

Behavioral Health Integration **Compendium**

PRESENTED BY THE BHI COLLABORATIVE



Behavioral Health Integration Compendium

THIS BEHAVIORAL HEALTH INTEGRATION COMPENDIUM

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This Compendium was developed based on the generous contributions of time and expertise by the following BHI Collaborative members:



A special thanks to BHI Collaborative member, American College of Obstetricians and Gynecologists (ACOG) for their additional insights and feedback.

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Welcome to the Behavioral Health Integration Compendium

This Compendium has been developed by the [Behavioral Health Integration \(BHI\) Collaborative](#), led by several of the nation's leading physician organizations, as a tool for physicians and their practices to learn about, implement, and ultimately sustain BHI in order to achieve the goal of enabling timely access to optimal, equitable whole-person care.



Compendium Introduction

Our aim is to provide accessible, detailed information on the steps required to integrate behavioral health care, which includes promotion, prevention, early identification, and treatment of mental health and substance use disorders (SUD), into your practice and links to key open-source resources should you desire further, more specific information.

For more targeted support on specific topics, the AMA has also developed detailed how-to guides focused on [pharmacological treatment](#), [Care for SUD](#), [suicide prevention](#), [workflow design](#), [billing and coding](#), and [BHI for older adults](#). So, while the Compendium will guide your practice through the overall steps and considerations regarding implementing and sustaining BHI, the how-to guides provide targeted knowledge and actionable resources for specific areas in need of additional support.

This Compendium condenses a wide range of carefully vetted existing resources and is intended to provide

helpful frameworks and actionable information to effectively implement behavioral health care. It will be updated as new content becomes available, ensuring the most current, relevant information is available for your use. As you use the Compendium in your practice, we encourage you to share your stories about your experience using it and to point us to additional resources. We welcome your suggestions on what additional information should be featured in future iterations. You may contact us at Practice.Sustainability@ama-assn.org. If you are interested in learning more about our BHI Collaborative initiatives, you can find more resources at the [BHI Collaborative website](#).

A Note About Using the BHI Compendium

Different pathways may be taken to integrate behavioral health into primary care—whether that’s family medicine, internal medicine, pediatrics, obstetrics and gynecology, or other specialty care. The BHI Collaborative recognizes the importance of meeting your practice wherever you are on your journey to integration and providing relevant tools for success as you go forward. Integration is a continuous process and not a time-limited project. There are many ways to pursue BHI and numerous opportunities to modify such efforts as patient needs and practice resources evolve.

This document is intended to provide relevant foundational information and resources so you and your practice have what you need to make the best decisions for *your* practice and patients.

TERMINOLOGY:

- When “primary care physician (PCP)” is utilized in this document, it is inclusive of physicians across specialties—including family medicine, internal medicine, pediatrics, and obstetrics and gynecology. While not trained in primary care, non-primary care specialties, such as cardiology, gastroenterology, neurology, and oncology, can also benefit from integrating behavioral health into their practices to support their patients.
- While “patient” will be used throughout, note that this also encompasses the families and caregivers, who play an important role in integrated care.



**CHILD AND
ADOLESCENT**

A Developmental Approach to Child and Adolescent Mental Health Care

PCPs who serve children and adolescents have a unique opportunity to promote healthy mental and emotional development and safe, stable, nurturing relationships in families. Mental health concerns manifest differently in children than in adults; as such, pediatric approaches to BHI may differ compared to adult practices.

To that end, we have included guidance specific to child and adolescent mental health care where appropriate. This type of information will be noted with the icon above. Additional resources pertaining to pediatrics can be found at aap.org/mentalhealth.



Foundational Elements

Chapter 1: Key Terms and Building Blocks



BH: WHAT IS BEHAVIORAL HEALTH (BH)?

- **BH:** Throughout this Compendium, behavioral health (BH) will refer to mental health and SUD, life stressors and crises, and stress-related physical symptoms. BH care will refer to the prevention, diagnosis, and treatment of those conditions in the pursuit of whole-person, patient-centered care.
- In alignment with the [American Academy of Pediatrics \(AAP\)](#), when discussing BHI in the pediatric setting, we will use the term “mental health” (MH) rather than “behavioral health” to encompass behavioral, psychiatric, psychological, emotional, and substance use as well as family context and community-related concerns. The use of mental health is also intended to encompass somatic manifestations of psychosocial issues, such as eating disorders and gastrointestinal symptoms.

BHI: WHAT IS BEHAVIORAL HEALTH INTEGRATION (BHI)?

- **BHI:** BHI is widely accepted as the result of PCPs (or other subspecialists), psychiatric physicians, and other MH clinicians working together with patients, families, and caregivers using a systematic approach to provide patient- and family-centered care.

WHY IS BHI IMPORTANT?

One in five adults is living with a significant mental health or [SUD](#).

Additionally, perinatal MH conditions affect more than one in five people.^{i,ii,iii} Stigma, system fragmentation, and shortages in BH clinical resources and qualified BH professionals have resulted in a substantial mismatch between the prevalence of these conditions and the proportion of individuals who receive effective treatment. One of the most effective solutions for closing the gap between need and access is BHI in primary care.^{iv} While primary care is how many individuals access their care, non-primary care specialties that provide longitudinal care to patients with chronic illnesses also recognize the impact that BH conditions have on their patients.

Additionally, suicide death rates among those ages 10 to 24 have increased by 47% between 2009 and 2018.^{vi} However, only 13.8% of U.S. children and adolescents ages 3 to 17 receive any treatment or counseling from an MH professional.^{vii} Further, psychiatric disorders impacting children and adolescents are estimated to have an annual treatment cost of around \$40 billion.^{viii}

For more information on how to provide comprehensive care to children, adolescents, and families, watch the BHI Collaborative’s [“How to Address the Growing Behavioral Health Concerns Among Children, Adolescents, and Families”](#) webinar.



The scope of MH concerns among children ranges from those with functional impairments to those with a disorder. Approximately 19% of children in the U.S. have impaired MH functioning that does not meet the criteria for a disorder.^v Thirteen percent of school-aged and 10% of preschool children with normal functioning have parents who expressed concerns about their child’s behavior.^v In addition, MH disorders impact approximately one in five of America’s youth, which can cause significant challenges at home, school, and/or in their community.

Research focused on the design, implementation, and outcomes of various models of integrated health care has shown that BHI is integral to achieving the Quadruple Aim:^{ix}

- Improved patient experience
- Improved population health
- Reduced costs
- Improved care team well-being

BUILDING BLOCKS OF BHI

The building blocks of BHI are eight elements that are foundational to providing integrated primary care. Regardless of how BHI comes to life in your practice, these building blocks can be used across the integration spectrum.

Building Blocks	Description	Corresponding Actions
1/ BH as a routine part of care	Systematically identifying need and access to BH care as part of primary care	<ul style="list-style-type: none"> • Offer routine, universal, and age-appropriate screening • Establish clear assessment response and scheduling processes • Provide same-day access to BH services via “warm handoffs” • Enable patient-centric scheduling
2/ Integrated care team	Establishing a unified care team to positively affect rates of engagement and effectiveness of the BH clinician	<ul style="list-style-type: none"> • Commit to a culture of teamwork with regular communication in pursuit of unified treatment plans and documentation • Clearly define roles for all team members
3/ Accessibility and sharing of patient information	Rich information sharing for coordination of care within the team, with the patient, and with specialty services	<ul style="list-style-type: none"> • Ensure shared access to patient health information and treatment plan • Encourage patient access to their medical information to build trust and promote engagement • Protect adolescent confidentiality per state-level confidentiality laws
4/ Practice access to specialty services	Reducing unnecessary specialty referrals and ineffective patterns of health care utilization by using specialist consultation and clear referral processes	<ul style="list-style-type: none"> • Establish clear referral and coordination process to specialty care for patients who require specialty care • Build protocols for physician access to psychiatric consultation services (on-site/virtual)

5/ Workflows to support population-based care	Identifying designated populations by weaving BH services into the flow of care	<ul style="list-style-type: none"> • Define the population to be served by your BHI program and a reliable screening method for identifying potential members of the designated population • Implement routine, age-specific primary screening for functional concerns to identify those at risk and those who require further screening and diagnostic workup • Implement a system for enhanced follow-up for those at risk • Follow up and adjust treatment plans if patients are not improving as expected
6/ Evidence-based tracking and treatment	Adapting evidence-based interventions and screening tools for a practice’s patient population Establishing a system for follow-up of function in home and community settings and co-management with a specialist as indicated	<ul style="list-style-type: none"> • As available for specific diagnoses, use quantifiable BH symptom rating scale to track patient improvement • Consult with BH clinician to determine best treatment approach • Establish a plan for regular follow-up visits and gathering functional data • Include goals of treatment and support self-management strategies where appropriate
7/ Patient, family, and caregiver involvement in care	Engaging the non-clinical support team to positively influence patient outcomes and adherence	<ul style="list-style-type: none"> • Assess and address patient-identified barriers to care related to biological/physical, psychological, cultural, and social aspects of their health • Allow patient voice to inform the treatment plan, with shared decision-making between patient, family, caregiver, and team where appropriate
8/ Data for quality improvement	Leveraging key quality metrics to assess program impact and establish a sustainable model	<ul style="list-style-type: none"> • Establish quality improvement structure to achieve organizational access goals and other identified outcome standards • Systematically track patient feedback, organizational data, and engagement with BH services

Chapter 2: Potential Approaches



There are many ways to approach BHI, and practices have a number of models to choose from.

Many practices have taken a hybrid approach, implementing elements from available models of care and picking and choosing based on the needs of their patient population and the resources available in their community. What's possible and what works in a large urban setting may not be feasible in a rural or frontier setting. **One size does not fit all.**



TIP:

This chapter describes the basic elements of the most common models of care, which can be implemented "as is," or in a combination, as most appropriate for your specific practice's needs.

BHI: IDEAL PATIENT POPULATIONS

BHI has been shown to be beneficial to patients with mild-to-moderate depression and/or anxiety and those receiving treatment for SUD in the primary care setting.^x



In pediatrics, BHI addresses the spectrum of social, emotional, and behavioral well-being. Services include MH promotion, identification, early intervention of behavioral concerns, and managing disorders. Integration of BH care within primary care can also be effective for patients with chronic health conditions, such as asthma, obesity, diabetes, hypertension, or chronic pain (with or without SUD).

For more information on the relationship between physical and behavioral health, watch the BHI Collaborative's "[Bolstering Chronic Care Management with Behavioral Health Integration](#)" webinar.



WATCH OUT:

Not all BHI models of care are ideal for meeting the needs of patients with complex BH issues (e.g., bipolar disorder, schizophrenia, unstable psychosis, etc.) or for those who require urgent referral for psychiatric care and/or in-patient behavioral care (e.g., substance withdrawal or detoxification, imminent risk from suicidal ideation, violent or destructive behavior). Practices implementing BHI should have protocols in place to identify patients experiencing any urgent or life-threatening conditions and referral pathways if external support is required.

Integrated Care Spectrum^{xi}

While BHI can take many forms, care can be delivered along a spectrum from coordinated to integrated, with six defined levels.

At one end of the spectrum is **coordinated care**, in which clinicians working in different health care settings exchange information about shared patients to facilitate care. The key element here is *communication*.

In the middle of the BHI spectrum is **co-location**, in which the BH clinician is physically located in a primary care clinic or the PCP or other clinician is physically located in an MH or SUD treatment setting. The distinguishing feature here is *physical proximity*.

At the other end of the spectrum is **integrated care**, where the practice team includes PCPs, psychiatric physicians, and other clinicians working together with patients using a systematic, seamless approach to provide patient-centered care for a defined population. The defining feature here is *practice change*.

UNDER COORDINATED CARE ARE LEVELS 1 AND 2:

LEVELS 3 AND 4 FALL UNDER CO-LOCATION:

LEVELS 5 AND 6 ARE VARIATIONS OF INTEGRATED CARE:

Level 1:
**Minimal
Collaboration**

Level 2:
**Basic Collaboration
at a Distance**

Level 3:
**Basic Collaboration
On-site**

Level 4:
**Close Collaboration
On-site**

Level 5:
**Close
Collaboration**

Level 6:
**Full
Collaboration**

Care is delivered in separate facilities with separate systems; communication is infrequent and typically initiated only under compelling circumstances driven by physician and other clinician needs; understanding of the others' roles is limited.

Behavioral and non-behavioral health clinicians practice in separate facilities with separate systems; periodic communication about shared patients is driven by patient issues; there is appreciation of other physicians' and other clinicians' roles as resources.

Physicians and other clinicians practice in the same facility but not necessarily in the same offices. Although they have separate systems, they communicate regularly about shared patients due to the need for each other's services and referrals.

Physicians and other clinicians practice in the same facility with some shared systems, such as scheduling and medical records. They collaborate through consultation, co-create coordinated care plans for patients, and interact face-to-face about shared patients on a regular basis.

Physicians and other clinicians are in the same facility with some shared space and identify delivery system challenges and implement system solutions together. They collaborate via frequent in-person team meetings to discuss patient care and specific patient issues and have an in-depth understanding of others' roles and culture.

Physicians and other clinicians are in the same facility and share all practice space, functioning as one integrated team. There is consistent communication at the team and individual levels, and collaboration is due to a shared concept of optimal health care. The roles and cultures of care team members blur or blend together.

