What is the recoupment rate? How good is your organization with Accounts Receivable? What do you get back from what you send?

Coordination and collaboration with the county serious mental illness system and other providers

BG: In terms of our partner organizations in integrated behavioral health, there is the interplay between the SMI system and FQHCs for SMI and SUD. There is endless debate about when you refer out. FQHCs care for the full range of mental health conditions, in part because access in county system is not good. And for the people with complex medical needs and behavioral health needs, we want to provide the complex care and not fragment it.

What we don't have at LifeLong is the wrap-around case management out in the community that the specialty system can provide. That need affects when we refer patients out to the SMI system, as much as the question of whether we have licensed staff who can work with people on recovery and managing their symptoms, for psychiatry and counseling. We also refer people through Medi-Cal managed care for counseling, for example, if someone who wants more sessions than we can offer. Or if we have a wait list and the patient wants to be referred out. Or do they have a special need we can't meet: a certain condition? A language need? Do they want a transgender specialist? We are always looking at access and the best fit for each person.

In the substance use disorder area, we are not a 42CFR program. [Title 42 of the Code of Federal Regulations defines "federally assisted programs" that diagnose and treat substance use disorders. Federally assisted programs register with the U.S. Department of Health Services and abide by specific regulations that govern issues including how substance abuse treatment data can be shared with other health care providers.] We have recovery support counselors who provide services to patients interested in SUD recovery but we consider our services to be an integrated part of primary care and do not hold ourselves out to be a treatment provider. Medication for Assisted Treatment (MAT) for opioid and alcohol use is provided as part of primary care. Many patients want to change their substance use, but are not ready to go into formal recovery programs. We provide counseling and support to help them move towards recovery.

Question 3

Will alternative payment models soon make it possible to build a sustainable integrated care team to deliver an effective continuum of integrated services?

Funding beyond per-member-per-month and fee-for-service

Brenda Goldstein: I worry that when we focus on the business case and what payment covers, we focus on the medical model and not holistic care. The business case does not promote the important other work, so we struggle to provide the other services. It's a self-fulfilling prophecy that we never get to it. Can we figure out a model that helps support the other work, including case management and other non-medical services?

Funding is an opportunistic mix

BG: Our current funding is a real mix. The majority of collaborative care is funded by our Medi-Cal PPS rate and direct billing from the services provided by licensed staff (and now associates, with the new ability to bill for associate social workers and marriage and family therapists). We also use HRSA grant funding and a grant from our county behavioral health agency.

For the number and duration of visits per patient, it's a balancing act between shorter and longer visits. The PPS rate for FQHCs doesn't care about visit duration. We are paid more for seeing more visits in a session or in a day. Funding does affect the model of care.

We ask, what's the ideal balance for clinicians to keep them happy and productive? There is important non-billable time for training and meetings. The team meetings time required for coordination and collaboration is a big factor in the business model. We also need to provide access for new patients, but there is a high no-show rates with new patients and the additional time required to initiate the care relationship and assist with more needs for new patients. It's a regular balancing act.

Julie Fortune: It has been a series of grants that funded our program and its expansion. We were able to launch this program with the support of the Wellbeing Trust. During our implementation, our Blue Shield representatives came to tour the practice and observed this model in action. As a result, they offered support to expand our program reach to more patients and practice sites. And in 2021, we were awarded a grant from the California Department of Health Care Services through Proposition 56 funding. We have been completely grant funded from our start in 2018 through 2023.

However, we have always talked about financial sustainability since day one. When looking at financially viability, we look not only at direct revenue generated by the utilization of the Collaborative Care CPT codes but at other cost savings and cost avoidant metrics & reports.

We bill fee-for-service to the major health plan contracts (for the CoCM billing codes). We see a wide range of reimbursement amounts from the different payers. One health plan pays just above Medicare; one pays three times the Medicare rate.

Another area that we were able to impact not just clinically but financially was in our Medicare Advantage Hierarchical Condition Categories (HCC) metrics for behavioral health from CMS, which use risk factors to weight payment based on disease burden and patient demographics. There are HCC categories for major depression, bipolar disorder, and psychotic disorders that make a difference in the payment we receive for our Medicare patients. Our therapists were directly able to improve and impact this metric because of their clinical assessment and appropriate diagnosis of our behavioral health patients.

We calculated total cost of care to make our financial argument for cost savings to our payers. We pulled a patient roster for the CoCM program, and look at year-prior to program enrollment vs year-post, to see if there's a cost of care decrease. Our first analysis was for 2019, with only a six-month pre/post to look at. We saw a 10% decrease in total cost of care. We are redoing this analysis, with the longer timeframe now available, to capture full year pre- and full year post-.

Take-aways

- The funding landscape for integrated behavioral health is complicated and challenging to navigate. This is a time of successful experimentation for the pioneers in this area, instead of the arrival at a stable care model for the long term.
- A sustainable program for behavioral health services within a primary care practice is possible, with flexibility, careful planning, and close management of program operations (including billing and staffing). Our experts have used creativity, grant funding, and close partnerships with leading payers to achieve the levels of care integration and program capacity their patients benefit from today.
- The Collaborative Care Model is an important and proven way to deliver integrated behavioral health care in primary care. It is not the only solution. Funding issues are one reason that a provider organization may decide not to implement CoCM with full fidelity.
- For organizations early in their journey of providing integrated care, the classic change management and quality improvement advice applies: Start with one site and scale up to other sites as you learn what works. Monitor the data, including visit volumes, billing generated, recoupment rate on billing, staffing ratios, and patient caseloads.
- One size may not fit all. These two pioneering organizations use a mix of staffing models and services across their primary care practice sites. Both experts described different models of integrated care across their organizations: in care team composition and fidelity to the CoCM (at LifeLong), and in the mix of virtual and in-person behavioral health care provided by clinicians and other staff (at Providence – St. Joseph).
- The most popular frameworks for integrated primary care and behavioral health care assert that in-person care by an integrated care team that works together in person is ideal. The transition to more virtual care during the COVID-19 pandemic has called these assumptions into question, by showing many benefits of virtual care for patients, families, and provider organizations and their staff. These benefits include convenience for patients and improved appointment access.
- Maintaining an integrated behavioral health program, particularly in the current behavioral health workforce shortage, requires an explicit commitment to provider and staff resilience. Organizations will have to dedicate resources to address team bandwidth and support their emotional needs.

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