Selection Criteria for Level of Integration^{xi}

There are two models of integrated care, both of which can vary depending on patient population needs and practice capabilities.

The model selected and the elements included are often based on the goals, stage of development, and what is practical at any given time. While this Compendium describes options for providing basic BH care, some practices may expand their model of care to offer a broader range of BH services.



TIP:

When choosing a model of care, do not allow the process of selecting a model to become a barrier to action. Elements of each model can be adapted to meet practice and patient needs, and it is not necessary to have every piece in place before you begin your implementation journey. That said, all the core elements must be in place before caring for patients (and billing) can commence. Whatever the initial approach, it can later be modified based on experience.



Integrated Models of Care

The Collaborative Care Model and the Primary Care Behavioral Health Model have been the subject of rigorous research demonstrating efficacy.

As a result, these models are better understood and may be viewed more favorably by practices planning to implement BHI:

- One of the most common models of care is the **Collaborative Care Model (CoCM)**, as it is evidence-based and employs a cost-effective strategy for treating BH conditions in primary care^{xii}
 - The cornerstone of CoCM is the implementation of a care team, including a BH care manager who collaborates with the PCP and a psychiatric consultant when needed. The BH care manager is typically someone with a master’s level education (e.g., MSW and LMSW) or specialized training in behavioral health
 - In this model, the psychiatric consultant provides weekly consultation to the primary care practice on a panel of patients, typically focusing on those who are not improving. The psychiatric consultant discusses those patients with the care manager and makes treatment recommendations
 - Treatment can include focused talk therapies and, when indicated, medication prescribed by the PCP and overseen by the psychiatric consultant. Patient progress is routinely monitored through the use of screening tools and a practice registry

For more detailed information on the use of psychopharmacology in the primary care setting, see the [Psychopharmacology How-To Guide](#)

- CoCM is the most studied model that has evidence of effectiveness.
- The **Primary Care Behavioral Health (PCBH) Model**, otherwise known as the Behavioral Health Consultant Model, addresses the needs of the entire patient population^{xiii}
 - In the PCBH Model, the BH clinician, who may be a PsyD, PhD, master’s level clinician, LCSW, or CRNP certified or trained in behavioral health, is a member of the practice team. They partner during routine visits and typically see patients for short-term therapy. They balance scheduled visits with individual patients while maintaining enough flexibility in their appointment schedule to be available for same-day “warm patient handoffs” or other referrals from the PCP and other members of the team

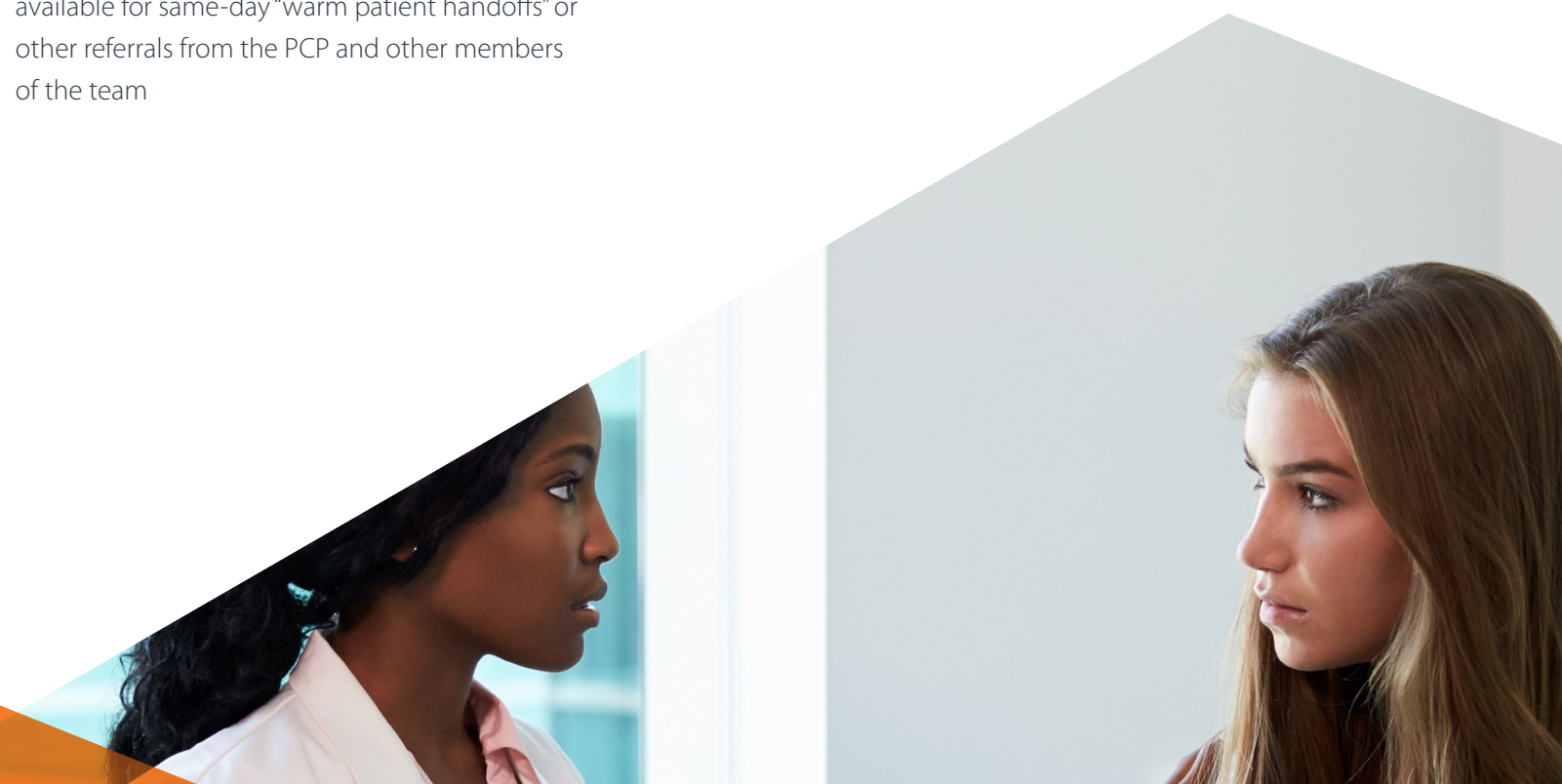
Practical Differences: Though you may ultimately choose to pursue both in your practice, understanding what sets them apart can help guide how you approach staffing and billing, especially at the early stages of integration.

	COLLABORATIVE CARE MODEL (COCM)	PRIMARY CARE BEHAVIORAL HEALTH (PCBH) MODEL
TARGET POPULATION	Focuses on patients with BH signs and/or symptoms or a diagnosed BH condition, though patient does not need to have a BH diagnosis	Targets entire patient population to address healthy mental and emotional development. Patient does not need to have a BH diagnosis
BH STAFF	Care manager (remote or in-person) and psychiatric consultant (may be remote) to the team	BH clinician in clinic as part of the practice team
TREATMENT APPROACH	Uses brief interventions to engage patients in care and a registry to achieve population-based “treatment to target” strategy where clinical outcomes are routinely measured using evidence-based tools	Core principles are brief therapeutic interventions, improving health behaviors, and preventive care. Approach includes secondary screening and diagnosis, follow-up, and referral and co-management with specialty behavioral health, if indicated
BILLING	Bill for BHI services primarily using CoCM codes	Bill for BHI services primarily using psychotherapy and Health Behavior Assessment and Intervention (HBAI) codes



CALLOUT:

Many states are developing [Pediatric Mental Health Care Access \(PMHCA\) Programs](#) or [Child Psychiatry Access Programs \(CPAP\)](#) to provide child psychiatry consultation services to PCPs who serve children and adolescents. This consultation model has also been applied to address perinatal mental health conditions. For more information, see the [Resources section under Potential Approaches](#).



Practice Spotlights

A Case in Implementing Both CoCM and PCBH

Recognizing the absence of specialty BH services within its system as an opportunity to introduce integrated care, in 2021, the team at Cayuga Health, a regional nonprofit health system, began assessing their primary care clinics' care needs and resources.

As they examined both the CoCM and PCBH model, they determined that their clinics would benefit from implementing both complementary approaches. PCBH was well suited to address the need for acute BH management by having a BH clinician available for warm handoffs to address routine care needs and crisis intervention. Since common BH care needs, such as depression and anxiety, take up more of a clinician's time, CoCM's systematic wraparound support was an effective way to address more targeted needs within the scope of primary care.

The team leveraged the [New York State Collaborative Care Medicaid Program \(CCMP\)](#)'s professional consultation to answer questions like "can the same person serve as our BH clinician and care manager across both models?" Ultimately, they found that clearly delineating roles can help avoid

duplication of care as well as ensure proper billing.

The hybrid model they've landed on ensures flexibility, with PCBH conducted in-office and CoCM facilitated by remote care managers. These efforts are unified by PCPs that serve as leaders of the patient care plan, matching individuals with appropriate services based on their needs.

Key to executing both models of care in the same clinic is a close relationship with billing and coding partners. Monthly revenue cycle meetings to address denials and track administrative markers alongside clinical metrics ensure that financial sustainability is built into their procedures and workflows.

The team's efforts proved highly successful, and by 2024, Cayuga Health had expanded BHI to four sites including family practice, women's health, internal medicine, and college health clinics. Their aim is to extend this integrated approach to over 10 sites in the next five years, demonstrating the efficacy and scalability of their hybrid approach.



CALLOUT:

Regardless of the care model you choose, telehealth technologies can support the implementation of BHI and allow primary care practices to offer comprehensive and accessible patient-centered care. Consider leveraging telehealth in the following ways:

- Brief virtual BH interventions (motivational interviewing, goal setting)

- Patient e-visits
- Virtual patient education
- Virtual BH treatment (digital therapeutics, e-prescribing)
- Virtual care coordination and collaboration by care team

For more information about the opportunities and challenges associated with leveraging telehealth technologies, among other digital tools, access the AMA's [BHI Return on Health Report](#).



A Case in Child and Adolescent Psychiatry Access

There is a widespread shortage of child and adolescent psychiatrists in the United States, with a national average of 14 child and adolescent psychiatrists per 100,000 children.^{xv} Most mental illnesses begin in childhood, and early diagnosis and treatment can improve an individual's mental health, quality of life, and longevity. PCPs who serve children and adolescents have a critically important role in identifying and treating children's MH care needs but often do not feel adequately prepared to do so.

[The Massachusetts Child Psychiatry Access Program \(MCPAP\)](#) was established in 2004 and allows child and adolescent psychiatrists in this program to provide training and mentoring of primary care pediatricians through regional consultation teams to assist with medication, treatment, and referral needs for children with MH issues. The most high-risk and complex cases are referred to specialists.

Eighty percent of health supervision visits with primary care pediatricians in the MCPAP result in an MH screen, making MH care available to 95% of the children and adolescents in Massachusetts.

In addition, building on the success of this project, federal funding was allocated in 2018 to the Health Resources and Services Administration for the [Pediatric Mental Health Care Access \(PMHCA\)](#) grant program was created and funded to expand pediatric MH care into pediatric primary care through telehealth services at state or regional levels. Additional federal funding was allocated to this program in 2021 and 2022, allowing them to expand to 54 programs reaching over 46 states and regions.



MOVING FORWARD:

For more detailed information on the various models of care and how the six levels of integration differ, see the SAMHSA-HRSA Center for Integrated Health Solutions' [framework](#).



CALLOUT:

If your practice manages persons with SUD or those who are at risk of developing these disorders, [Screening, Brief Intervention, and Referral to Treatment \(SBIRT\)](#) is a public health approach to the delivery of early intervention and treatment that can be used to address other BH conditions as well.^{xiv}

For more detailed information on caring for patients with SUD in primary care, see the [Care for SUD guide](#).

Chapter 3: Establishing the Value

The Importance and Impact of an Integrated Approach

Practice leadership is a prerequisite to successful BHI. Sharing the evidence-based outcomes of BHI as well as patient case studies with leadership will allow them to see the importance and positive impact of integration into primary care.



 **TIP:**

To avoid burnout and the perception that BHI will add to the increasing workload on primary care staff, consider reframing integration as an opportunity to reduce inefficient utilization of primary care. When BHI is executed successfully, effective and appropriate resources to address behavioral health give clinicians more confidence to fully support their patients' needs and their ability to effectively manage their overall health. Collectively, this reduces the dependence on PCPs while increasing satisfaction on both sides. The American Psychiatric Association's (APA's) [Practice and Billing Toolkit](#) offers sample care team satisfaction surveys that can help measure the impact of integrated care. For a case study in how implementing BHI has helped to reduce administrative burden and increase physician satisfaction, watch the BHI Collaborative's "[Beating Physician Burnout with Behavioral Health Integration](#)" webinar.

Making the Case

There is increasing evidence and acknowledgment that BH issues are as disabling as cancer or heart disease in terms of lost productivity and premature death.^{xvi}

The impact of these illnesses can be substantial and creates a significant burden for the individuals living with them and the health care system. Issues surrounding behavioral health span all patients regardless of age, sex, gender, race, ethnicity, or socioeconomic status.

To learn more about how to address disparities that disproportionately affect racial and ethnic minority groups in receiving equitable BH care and accessing treatment, watch the BHI Collaborative's "[Advancing Health Equity through BHI](#)" webinar.

According to the National Center of Excellence for Integrated Health Solutions (CIHS), as many as 40% of all patients seen in primary care settings have a mental illness, and given that mental and physical health problems are often interwoven, as many as 70% of primary care visits stem from psychosocial issues.^{xviii} While patients may initially present with a physical health complaint, data suggests that underlying BH issues often trigger these visits.^{xvii}

Data released by the Centers for Disease Control and Prevention (CDC) demonstrates that the need for integrated care is more evident than ever before. Compared to the 2019 National Health Interview Survey (NHIS), this data found that in 2023, people are experiencing almost four times the symptoms of anxiety disorder (29.5% vs. 8.1%) and those of depressive disorder (22.8% vs. 6.5%), with racial and ethnic minorities being more impacted.^{xix}

Evidence shows that due to lack of financial support, resources, and time in their schedules, care teams are often ill-equipped to fully address the wide range of psychosocial issues presented by their patients. Approximately 67% of patients ages 18 to 54 with BH issues do not receive the care they need,^{xvi} and nearly 1 in 5 children have a mental, emotional, or behavioral disorder but only about 20% of them receive specialty MH care.^{xx}



TIP:

Delivering [integrated care via telehealth](#) can play a key part in an integrated BH practice. Additionally, this may help to mitigate the impact of uneven distribution and shortages of BH professionals, particularly in rural areas, and improve access to specialty professionals such as child and adolescent psychiatrists.

For more information on telehealth implementation and services, see the various resources from BHI Collaborative members, such as the [AMA](#), [APA](#), [American Academy of Child & Adolescent Psychiatry \(AACAP\)](#), and [AAP](#), in the [Resources](#) section under [Establishing the Value](#).

Creating a Shared Vision

Organizational alignment on "why BHI" provides focus and enables teams to build a shared understanding of their common purpose.

1

STEP 1: IDENTIFY YOUR EARLY KEY STAKEHOLDERS

These may include clinicians, non-medical staff, and organizational management.

2

STEP 2: REFLECT ON MOTIVATIONS AND GOALS

Discuss: Why do we want to implement BHI? How does BHI complement our overall mission? What are our biggest hopes for implementing BHI? What are our biggest fears in implementing BHI?

3

STEP 3: CRAFT YOUR VISION STATEMENT

Ensure all voices are heard and incorporated into a compelling vision statement that provides inspiration for daily operations.

The [Advancing Integrated Mental Health Solutions \(AIMS\) Center's Creating a Shared Vision for Collaborative Care](#) resource provides a useful guide on how to align on a shared vision, ways to make it operational, and how to further iterate. For a resource that can be applied across implementation models, see the [Shared Vision Exercise Template](#).

Establishing the value of BHI is an ongoing process. You may want to repeat the process each time you make a change to your BHI program or address new priorities. To ensure continuous engagement, you may also modify and repeat this process for different stakeholder groups, such as reception staff, a community advisory board, etc. Bringing in additional stakeholders at different points in your implementation journey is important to ensure engagement and buy-in.

Identifying Value for Key Stakeholders

While there is an initial financial investment for integrated care (e.g., additional training time for your team and/or potentially bringing on more staff), implementing BHI is a worthwhile investment in the long term, considering the benefits for various stakeholders:



PHYSICIAN/PRACTICE

- Increase in work satisfaction and decreased burnout, which brings financial benefits^{xvi}
- Deliver care more efficiently and effectively^{xvi}
- Increase in confidence and competence in addressing BH issues^{xix}
- Connect more efficient care with increased number of patients who can then be billed for services^{xvi}
- Increase in ability to earn pay-for-performance rewards based on reduction costs, patient satisfaction, and improved outcomes



NON-CLINICAL STAFF

- Increase in access to a clinician to lighten the load of handling distressed individuals who present in need of services and care



PATIENTS, FAMILIES, AND CAREGIVERS

- Establish greater value in complete, comprehensive care, leading to healthier and more satisfied patients
- Greater likelihood to stay at one practice and/or recommend practice to friends and family due to increased satisfaction and symbiotic increase in comfort with raising health concerns with PCPs and other clinicians through maintained relationships
- May reduce overall health care costs^{xvi}
- Better equipped to fulfill one's roles in work, relationships, and other daily activities^{xvi}
- Added support for families and caregivers of patients^{xvi}



PAYERS

- Ability to identify and treat patients for behavioral health issues early, leading to lower levels of financial expenditures in the long termⁱⁱ
- Reduce emergency room visits, hospital admissions, and intensive care staysⁱⁱ



ORGANIZATIONAL MANAGEMENT

- Ability to meet increasing regulatory and accreditation requirements for patient-centered medical homes (PCMH) or quality patient payment initiatives
- Ability to meet Diversity, Equity & Inclusion initiative objectives by addressing disparities and systematic barriers
- Staff retention by reducing clinician workload and risk of burnout and improving clinician satisfaction
- New sources of revenue from an expansion of billable services and opportunities to negotiate quality incentives or care management fees with payers



BHI Value Streams

Once you understand what motivates your stakeholders, you can define what value looks like to your practice and tailor the case for BHI accordingly.

There are many specific benefits to incorporating BH services into primary and specialty care. Though you may wish to ultimately address all of these areas, it is helpful to prioritize one or two focus areas to begin.

1. **CLINICAL OUTCOMES, QUALITY, AND SAFETY.** Integrating behavioral health into primary care acknowledges the importance of physical and mental health to whole-person health
 - a. **Supports the equal importance of social-emotional health and physical health:** BHI allows physicians to more comprehensively promote and monitor this integral part of childhood development
 - b. **Promotes improvement in common MH problems:** Collaborative care is associated with significant improvement in depression and anxiety outcomes compared with usual care^{xxii}
 - c. **Supports the delivery of personalized care:** BHI provides pertinent patient insights to help clinicians identify what is working and tailor care plans
 - d. **Reduces the risk of self-harm/suicidal ideation:** Caring for patients' behavioral health plays an important role in diagnosing and treating self-harm and suicidal ideation, preventing one of the leading causes of death in the U.S.^{xxiii, xxiv} For more detailed information on how to incorporate suicide prevention protocol and/or helping patients experiencing suicidal ideation in your primary care practice, see the [Suicide Prevention How-To Guide](#) and the [AAP-American Foundation for Suicide Prevention \(AFSP\) Blueprint for Youth Suicide Prevention](#)
 - e. **Promotes early intervention:** Without early identification, diagnosis, and treatment, children with MH concerns can have problems at home, in school, and in forming friendships. BHI offers opportunity for early intervention to prevent MH problems from interfering significantly with functioning
2. **ACCESS TO CARE.** Aside from providing greater access to long-term monitoring and management to individuals affected, BH services can often be accessed more easily when integrated into primary care
 - a. **Closes treatment gaps:** Coordinating physical and behavioral health care helps close the gap between the prevalence of these issues and the number of people receiving treatment^{xvi}
 - b. **Expands access:** Providing BH care in the primary care setting can help overcome the widespread barriers to accessing specialty BH care—including clinician shortages, long wait times, high out-of-pocket costs, transportation issues, childcare coverage, gaps in insurance coverage, cultural stigma, and language barriers
 - c. **Helps address disparities across various populations:** Removing barriers to access can benefit those in underserved communities, including racial and ethnic minority groups, the LGBTQIA+ community, military service members and veterans, rural residents, and children and adolescents in foster care^{xv}
 - d. **Reduces stigma:** Delivery of BH services in a primary care setting may reduce the reluctance of some individuals to seek care at a facility that only delivers BH services. Community outreach, care coordination, and BH promotion by organizations that promote total patient care can reduce stigma and discrimination.^{xvi} For examples of how clinicians can be leaders in destigmatizing seeking and/or receiving treatment for people with BH conditions, watch the BHI Collaborative's "[Physicians Leading the Charge: Dismantling Stigma Around Behavioral Health Conditions and Treatment](#)" webinar.



3. **PATIENT, FAMILY, AND CAREGIVER EXPERIENCE.** Integrated care is more convenient for the patient and more effectively addresses their entire well-being, which leads to a sense of higher-quality care and greater satisfaction^{xxvi}
 - a. **Increases positive outcomes:** The majority of patients with BH issues treated in an integrated primary care setting exhibit positive health outcomes, particularly when they are connected to a network of services at a specialty care level in their community^{xvi}
 - b. **Builds trust:** Increase in comfort with raising health concerns with PCPs and other clinicians through maintained relationships
 - c. **Improves patient retention and practice reputation:** Greater likelihood to stay at one practice and/or recommend practice to friends and family due to increased satisfaction
 - d. **Impacts caregiver health:** Offering BH care and connecting families to support services can alleviate the stress-related negative health impacts that caregivers of children and adults with BH issues struggle with
4. **CLINICIAN EXPERIENCE.** Providing proactive, quality care for behavioral health and other chronic conditions can have a positive impact on care team satisfaction and well-being
 - a. **Builds knowledge and confidence:** With a multidisciplinary care team in place, clinicians can more readily identify MH concerns and have the systems in place to fully support their patients' needs
 - b. **Increases physician and other clinician satisfaction:** An indirect result of more effective treatment for behavioral health and other chronic conditions is the positive impact integration can have on care team satisfaction and well-being^{xxvii}
5. **FINANCIAL AND OPERATIONAL IMPACT.** Unaddressed BH risk is responsible for rising costs and inefficiencies. BHI enables clinicians to address BH conditions proactively, before they become costly
 - a. **Promotes long-term value:** Treating BH issues in primary care settings is cost-effective in the long term^{xvi}
 - b. **Increases billable episodes of care:** Uncovering unmet patient needs enables clinicians to direct patients to the BH services they need, creating billable, in-network episodes of care
 - c. **Improves potential for incentive payments:** Earning value-based or quality payment rewards based on reduced costs, patient satisfaction, and improved outcomes
 - d. **Reduces burden on hospital systems:** Integration is associated with reductions in the rates of ED visits, hospital admissions, and intensive care stays^{xxviii}

Fair Compensation for Services and Justification for Additional Team Members

Though many of these value drivers can be linked to positive financial impact, understanding direct compensation for BH services provided will be critical to making the case for integration.

Compensation for integrated care, particularly BH services in primary care settings, can often rely on fee-for-service (FFS) payment; however, there are several ways to review, report, and track the value of BHI, including:^{xvi}

CAPACITY	PRODUCTIVITY	PAYMENT	COST
Face-to-face time spent with patients out of the total time available	Count of visits provided vs. projected	Average payment for BH services across all payers	Average cost of BH visits across all physicians and other health care professionals

Practice Spotlight

A Case in Successful FFS Implementation

When Northwestern Medicine began the process of integrating behavioral health into primary care, they wanted to simplify workflow and add value throughout the process, all while ensuring their patients continued to be covered.

Focusing on simplicity for end users, they developed a smart form within the electronic health record (EHR) to translate clinical information directly into billing for services. This form captures time spent with the patient and automatically allocates it to a payment code hierarchy, thereby simplifying the billing process and ensuring sustainability of the program.

Their experience with the automated billing and coding process, which has now been expanded to 11 clinics, has identified gaps in documentation prior to claim submission, enables the team to appropriately allocate resources, and ultimately ensures patients are receiving clinically appropriate care.

For more information on BH coding and payment, watch the BHI Collaborative's "[Behavioral Health Billing & Coding 101: How to Get Paid](#)" webinar.



Practice Spotlight

Bringing Behavioral Health and Advanced Value-Based Primary Care Together to Serve Patients Through Collaborative Care

In order to address the unmet need for MH treatment in primary care, [Oak Street Health \(OSH\)](#) adopted CoCM for behavioral health in 2018.

OSH, now part of CVS Health, is a network of value-based primary care centers for older adults on Medicare. OSH was interested in building out an integrated multidisciplinary team and tracking their success based on sustaining optimal enrollment and positive patient experiences. Their decision to adopt CoCM was partially driven by the challenges of an external Medicare Advantage BH provider network that lacked the capacity to care for patients in OSH's primary care centers. They quickly learned they could not reliably depend upon external systems to provide timely and high-quality services to their vulnerable patient population. Even when they were successful in referring patients externally, the lack of integration and communication from these external providers remained a challenge. Their patients were not receiving high quality BH care—a requisite component of OSH's VBC model.

Another challenge was the recruitment of internal OSH therapists and psychiatric clinicians. With the increased prevalence of mental illness post-COVID and a therapist pool traditionally limited to LCSWs and psychologists in Medicare, it is difficult to provide timely, evidence-based psychotherapy embedded in primary care. Concurrently, psychiatric clinicians are scarce and difficult to recruit in many underserved communities. With difficult-to-fill roles and limited external referral options, the team at OSH was unable to fully manage the BH burden among their primary care population. A team-based and consultation-based model was needed.

OSH implemented CoCM with a team of 74 BH clinicians, 12 telepsychiatry practitioners, and 615 PCPs. PCPs identify patients who may benefit from collaborative care through universal depression and substance use screening, as well as daily clinical interactions with their patient panel. Physicians initiate warm handoffs to the BH clinician, who then assesses the patient's BH needs, supports with case management, makes referrals to other BH resources and specialists, and provides brief, evidence-based psychotherapy (e.g., problem-solving therapy, motivational interviewing, or behavioral activation) as indicated. The telepsychiatry practitioners provide recommendations on medication regimens, diagnoses, and appropriate levels of care to the PCP and BH clinician and provide direct care to patients.

The BHI team shares a defined group of patients, for whom clinical outcomes are tracked within a shared registry. The BH team can monitor and reach out to patients who are not improving and provide caseload-focused consultation rather than ad-hoc advice alone.

As a result, in 2023, OSH was able to screen 98% of patients for depression and 88% for substance use. They have seen that 65% of patients referred for BH treatment have enrolled in the BH program, and 67% of patients enrolled in the BH program have completed at least six weeks of treatment. Thirteen percent of patients who tested positive for substance use enrolled in treatment, compared to 11% nationally.

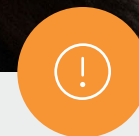
Outcomes of patients enrolled in the BH program have improved quickly (53% of patients had a five point or greater reduction in PHQ-9 scores within six weeks of enrollment) and consistently (44% of patients showed

a 50% or more reduction in PHQ-9 scores at 24 weeks after enrollment). Additionally, an initial pre/post quasi-experimental evaluation suggests that patients enrolled in the BH program showed a 50% reduction in per member per month (PMPM), from \$1,317 to \$776 total spend on medical costs, and 69% reduction in ED utilization.

Through implementation of CoCM, OSH became aware that many patients have complex symptom presentations, including severe mental illness (SMI) and multiple diagnoses. At this time, their ability to refer out

for specialized care remains severely hindered due to lack of specialized care in the communities they serve. As such, next steps for the BHI program include scaling their BH clinician cohort, providing more targeted care for patients with SMI and SUD, and evaluating the health equity implications of their interventions.

For more information on how practices can financially plan for and sustain BH integration, watch the BHI Collaborative's "[Financial Planning: Quantifying the Impact of Behavioral Health Integration](#)" webinar.



CALLOUT:

While FFS can be a commonly used method of payment for BH care services, many practices are leveraging the flexibilities that can be available in value-based care (VBC) or alternative payment models (APMs).

For more information about current VBC/APM efforts, see the [APMs Overview](#) from the Centers for Medicare & Medicaid Services (CMS).



MOVING FORWARD:

For guidance measuring the value of BHI, see the SAMHSA-HRSA Center for Integrated Health Solutions' [The Business Case for Behavioral Health Care publication](#).

Chapter 4: Financial Sustainability



There is no one-size-fits-all financial model for BHI.

Many practices primarily support their BHI efforts through FFS billing alone, utilizing relevant BHI codes and working directly with their state/federal coverage programs, local commercial health plans, or self-insured employers. Some practices leverage their participation via VBC arrangements to support their BHI efforts. In addition to FFS, there are many value-based payment (VBP) arrangements to consider, and no matter which you choose, it's important to note that BHI is not a revenue stream. With the ultimate goal of sustainability, the first 1–2 years of implementation may not result in a net or even financial impact.

For more information on financial models for BHI in your practice, watch the BHI Collaborative's [“How to Financially Sustain Behavioral Health Integration in Your Practice”](#) webinar.

Sample Timeline of Implementation Costs and Revenue Considerations

Actual timelines will vary based on circumstances such as your practice's implementation approach, the size of your practice, and the market you are in, among other variables.

6 MONTHS BEFORE LAUNCHING YOUR BHI PROGRAM:

- Identify staffing needs, looking for opportunities to “train up” existing team members to fill new roles
- Begin hiring process
- Hire a BH clinician/care manager or begin training up existing staff member to fill BH care manager role
- Begin credentialing process
- Estimate total monthly costs of running your BHI program (salary, ancillary personal costs, rental of additional space if needed)
- Educate billing staff about codes to be used

1 MONTH POST-PROGRAM INITIATION:

- Check in with your billing staff. Are claims going out clean, successfully processed, and reimbursed the first time?
- Obtain feedback from clinic staff and BH staff on scheduling, appointment times, billing processes, etc.

3 MONTHS POST-PROGRAM INITIATION:

- Monitor billing collection rates; compare monthly costs to monthly collections

4 MONTHS TO A YEAR INTO YOUR BHI PROGRAM:

- Repeat steps from months 1–3
- Consider surveying patients for feedback on program impact that can enhance the case for continued investment in BHI

1 YEAR INTO YOUR BHI PROGRAM:

- Conduct financial review of practice income statement, highlighting BHI expenses and revenue and assessing variance from initial estimates
- Your practice may be meeting or approaching your monthly revenue goal to cover costs
- Budget for upcoming year, adjust for BHI growth forecast and potential increasing costs (e.g., staffing)



TIP:

Leverage tools designed to help organizations model and estimate BHI revenue and expenses such as the [AIMS Center's Financial Modeling Workbook](#) or [The Center of Excellence for Integrated Health Solutions' Decision Support Tool](#).

Practice Spotlight



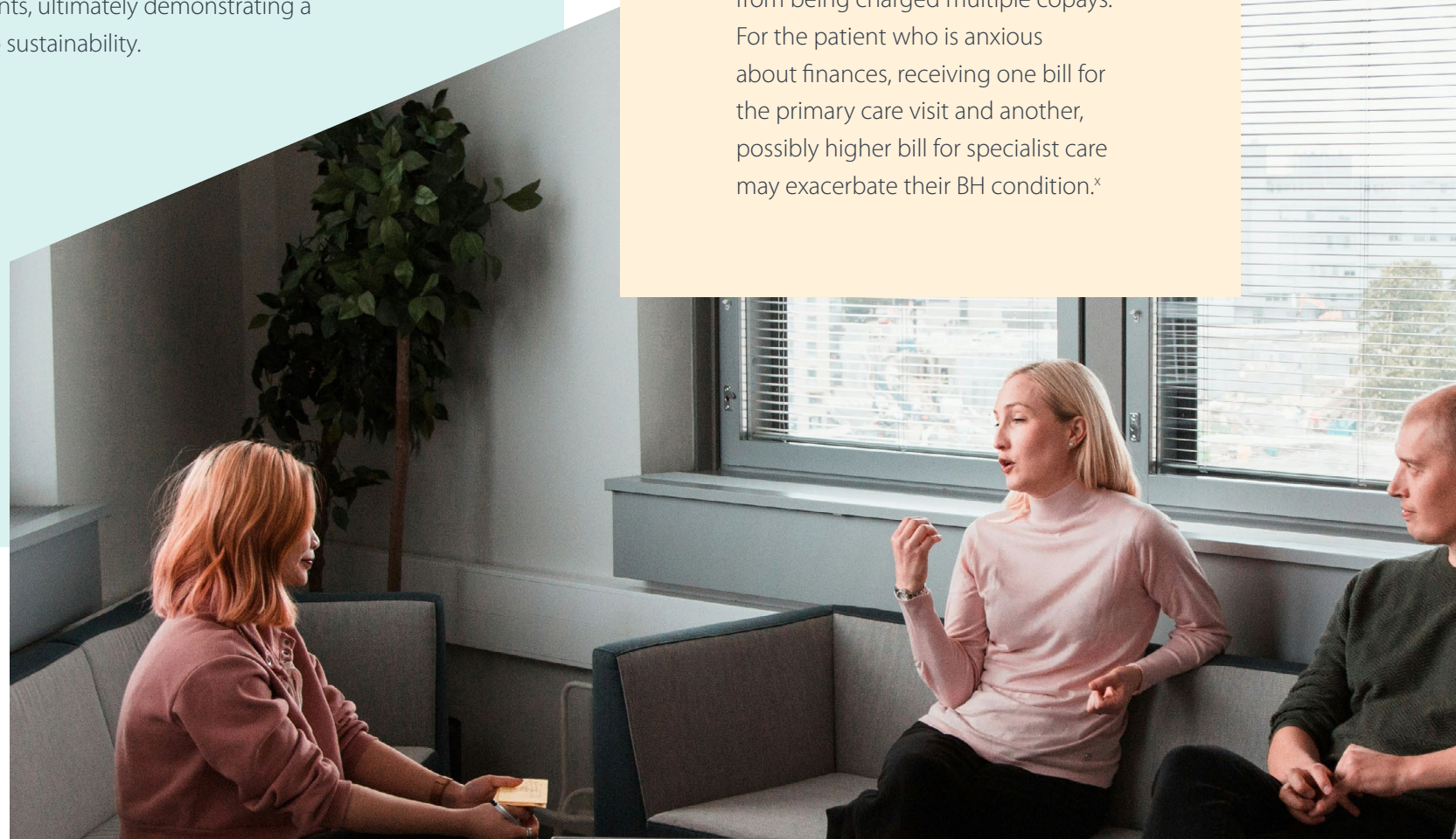
Modeling BHI Financial Sustainability in a Pediatric Practice

In preparation to implement CoCM, [Burlington Pediatrics](#) identified a gap in pediatric-specific BHI financial modeling tools, leading them to move beyond granular calculations and instead focus on defining the infrastructure needed to support their long-term financial sustainability. To effectively implement CoCM, they needed to align on key assumptions about organizational elements that would bolster revenue support: universal screening, MH follow-up visits, and monthly CoCM payments.

- **Universal screening:** A cornerstone of CoCM, the team knew that universal screening could be digitally integrated into practice workflows. They used Current Procedural Terminology (CPT®) code payments and total number of health supervision visits to estimate a financial impact exceeding \$100,000 annually, all attributable to their BHI program.
- **MH follow-up visits:** Burlington Pediatrics anticipated a 10% increase in MH follow-up visits from patients entering the program. To achieve this increase, staff would need to be diligent with scheduling and reminders, and clinician calendars would need open MH appointment slots in the mornings and afternoons. The payment from these additional visits would enable the practice to make a compelling case for scaling staff to meet the growing demand.

- **Monthly CoCM payments:** CPT® codes used to bill monthly for time spent by the MH care manager on each patient seen in CoCM were expected to also provide consistent supplemental revenue.

By grounding in the realities of their practice and focusing on the estimates they felt most confident in, Burlington Pediatrics arrived at a conservative best-to-worst case projection of revenue. Once these systems were in place, the team at Burlington Pediatrics understood they needed to give the program time to realize its impact and committed to regular progress check-ins. By month six, they were already seeing increases in screening, MH visits, and their associated payments, ultimately demonstrating a path to sustainability.



BHI Billing Under Medicare

Medicare pays for integrated BH services provided to patients,^{xxix} including assessments, monitoring, and care planning performed by clinical staff, as well as psychiatric collaborative care services.^{xxx}



TIP:

As many health plans and insurers are encouraging models of care that incorporate the use of psychiatric consultants and warm handoffs, conferring with them on appropriate coding may help prevent a patient from being charged multiple copays. For the patient who is anxious about finances, receiving one bill for the primary care visit and another, possibly higher bill for specialist care may exacerbate their BH condition.^x



CALLOUT:

The Medicare CPT® BHI codes are not limited to beneficiaries with certain BH conditions; codes may be used to treat patients with *any* BH condition (e.g., anxiety, depression, insomnia). Payment for these services requires that there be a presenting mental, psychiatric, or BH condition(s) that in the clinical judgment of the billing practitioner warrants BHI services. The diagnosis or diagnoses could be either pre-existing or first made by the billing practitioner and may be refined over time.^{xxxi}

BHI Billing Under Medicaid

Medicaid is the single largest payer for MH services in the U.S. and is increasingly playing a larger role in the payment of SUD services.^{xxxii}

The CMS is responsible for implementing laws passed by Congress related to Medicaid, and the Medicaid program is funded and administered by both the federal and state governments. The joint funding models allow each state the option to charge premiums and/or develop cost sharing for those enrollees at higher incomes, with protections against cost sharing for those at lower incomes. Clinicians considering enrolling in Medicaid should visit their state Medicaid website to understand requirements for Medicaid enrollees.

Cost sharing or out-of-pocket payments due from the Medicaid enrollee directly impact the practice. The cost share or out-of-pocket amount the Medicaid enrollee is required to pay is a copay, coinsurance, deductible, or other similar charge. These amounts may vary based on the Medicaid recipient's income or may require reporting the amount collected to the Medicaid program prior to claim payment. MH services for children and adolescents who have Medicaid are covered through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Note that most Medicaid recipients are children and adolescents (0–21 years) and do not have copays. Medicaid premiums and cost-sharing requirements differ by state, so check your state Medicaid program requirements for specific details.^{xxxiii}



MOVING FORWARD:

For more information on billing and coding strategies specific to CoCM, watch the BHI Collaborative's "[Practical Billing Strategies for the Collaborative Care Model](#)" webinar.

BHI Billing for Commercial Payers

It is important for a practice/system to establish a direct line of communication with their contracted health plans and large, self-insured employers in their community to understand and align on goals around the provision of and payment for BHI.

Behavioral health is a stated priority for many health plans and large employers, and they should welcome, and even support, a dialogue with practices on the provision of enhanced BH services to their beneficiaries and employees.



CALLOUT:

To better understand your payment potential, you may want to ask your payers the following questions:

- How much do they pay for CoCM, BHI, and psychotherapy codes?
- What are the requirements for billing these codes? (e.g., clinician license, place of service, etc.)
- Can therapy and evaluation and management (E/M) codes be billed on the same day?
- Will the patient have a copay/cost sharing?



Relevant Codes

The AMA's [Behavioral Health Coding Resource](#) outlines key CPT® and Healthcare Common Procedure Coding System (HCPCS) codes relevant to BHI so that physicians and their care teams can accurately bill for the BH services their practice provides.

The Behavioral Health Coding Resource includes codes for:

- Preventive Medicine
- Evaluation and Management Services
- Behavior Change Interventions
- Psychotherapy
- Developmental/Behavioral Screening
- Adaptive Behavior Services
- Health Behavior Assessment and Intervention
- Care Management
- Inter-Professional Digital Services
- Cognitive Assessment and Care Plan Services
- General Behavioral Health Integration
- Psychiatric Collaborative Care Model



MOVING FORWARD:

For additional information and specificity regarding codes and billing, see the [Resources section under Financial Sustainability: Billing and Coding](#).

Additional CPT® Codes

Additional CPT® codes may be relevant for certain BH services provided.

While this list is not exhaustive, it can serve as an additional resource:

- 99202–99205 Evaluation and management of a new patient in an office or outpatient location (15–29, 30–44, 45–59, 60–75 mins)
- 99212–99215 Evaluation and management of an established patient in an office or outpatient location (10–19, 20–29, 30–39, 40–54 mins)
- 99417 Prolonged services, additional time on an outpatient evaluation and management service, each additional 15 mins beyond 99205 or 99215
- G2212 Prolonged office/outpatient evaluation and management services
- G0444 Depression screen, 15 mins
- G0323 Care Management services for BH conditions, minimum 20 mins/month of CP or LCSW time (PCBH)



WATCH OUT:

Chronic Care Management (CCM) and CoCM codes are separate but can be confused with each other when billing. It is very important to distinguish between the two:^{xxxv}

- CoCM involves care planning for *all* health issues
- BHI involves care planning that focuses on individuals with BH issues and systematic care management using validated rating scales (when applicable)

Getting Started



Chapter 5: Assessing Readiness

Where to Start and Where You're Headed

Think about where your practice is today and where you want to be in six months, a year, three years, etc. This chapter will help you understand what needs to happen today and the short- and long-term goals you may want to consider.

Reflect on Your Organization's Mission

Once you've made the case for integration, consider the following:

- How does your mission align with integrated care?
- What are the current gaps that exist? How can they be filled now and over time?
- What are the opportunities for improvement (training, workforce development)?
- How does integration align with other local and/or national efforts available to your practice such as patient-centered medical homes, state innovation model planning, etc.?

Evaluate Where You Are in the Process

An important step to [assessing readiness](#) is evaluating where you are in the process. Many practices and physicians are already taking steps to incorporate behavioral health into their practice. For example, ask yourself:

- Do you currently promote mental wellness?
- Do you currently see patients with BH issues, such as anxiety, depression, and/or substance use?
- Do you provide patients who have BH issues with references or resources related to mental health and substance use?
- Do you routinely ask patients to fill out [Patient Health Questionnaires](#), such as the [PHQ-9](#), [GAD-7](#), [PHQ-2](#), [PSC](#), [EPDS](#), etc.?
- Do you have partnerships in place for timely referrals and information sharing?

If you answered "yes" to any of these, you have already begun to integrate behavioral health into your practice.

MOVING FORWARD:

There are various self-assessment tools available to help you better understand your practice's readiness for implementation:

- **[AAP's Mental Health Practice Readiness Inventory](#):** The aim of this tool is to help you and your practice team members assess the strength of your organization's readiness to provide essential MH services across various dimensions including community resources, health care financing, support for children/adolescents/families, clinical information systems, and decision support for children.
- **[Maine Health Access Foundation \(MeHAF\) Site Self-Assessment Survey](#):** This survey was developed to assess levels of primary and behavioral care integration across two domains: 1) integrated services and patient and family-centeredness and 2) practice/organization.
- **[Integrated Practice Assessment Tool \(IPAT\)](#):** This tool places practices on the level of collaboration/integration defined by the Standard Framework for Levels of Integrated Care. It includes descriptions of each level, key differences between levels, and the advantages and weaknesses of each level.
- **[Agency for Healthcare Research and Quality \(AHRQ\) Integration Self-Assessment Checklist](#):** This tool is linked to AHRQ's Integration Playbook so practices can customize their implementation approach for their setting. The 37-question survey can be used before, during, or after implementation of an integrated program.

Chapter 6: Establishing Goals and Metrics of Success



Set Goals: Progress over Perfection

Integration of BH can begin (or continue) simply by identifying the best next step that your organization, its partners, and each of its programs can and will take. While practices will evolve and iterate their BHI processes, it's important to keep in mind that any action toward integration, no matter how small, can have a significant impact.

Establish a Baseline

An important preliminary step includes conducting a baseline assessment to document how many patients are seen and how care is currently delivered for individuals with both physical and BH needs within your practice. Once that baseline is established, the team can select targets for improvement and identify measurable indicators of progress to demonstrate success.



TIP:

Work with your EHR vendor to optimize your system for recording and tracking BHI outcomes. If an EHR is not an option for your organization or practice, stand-alone software solutions are available that can help facilitate the delivery of critical informatics support needed for successful integration of a variety of BH conditions.

Identify Metrics of Success

Whether a single practice or multiple clinician groups are collaborating to serve the same patient, identifying metrics prior to implementation helps align everyone to the same end goal and ensures the systems are in place to meet requirements for payment. [Metrics/benchmarks](#) should be detailed enough to minimize ambiguity and enable comparisons to be drawn internally, externally, and over time.

In the absence of universal standards to track BHI progress, it's best to align metrics to the goals and capabilities of your organization. The [Atlas of Integrated Behavioral Health Care Quality Measures](#) offers a tool to guide your selection. However, some common metrics to consider include increased/improved:

- Execution of diagnostic assessment tools (PHQ-9, AUDIT-C, etc.)
- Referral completion percentage
- Care transition meetings held
- Time to first contact with BH clinician (decreased time)
- Appointment, follow-up, and medication adherence
- [Patient assessment scores](#) (PHQ-2, PHQ-9, C-SSRS, GAD-7)
- Hospital admission (reduced visits to ED)
- Staff capacity (visits completed/projection and/or productivity (visit time spent/availability)
- Use of concurrent/collaborative documentation (patient records release)
- Financial sustainability (immediate charting, claim approvals, reduced denials)
- Interprofessional collaboration, such as with schools/external MH clinicians

For further examples of metrics and impact goals, visit the [AMA's BHI Return on Health Report](#).



MOVING FORWARD:

Not all metrics of success will be achievable right away. Consider establishing a target and a threshold as demonstrated by these New York State Collaborative Care Benchmarks:

- **Improvement Rate** – Number and proportion of patients seen for treatment for 90/120 days or greater who demonstrated clinically significant improvement either by a 50% reduction from baseline PHQ-9 or a drop from baseline PHQ-9 of at least five points and to a final total score of less than 10 (Target: 50%, Threshold: 35%)
- **Consultation Rate** – Among those in treatment for 90/120 days who did not improve, proportion who received a psychiatric consultation note. A psychiatric consultation is a patient case review between the care manager and the psychiatric consultant (Target: 75%, Threshold: 60%)
- **Change in Treatment Rate** – Among those in treatment for 90/120 days or greater who did not improve, proportion who had a change in treatment (Target: 75%, Threshold: 60%)
- **Referral Completion Rate** – Among those who were referred to specialty care, proportion who ultimately attend a consultation with the specialist to whom they were referred (Target: 80%, Threshold: 65%)
- **Age-Specific Screening Rates** – Percentage of patients 8–18 who had a health supervision visit in the past six months who were screened for anxiety using SCARED or GAD-7 tools (Target: 25% increase from past six months, Threshold: 15% increase from past six months)
- **Improvements in Functional Screening Scores** – Improved functional scores in screens such as the Strengths and Difficulties Questionnaire (SDQ) (Target: 80%, Threshold: 50%)
- **Referral Completion Rate** – Among those who were referred to specialty care, proportion who ultimately attend a consultation with the specialist to whom they were referred (Target: 80%, Threshold: 65%)

Chapter 7: Assembling and Aligning the Team

Anatomy of the Team

In a physician-led, team-based BH model of care, the entire team—the PCP, BH clinician, nurses, medical assistants, psychiatric consultant, etc.—works together to provide integrated care to patients.



Assembling Your Team

Staffing needs may vary from practice to practice. Determining your needs will largely depend on your clinical setting.

Clinical Setting

- Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) often serve more vulnerable patients and receive government grants in addition to Medicare and Medicaid funding, making them ideal settings for an integrated BH team
- Solo or group practices should consider the average patient load per clinician and the needs of their population when determining if there is a need for an on-site, on-call, or virtual BH clinician, as well as additional roles, such as a case manager

It is important that everyone on the team has a good understanding of his or her role and the roles of others.

The list below includes examples of potential responsibilities that each care team member may have:^x

Primary Care Physicians:

Lead the care team

- Oversee the patient’s whole-person care and emphasize the importance of mental and behavioral health to overall health
- Describe and advocate for the BHI program to appropriate patients, encouraging their participation
- Implement screening and monitoring tools for BH disorders, make the diagnosis and/or determine the level of severity, initiate treatment, and [manage medications](#)
- Supervise the hands-on work of the BH clinician and collaborate in frequent case conferences with the team to identify patient needs and opportunities for improvement
- Educate staff on BHI practices
- Foster connections with key community clinicians

Medical Assistants, Nurses, or Clinic Staff:

Serve as the first touch point for patients

- Assess patients’ BH needs by actively listening to patient responses and reviewing responses to screening questions on the pre-visit questionnaire
- Accurately describe BH services to appropriate patients and encourage their participation
- Ensure the PCP receives screening results prior to the visit
- Enact risk protocols for dangerous/emergent situations

BH Clinicians:

May be a PsyD, PhD, master’s-level clinician, LCSW, or CRNP certified or trained in behavioral health

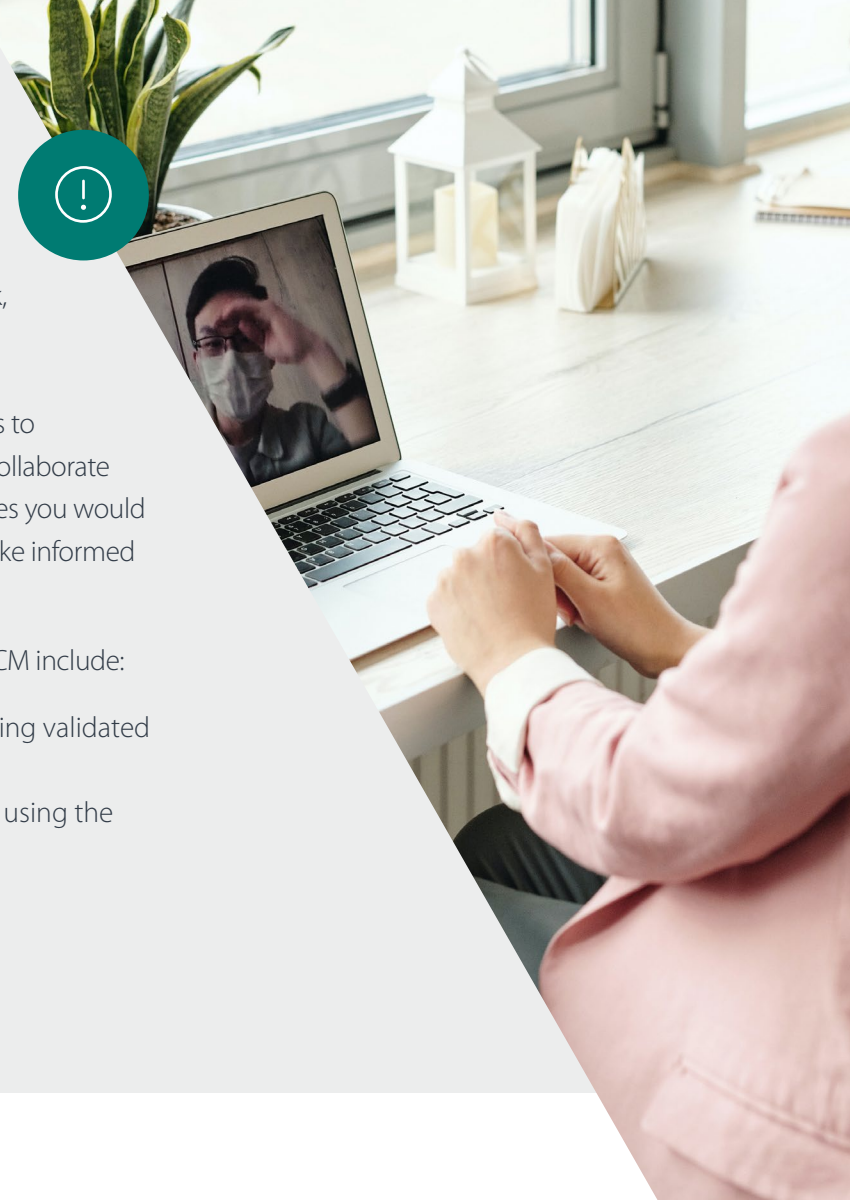
- Receive warm handoff from PCP
- Conduct patient intakes, focusing on diagnostic and functional evaluations
- Provide brief behavioral interventions using evidence-based techniques such as [behavioral activation](#), [problem-solving treatment](#), or [motivational interviewing](#)

CALLOUT:

CoCM requires a BH care manager. This role may be filled by a BH clinician or another individual with education or training in behavioral health (e.g., social work, nursing, counseling, psychology). CMS does not specify minimum education or licensure requirements and does not mandate that the individual meet all the requirements to independently provide and report services to Medicare. Collaborate with your billing team to identify your key payers, the codes you would like to bill, and the licensure required to bill so you can make informed hiring decisions.

Additional BH care manager responsibilities unique to CoCM include:

- Tracking patient follow-ups and clinical outcomes using validated rating scales and a [registry](#)
- Documenting patient encounters in the registry and using the system to identify and re-engage patients
- Participating in regular case load reviews with the psychiatric consultant



CALLOUT: Integrated MH Professional in Pediatric Practice

Within a pediatric primary care setting using the PCBH model, an integrated MH clinician would have these key roles:

- Part of family-centered medical home team
- Participates in morning team huddle
- Partners during routine visits (e.g., psychosocial history, screening, parenting education)
- Immediate triage/response to positive screen
- Follows up with secondary screens
- Involved routinely in visits for children with chronic/complex conditions
- Provides self-management counseling for patients with chronic medical conditions
- Accepts warm handoffs and may see child and family for short-term therapy
- Provides liaison with MH specialty system, schools, and agencies
- Monitors child/adolescent’s course

- Effect behavioral changes in patients with, or at risk for, physical disorders and help them make healthier lifestyle choices
- Help patients cope with chronic conditions, such as asthma, pain, or diabetes, encouraging adherence to treatment
- For practices managing patients with addiction, BH clinicians can support patients’ addiction treatment, dosing, and recovery in consultation with the PCP
- Consult with patient and PCP about treatment options and preferences; coordinating initiation of treatment plan and facilitating treatment referrals as needed
- In pediatrics, participate in shared visits for children and youth, provide support to parents and communicate with childcare providers, teachers, and school guidance counselors
- Initiate follow-up to ascertain how patients are doing and to determine if any changes in treatment approaches are indicated



TIP:

Because psychiatry specialists are often in short supply, consider different strategies to obtain their services, such as the use of telepsychiatry through your state or region’s [PMHCA](#) or [CPAP](#).



GETTING STARTED

CHAPTER 7: ASSEMBLING AND ALIGNING THE TEAM

- Advise physicians about patients requiring referral to specialty BH services
 - Provide recommendations, consultations, and training to physicians to enhance their BH skills and effectiveness
 - Support knowledge transfer to help PCPs understand how to care for people with BH conditions, including [SUD](#)
- Psychiatric Consultant:**
A required role in CoCM, this role is optional though encouraged in other implementation models. This individual may be a psychiatrist or a psych NP/PA
- Consult in-person or virtually with the BH care manager and the PCP on the management of patients
 - Assist with case conferences to review challenging cases of patients with BH conditions
 - Collaborate with the PCP and/or BH care manager about diagnosis and treatment planning
 - Support knowledge transfer to help PCPs understand how to care for people with BH conditions, including [SUD](#)
 - Increase acumen of primary care team through means such as brief didactics and case review to improve the condition of not only the patient being discussed but also to inform approaches to future patients who may present with similar issues and diagnoses



CALLOUT:

Cultural competency is essential to reducing health disparities and meeting the needs of increasingly diverse patient populations. This is particularly important to BHI, as culture and language can impact how your patients view and respond to BH challenges.

When building and training your team, consider:

- **Cultural and linguistic competence:** Understanding how a patient's culture, race, ethnicity, and language may influence their behavioral health and the best approach to treating them
- **Cultural humility:** Admitting what we don't know and appreciating patients' expertise on the social and cultural context of their lives
- **Staff reflective of the patient population:** Ensuring that no matter who walks through the door, there is someone on staff who can identify with them and communicate with them to better serve their individual needs



WATCH OUT:

Responsibilities can be shared, divided, or moved, where appropriate, to less specialized health care workers to make more efficient use of the human resources available and quickly increase capacity through an approach known as task shifting. However, be aware that special considerations or limitations may exist when involving unionized health care workers.



CALLOUT:

For smaller practices or those in areas with limited resources, a BH clinician could support the patients of multiple physicians and other clinicians within a practice and multiple practices, either through in-person appointments, physician consultation, or virtual appointments.^x

To hear from independent physician practice experts on how they've successfully implemented BHI, watch the BHI Collaborative's "[BHI Strategies for Independent Practices](#)" webinar.

Establishing a Successful Team

Effective teams require more than just taskwork. They are characterized by their ability to collaborate, coordinate, and communicate among PCPs, BH clinicians, psychiatrists, clinic staff, and patients with a shared understanding of their organization's resources, protocols, and objectives. Engaging the full team in regular meetings, education opportunities, and performance reviews can help build a culture that emphasizes each member's potential and enhances daily interactions with patients.

For more information on how best to collaborate across clinical teams, watch the BHI Collaborative's "[The Value of Collaboration and Shared Culture in Behavioral Health Integration](#)" webinar.



Practice Spotlight



BHI in Action: Facilitating the Transition to College

A young woman facing long-standing challenges with anxiety and ADHD had struggled to make progress with a child and adolescent psychiatrist and therapist outside of her pediatrician's office. Although medication management was eventually transferred to the pediatrician, the office was unable to connect and collaborate with the external therapist on the patient's care.

A transition to college posed an opportunity to introduce the patient to the integrated care program within her pediatrician's office. The patient began virtual visits with the practice's therapist who introduced combined cognitive behavioral therapy (CBT) and exposure response therapies. This new therapeutic model sparked improvement almost immediately, and because of the close collaboration with the pediatrician and child and adolescent psychiatrist, they were able to adjust her medication accordingly and build on the success of therapy.

With the collaborative efforts of her integrated care team, the young woman experienced a remarkable transformation. Previously held back by social anxiety, she flourished in college, immersing herself in activities, socializing, and even forming new relationships. The seamless teamwork within the practice allowed for quick responses to emerging issues, such as when the patient reported consistent nausea. With background on her recent lifestyle changes from the therapist, the pediatrician was able to address a physical symptom that was related to her mental health, ultimately highlighting the importance of comprehensive care delivery.

Establishing Partnerships Outside the Practice

Assessing the capabilities and availability of additional supportive services in the surrounding community can be just as important as preparing the practice for integration.

When looking to form partnerships outside the practice:

- Apply a "population" perspective to gain understanding of the BH needs of children, youth, and adults in the community
- Consider the services your practice needs but does not currently provide or does not plan to provide
- Inventory community MH and addiction resources (e.g., Intensive Outpatient Program (IOP)/Partial Hospitalization Program (PHP), respite care, smoking cessation, support groups, medications for opioid use disorder (MOUD), substance use programs, schools, psychological/educational testing, vaping cessation, and emergency rooms)
- Collaborate with administrative support resources, such as IT and insurance, in addition to clinical partners
- Prioritize potential partners who share your organization's mission, vision, and values



MOVING FORWARD:

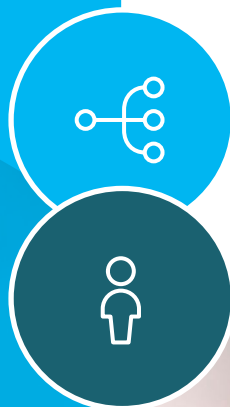
For more information on how to identify practice needs, train care team members, and assign roles and responsibilities for addressing patient BH needs, watch the BHI Collaborative's ["Assembling the BHI Care Team: Roles and Responsibilities"](#) webinar.

Implementation



Chapter 8: Establishing Assessment and Treatment Capabilities

Given the variation in approaches to BH and MH care in adult and pediatric practice, the contents of this chapter have been separated accordingly.

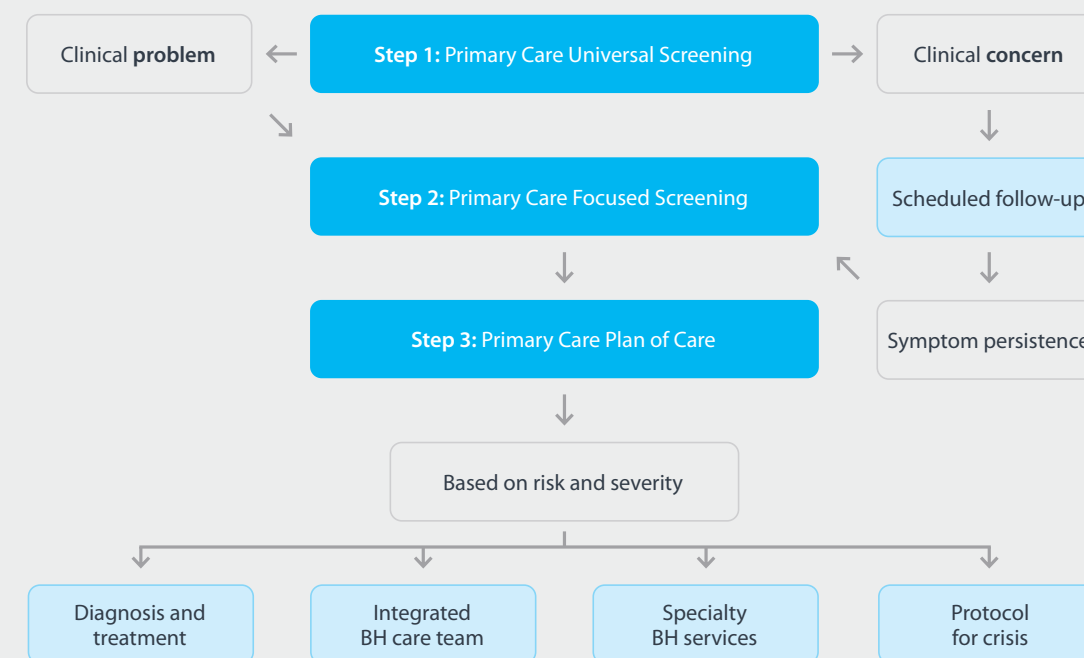


Chapter 8a: Adult Care Guidance

Developing Clinical Pathways

Well-defined clinical pathways for BH care provide teams with a structured and efficient way to identify the appropriate patients and deliver quality, evidence-based interventions. Key components of a BHI clinical pathway include screening, assessment, and plan of care. Each step in the pathway can be customized based on your practice population and the scope of your BH offering but should detail what to do, when to do it, and who on the team is responsible.

SAMPLE BHI CLINICAL PATHWAY



Step 1: Primary Care Universal Screening

A routine universal screening process is critical to establishing a collaborative, therapeutic relationship.

WHO:

- Front office staff or medical assistants
- Patient

WHAT: Front office staff or medical assistants present common screening tools such as the [PHQ-9](#) and [GAD-7](#) to patient either in person at time of visit or digitally for completion prior to the PCP visit.

Note: Any positive endorsement of PHQ-9 “Q9: Thoughts that you would be better off dead or thoughts of hurting yourself in some way?” must be addressed promptly.

WHEN: Based on your practice’s approach to screening:

- **Universal:** Will you screen all patients annually? Which population? (e.g., all patients 12 and older)
- **Targeted:** Will you screen patients who present with specific chief complaints/reasons for visit? (e.g., depressed mood, anxiety medication follow-up)
- **Both:** Will you combine these approaches? (e.g., universal depression screening by administering a PHQ-9 for all patients 12+ annually AND targeted screening by administering a PHQ-9 when there is clinical concern for depression.)



TIP:

For additional guidance around selection and timing of screening tools, as well as effective communication and patient engagement strategies, watch the BHI Collaborative’s [“Behavioral Health Screening as a Part of Ongoing Care”](#) webinar.

Step 2: Primary Care Focused Assessment

When initial screening indicates a clinical problem, the PCP can use a psychiatric review of systems to begin developing a differential diagnosis for common psychiatric disorders.

WHO:

- PCP
- Integrated care team member, as needed

WHAT:^{xxxiv}

- [The Primary Care Psychiatric Interview](#): Similar in style and complementary to the general medical history interview, this assessment of a patient’s psychosocial functioning can help surface risk factors and symptoms that may indicate need for further evaluation and potential BH clinician involvement.
- Targeted assessment for common psychiatric disorders: Patients presenting with psychiatric symptoms and unexplained physical complaints and those with established psychiatric conditions should be assessed for the presence of anxiety, mood, psychotic, and SUD.
 - **Anxiety Disorders:** Anxiety is common in the primary care setting and often comorbid with mood, psychotic, and substance abuse disorders.
 - Targeted assessment tools may include: Mood Disorder Questionnaire ([MDQ](#)) used to rule out bipolar disorder, Yale-Brown Obsessive-Compulsive Scale ([Y-BOCS](#))
 - **Mood Disorders:** Depression is often secondary to and comorbid with primary anxiety, sleep, substance use, and other psychiatric disorders. The two main components of mood (depression and mania) should be fully assessed.
 - Targeted assessment tools may include: Mood Disorder Questionnaire ([MDQ](#)) used to rule out bipolar disorder, Columbia-Suicide Severity Rating Scale ([C-SSRS](#)) Screener
 - **Psychotic Disorders:** Psychotic symptoms, such as disorganized speech, paranoid delusions, and hallucinations, do not commonly present in the primary care setting. Because psychotic disorders can be complex and require co-management with specialty care, consider this assessment a starting point.
 - Targeted assessment tools may include: Mood Disorder Questionnaire ([MDQ](#)), Diagnostic and Statistical Manual of Mental Disorders ([DSM-5TR](#)), Abnormal Involuntary Movement Scale ([AIMS](#))
 - **SUD:** The effects of certain substances can mimic psychiatric symptoms, especially anxiety, depression, insomnia, hyperactivity, irritability, and hallucinations.
 - Clues may include:
 - Social factors such as inability to maintain employment
 - Interpersonal and financial problems
 - Repeated legal offenses
 - Poor adherence to treatment
 - Targeted assessment tools may include: Alcohol Use Disorders Identification Test ([AUDIT-C](#) or [AUDIT](#)), Drug Abuse Screening Test ([DAST-10](#))



TIP:

Ensure screening assessments are available and administered in languages that reflect your practice’s patient population.

For a detailed overview of the psychiatric interview and assessment of common psychiatric disorders in primary care, see [this excerpt](#) from the Association of Medicine and Psychiatry's (AMP's) Primary Care Psychiatry, Second Edition.

WHEN:

- If there's any question or concern about a BH condition
- If initial screenings indicate need for further assessment

Step 3: Develop Primary Care Plan of Care

When focused assessment indicates intervention is needed, the PCP will initiate a care plan based on degree of patient need.

WHO:

- PCP
- BH clinician

WHAT: Based on patient need, one of the following intervention pathways:

- **Diagnose and Treat:** For patients with mild BH need, the PCP may choose to lead diagnosis and treatment independently, consulting with the BH clinician or psychiatric consultant as needed. *These patients will be managed by the PCP until symptom persistence or complexity indicate a need to activate another clinical pathway.*



CALLOUT:

Shared Decision-Making helps clinicians and patients agree on a plan forward. When patients participate in decision-making and understand what they need to do, they are more likely to follow through. The "SHARE" approach presents five steps that can help with shared decision-making:^{xxxv}

- **Step 1:** Seek your patient's participation
- **Step 2:** Help your patient explore and compare treatment options
- **Step 3:** Assess your patient's values and preferences
- **Step 4:** Reach a decision with your patient
- **Step 5:** Evaluate your patient's decision

- Elements may include:
 - Additional BH assessment
 - Brief intervention, such as [motivational interviewing](#) or [CBT](#)
 - Basic [psychopharmacology](#)
 - Psychiatric consult, if needed
- **Engage the BHI Team:** For patients with moderate-to-severe BH need, the PCP may choose to introduce the patient to the BH clinician for further assessment, additional psychotherapy, and co-management. *These patients will work with the BH clinician who may provide immediate brief intervention and determine need for follow-up visits. If available, a psychiatric consultant may also collaborate on diagnosis and treatment planning. A typical course of care may be six months or less, after which the patient will either return to the practice's general care population or require referral to specialty BH services.*
 - Elements may include:
 - Warm handoff to BH clinician, follow-up visit scheduled with PCP
 - In CoCM, BH care manager meets patient, schedules a BH visit, and adds patient to registry
 - In the PCBH model, BH clinician may conduct a visit/brief intervention on the spot
- **Refer Patient to Specialty BH Services:** For patients with severe BH needs that do not resolve, the PCP may choose to refer to specialty BH services for further evaluation, intervention, and co-management. *These patients will be co-managed by the PCP and specialty clinician. PCP may support the plan of care by checking in on medication compliance and monitoring for possible metabolic side effects.*
 - Elements may include:
 - PCP refers patient to counselor/therapist and/or psychiatry clinician for further evaluation and treatment options (e.g., psychotherapy, medication management)
 - PCP supports the specialists' plan of care and co-manages patient
- **Initiate Crisis Protocol:** For patients at risk of or actively contemplating suicide, the PCP will conduct a full suicide safety assessment to determine next steps. For patients at immediate high risk for harm to self or others, the PCP and patient may agree to call EMS for safe transfer to the ED for further evaluation and possible inpatient admission. *Because patients with a history of suicide attempts are more likely to have a repeated attempt, a [PHQ-9](#) is performed at every visit (usually every 1–3 months), and this will include regular updates to the safety plan.*
 - Elements may include:
 - Administering the Columbia-Suicide Severity Rating Scale ([C-SSRS](#)) Screener
 - Developing a [safety plan](#) with the patient for managing suicidal thoughts
 - Determining if patient needs emergent psychiatric evaluation

For more information on identifying patients at risk for suicide and connecting them to an appropriate treatment plan, see the [Suicide Prevention How-To Guide](#).

WHEN:

- As indicated for treatment of symptoms or conditions uncovered in focused screening and assessment
- If patients are open and willing to engage in their treatment



CALLOUT:

Though clinical pathways can be a valuable tool to guide treatment decisions, trust your clinical judgment and know that with BHI, you can always lean on your psychiatric consultant, BH clinician, and other integrated care team partners.

Practice Spotlight

BHI in the Oncology Setting

[New England Cancer Specialists](#) is a physician-owned medical oncology and hematology private practice. Over years of extensive and direct patient care, it has witnessed firsthand the emotional impact of a cancer diagnosis and the consequences of cancer treatment on the body, mind, and spirit. Experiences such as a young mother in emotional crisis referred to the ER for inpatient psychiatry admission and the news of an elderly patient's death by suicide have underscored the urgency to provide whole-person care that includes attention to behavioral health.

Facing challenges in accessing counseling resources in the community, the practice took steps to build their BHI program in late 2021. While the practice was already providing universal depression screening (PHQ-2), they did not feel they had the tools to address patients' needs. They conducted a thorough analysis and crafted a business case, primarily looking at CPT® codes, to support the addition of counselors within the practice. With these resources in place, they began using a distress scale to identify and direct patients in need of BH support.

A dedicated department was created to establish supportive services that New England Cancer Specialists saw as a necessity to provide quality care. Including services in behavioral health, nutrition, survivorship, prevention, palliative care support, and lifestyle medicine topics such as weight management and physical movement have become wildly popular in a cancer patient's treatment plan. LCSW-led programs within these services have increased awareness and sustainability, such as regular catch-up meetings for older patients to combat isolation and [Cancer Connections](#), a patient peer-to-peer support program.

With a focus on normalization, clinicians now routinely discuss emotional distress associated with cancer diagnoses and emphasize the importance and availability of support resources. This inclusive and comprehensive approach extends to caregivers and allows for flexible scheduling, with counselors often meeting patients simply when is best for them.

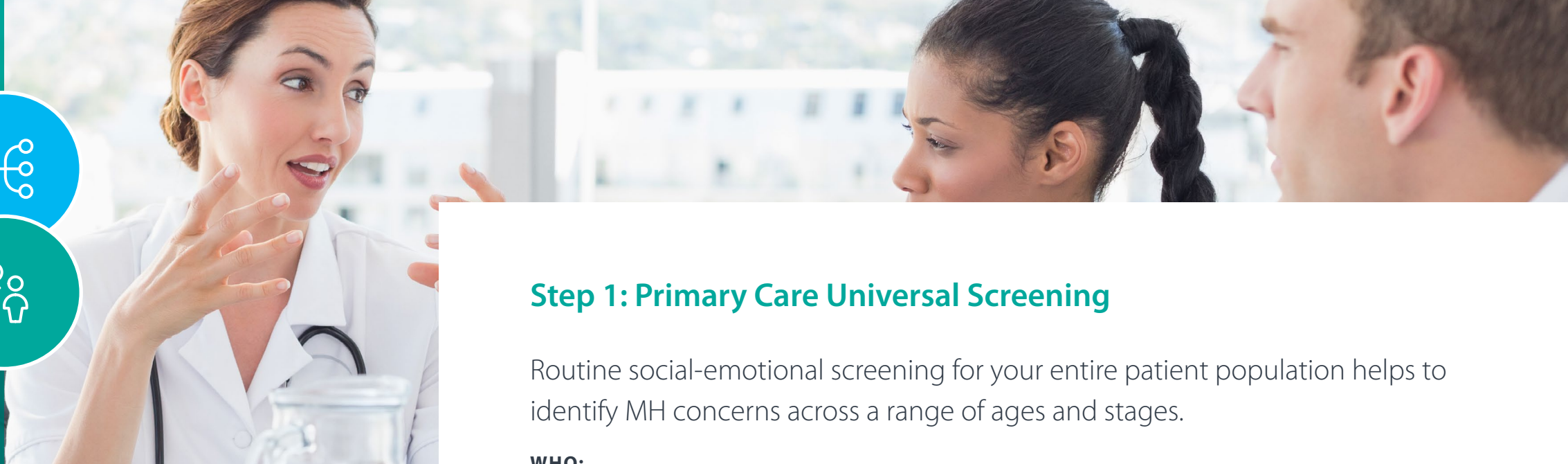
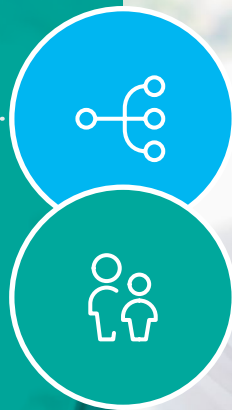
The outcomes of their BHI program have been welcomed by the patients and are promising; as of 2024, they have served over 700 unique patients and have added a new counselor each year to meet demand. Looking forward, the practice is looking for ways to support and maintain this program with the aim of continued BH service expansion through growing the team of counselors and hiring a psychiatric NP for psychotropic medication prescription.



MOVING FORWARD:

For more practical guidance on the role of screening tools in assessing and monitoring patients' behavioral health, watch the BHI Collaborative's "[Behavioral Health Screening as a Part of Ongoing Care](#)" webinar.

Chapter 8b: Child and Adolescent Care Guidance



Step 1: Primary Care Universal Screening

Routine social-emotional screening for your entire patient population helps to identify MH concerns across a range of ages and stages.

WHO:

- Front office staff or medical assistants
- Patient, family, and/or caregiver

WHAT:

- Front office staff or medical assistants present screener to patient, family, and/or caregiver either in person at time of visit or digitally for completion prior to the PCP visit
- Psychosocial function screening such as the Pediatric Symptom Checklist ([PSC](#) for 4–16 years; [PPSC](#) for 18–65 months; [BPSC](#) for < 18 months)
- Age-Based Behavioral/Social/Emotional screening per [Bright Futures Guidelines](#), including as examples:
 - Ages & Stages Questionnaires®: Social-Emotional, Second Edition ([ASQ:SE-2](#) for 1–72 months, available for a fee)
 - PHQ-9 Modified for Teens ([PHQ-9A](#), for 11–17 years)
 - Ask Suicide-Screening Questions ([ASQ](#), tool validated 8 years and older; AAP recommends universal screening for suicide beginning at 12 years)
 - Brief Screener for Alcohol, Tobacco, and other Drugs ([BSTAD](#), for 12–17 years)
 - Car, Relax, Alone, Forget, Friends, Trouble ([CRAFFT](#), for 12–21 years)
 - Screening to Brief Intervention ([S2BI](#), for 12–17 years)

For robust resources on common developmental and MH screening tools for infancy, early childhood, middle childhood and adolescence, visit the AAP’s [Screening Technical Assistance and Resource \(STAR\) Center](#) and [Mental Health Tools for Pediatrics](#) resource.

WHEN:

- Before patient sees PCP
- Social-emotional screening at every health supervision visit
- Developmental screening at infant and early childhood visits; depression, suicidality, and substance use screening at adolescent visits



TIP:

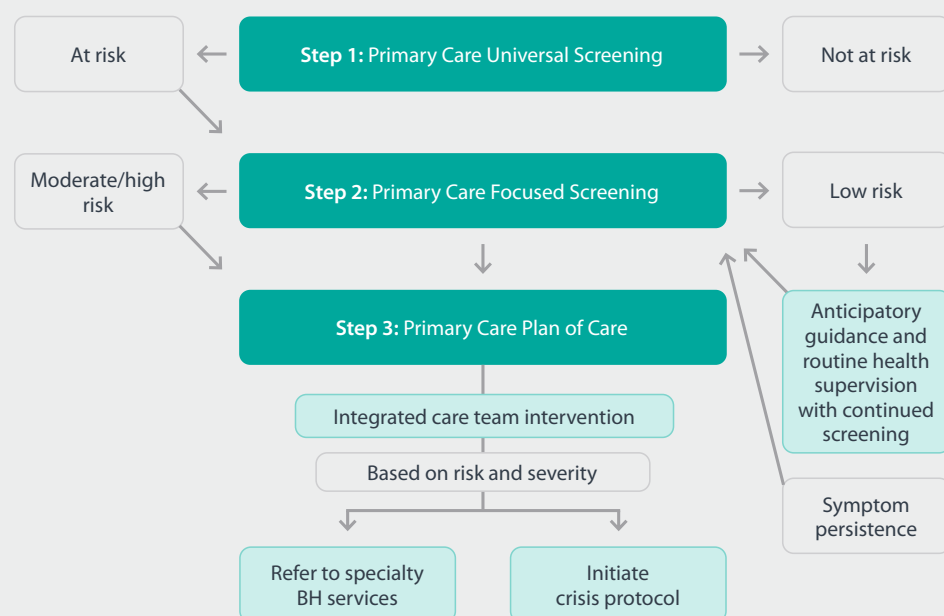
For additional guidance around selection and timing of screening tools and effective communication and patient engagement strategies, watch the BHI Collaborative’s [“Behavioral Health Screening as a Part of Ongoing Care”](#) webinar.

Developing Clinical Pathways

In child and adolescent primary care settings where a [developmental approach to MH care](#) is recommended, clinical pathways should encompass: primary prevention through promoting social-emotional health and safe, nurturing relationships; secondary prevention through screening, identification and assessment; and tertiary prevention through treatment and co-management with MH professionals.

Key components of a BHI clinical pathway include screening, assessment, and plan of care. Each step in the pathway can be customized based on your practice population and the scope of your BHI offering but should detail what to do, when to do it, and who on the team is responsible.

SAMPLE CHILD & ADOLESCENT BHI CLINICAL PATHWAY



Step 2: Primary Care Focused Assessment

When primary screening indicates a clinical concern, secondary screening tools may be used to explore symptoms and drivers of common MH concerns.

WHO:

- PCP
- Integrated care team member, as needed

WHAT:

- Targeted screening assessments for potential areas of MH concern
 - **Infant and Early Childhood Mental Health:** Early childhood mental health is key to a child's healthy development. Presenting concerns may include crying, withdrawal, clinging, and separation fears.
 - Targeted assessment tools may include: [ASQ:SE-2](#) (1–72 months); Brief Infant Toddler Social Emotional Assessment ([BITSEA](#), for 12–36 months); Survey of Well-being of Young Children ([SWYC](#), for 5 years and under)
 - **Anxiety Symptoms:** Anxiety is common in the primary care setting and often tied to somatic symptoms. The breakdown of anxiety manifestations may include social anxiety, separation anxiety, school avoidance, sleep difficulties, panic disorder, and generalized anxiety.
 - Targeted assessment tools may include: Screen for Child Anxiety Related Disorders (SCARED, for 4–18 years); Spence Children's Anxiety Scale ([SCAS](#), versions available for 2.5–15 years); [GAD-7](#) (for 12+ years)
 - **Trauma:** PCPs who serve children and adolescents are likely to be the first, and often only, professionals who encounter the 68% of American children who have experienced trauma and have the greatest potential for early identification and response to childhood trauma. Many children who have experienced trauma may present with anxiety symptoms.
 - Targeted assessment tools may include: Child Traumatic Stress Care Process Model ([CPM](#), for 6+ years); Child and Adolescent Trauma Screen ([CATS](#), caregiver and youth versions available for 3–17 years); Child PTSD Symptom Scale for DSM-5 ([CPSS-5](#), for 8–18 years)
 - **Depressive Symptoms:** Depressive symptoms are often secondary to and comorbid with primary anxiety, sleep, substance use, and other MH concerns.
 - Targeted assessment tools may include: [PHQ-9A](#) (for 11–17 years); Center for Epidemiological Studies Depression Scale for Children ([CES-DC](#), for 6–17 years)
 - **Suicide Risk/Safety Assessment:** It is recommended to screen all youth 12 years and up and youth 8–11 years who present with MH concerns. While screening is not indicated below age 8, consider screening and assessment if warning signs are present. Youth who screen positive should receive a risk/safety assessment to determine level of risk severity.
 - Targeted assessment tools may include: Ask Suicide Screening Questions ([ASQ](#) for 8–24 years); Columbia Suicide Severity Rating Scale ([C-SSRS](#), for 11+ years)

- **Inattention, Impulsivity, and Hyperactivity:** ADHD is one of the most common neurodevelopmental disorders of childhood. Children with ADHD may have trouble paying attention, controlling impulsive behaviors (may act without thinking about what the result will be), or be overly active.
 - Targeted assessment tools may include: NICHQ Vanderbilt Assessment Scale (for 6–12 years, [available for a fee](#)); Conners Comprehensive Behavior Rating Scale (CBRS, for 6–18 years, [available for a fee](#)); Behavior Assessment System for Children (BASC-3, for 2–21 years, [available for a fee](#))
- **Other Presenting Concerns:** Other concerns may include behavioral issues such as SUD ([vaping](#), cannabis, alcohol), [screen/device dependency](#), aggressive behaviors, and [eating disorders](#).
 - Targeted assessment tools may include: [CRAFFT](#) (for 12–21 years); [AUDIT](#) (for 12–19 years); Global Appraisal of Individual Needs ([GAIN](#), for 12–17 years); Modified Overt Aggression Scale ([MOAS](#), for 13+ years)

WHEN:

- If initial screenings indicate need for further assessment
- If reason for visit indicates there may be an MH concern
- If there's any question or concern about an MH condition



CALLOUT:

In child and adolescent care, the [Common Factors Approach](#) offers communication techniques that help to build a therapeutic alliance which, in turn, increases the family's optimism, feelings of well-being, and willingness to work toward improved health. The mnemonic HEL²P³ summarizes components of the common factors approach:^{xxxxvi}

- **H = Hope** facilitates coping
- **E = Communicate empathy**
- **L2 = Use the child's or family's own language** and communicate **loyalty**
- **P3 = Ask the family's permission, partner** with the child and family, and establish a **plan**

Step 3: Develop Primary Care Plan of Care

After focused assessment, the PCP will initiate a care plan based on degree of patient need.

WHO:

- Patient, family, and/or caregiver
- PCP
- MH clinician
- Other possible contributors may include community-based MH clinicians, the PCMHA Program, or CPAP

WHAT: Based on patient need and family/caregiver preference, one of the following intervention pathways:

- **PCP-led Integrated Team Management:** Based on clinician case load and patient need, the PCP may choose to deliver brief intervention themselves or introduce the patient to the MH clinician for further assessment, intervention, and co-management.

Note: in pediatric primary care, most concerns will be mild to moderate, and the MH clinician will be engaged early in screening, identification, and planning processes.

These patients will be co-managed by the PCP and MH clinician until symptoms resolve or symptom persistence/complexity indicate a need to activate another clinical pathway.

- Elements may include:
 - Additional MH assessment
 - Elements of brief intervention delivered by the PCP
 - Warm handoff to MH clinician
 - In PCBH models, MH clinician provides a brief intervention, plans follow-up with the PCP, and may refer out for therapy, if indicated
 - In CoCM models, MH care manager schedules MH visit and adds patient to registry; psychiatric consult, if needed. Once the patient has improved, the MH care manager will do brief check-ins during PCP visits
 - Basic psychopharmacology, if indicated, managed by PCP in consultation with a child and adolescent psychiatrist, if needed
- **Integrated or Co-Managed Specialty MH Services:** Based on their staff and capabilities, some integrated care teams may be able to provide MH care to moderate-to-severe patients. In case of complex MH needs, the PCP may choose an integrated, co-managed, or specialty MH referral for further evaluation.

These patients will be co-managed by the PCP and specialty clinician through maintenance and support of the plan of care and team meetings in addition to brief check-ins during visits to either clinician.

- Elements may include:
 - PCP refers patient to MH counselor/therapist and/or psychiatry clinician for further evaluation and possible medication management
 - PCP supports specialists' plan of care and co-manages patient
- **Initiate Crisis Protocol:** For patients at risk of or actively contemplating suicide, the integrated team will conduct a full suicide safety assessment to determine next steps. For patients at immediate high risk for harm to self or others, the integrated team, patient, family, and/or caregiver may agree to call community crisis services (988) for safe transfer to ED for further evaluation and possible inpatient admission.

Because patients with a history of suicide attempts are more likely to have a repeated attempt, frequency of suicide risk assessment (e.g., ASQ) may increase, performed at every visit (every 1–3 months), and used to monitor symptoms and assist with updates to the plan of care.

- Elements may include:
 - Assessing suicide risk
 - Developing a safety plan
 - Discussing secure storage of lethal means
 - Determining if patient needs emergent psychiatric assessment

For more information on identifying strategies and key partnerships to support youth at risk for suicide, visit the AAP/AFSP's [Blueprint for Youth Suicide Prevention](#).

WHEN:

- As indicated for intervention of symptoms or conditions uncovered in focused screening and assessment
- If patient and their family/caregivers are open and willing to engage in intervention



CALLOUT:

Though clinical pathways can be a valuable tool to guide treatment decisions, trust your clinical judgment and know that with BHI, you can always lean on your psychiatric consultant, MH clinician, and integrated care team partners.

Practice Spotlight

BHI in Action: Crisis Management

During a health supervision visit, a 16-year-old male mentioned experiencing stress, anxiety, and mood issues. With high scores on the PHQ-9 and SCARED screeners, the pediatrician discussed concerns with the patient and caregivers and recommended therapy.

The patient chose to seek therapy outside of the practice. Approximately a month later, his caregivers contacted the office with concerns about the patient's declining grades, ongoing social issues, and increased family conflict. The pediatrician collaborated closely with the consulting child and adolescent psychiatrist to recommend appropriate medication, and they began to co-manage the patient's treatment. After adjustments to his dosing, the patient reported gradual improvement in his symptoms.

However, two days later, a crisis unfolded at the patient's school, where he exhibited erratic behavior and was removed from the classroom. Acting swiftly, the pediatrician and psychiatrist consulted to activate an established safety plan and strategize medication management. Additionally, a video visit was arranged with the family to provide guidance and support.

Since the patient had been co-managed by the pediatrician and child and adolescent psychiatrist, the crisis was effectively managed without necessitating an ED visit or admission to the crisis unit. The patient's next appointment with the child and adolescent psychiatrist was expedited to the following week, with interim support provided by the pediatrician. Currently, under the ongoing care of the child and adolescent psychiatrist, the patient is being managed without medication and is showing signs of improvement.



Chapter 9: Preparing the Team and Establishing Workflow



Steps to Prepare the Care Team

Successful integration of behavioral health requires buy-in from all members of the care team.

Success depends on a shared commitment to training on best practices for delivering care, implementation of new workflow procedures, and understanding and use of patient-focused engagement materials. Establishing BH care as an organizational priority with practice leaders is essential to ensuring continued engagement and support.

Steps for preparing the team include:^{xxxvii}

- Identify staff leaders who will champion the effort, be accountable for the integration and training processes, and share plans of care across systems
- Develop (or procure) written and/or video training materials (scripts, guides, reference documents) for staff
- Schedule group training session(s)
- Plan for how and when training will be refreshed/reviewed
- Communicate with the team on a regular basis
- If finances allow, consider hiring an external consultant to assess your practice's needs and develop customized staff training

Training Members of the Primary Care Team

A PCP, psychiatrist, and/or BH clinician should take the lead in determining the skills that should be acquired by the end of the training process.^x

Examples of important skills include being able to engage patients in a manner that is supportive and nonjudgmental, being well-versed in active listening, being at ease using positive, person-first language, managing stressful encounters with a positive attitude, and speaking to cultural differences between care team members to help ease the transition to integrated care.

[Online and in-person training](#) is available through many different organizations. Practices should choose the programs they implement based on skills that their staff needs to develop further. Review of training offerings can also help when taking inventory of current team members' skills and deciding which skills need to be recruited for. For training tailored to CoCM, see the APA's free [online training program](#).



CALLOUT:

Though clinical pathways can be a valuable tool to guide treatment decisions, trust your clinical judgment and know that with BHI, you can always lean on your psychiatric consultant, MH clinician, and integrated care team partners.

With team members taking on new responsibilities, everyone in your practice can benefit from expanding their skills to successfully implement BHI. Consider exploring trainings in the following core competency areas:

Entire Team

- Foundations of integrated care
- Interdisciplinary interaction
- [Trauma-informed care](#)
- [Shared decision-making](#)
- [Crisis care planning](#)
- [BH care for diverse populations \(multicultural, LGBTQIA+\)](#)
- [Protecting patient privacy](#)
- [EHR utilization](#)
- [Telehealth applications](#)

Clinic Staff (front office staff, medical assistants, nurses)

- [BHI screeners & scoring](#)

Medical Team (physicians, PAs, NPs)

- [BHI screeners & scoring](#)
- [Motivational interviewing](#)

BH Team (BH clinician/care manager)

- [Brief, focused prevention and intervention](#)
- [Health behavior change](#)
- [Chronic disease management](#)

Resources are linked as examples and are not intended to be exhaustive. For additional training resources and programs to consider, see the [Resources Section under Preparing the Team & Establishing Workflow](#).

Preparing for and Designing an Updated Workflow

When a patient requires a BH intervention, the team must have an explicit pathway to follow to decide: Should the patient be assessed that day?

Are they at risk of harming themselves or others? Do they need a full consult with a psychiatrist or BH clinician? [Create processes and protocols for the entire care team](#) to recognize their roles and when the BH clinician should become involved. Also, ensure each team member knows which aspects of patient follow-up are their responsibility and which belong to the BH clinician. This should be reflected in shared practice protocols under the PCP's leadership.

Determining How and When to Perform an Assessment

Know how and when to perform BH assessments:

- Team members who will be conducting pre-visit planning and rooming patients should be trained on how to perform a BH screening using a validated questionnaire, such as the PHQ-9^{xxxviii, xxxix}
- Events such as a death in the family, job loss, a recent disease diagnosis (for the patient, a partner, family member, or friend), proximity to domestic abuse, or a history of MH conditions should prompt a BH assessment and, potentially, a BH referral. For a patient who is experiencing one or more of these stressors, the frontline clinician may recommend that the BH clinician become involved in the patient's care^x
- After interviewing and examining the patient, check in with present members of the team for input and to clarify the diagnostic impression and feasibility of a treatment plan
- Help the patient understand why a BH assessment is being recommended, using phrases such as "In taking care of people experiencing situations like yours, we have found that they do better and feel better sooner using this approach" and explaining the roles of various team members involved in their care. This is a good time to reassure them that BH assessment and care are provided "in addition to" their usual care



TIP:

Health coach training could help your team develop the skills they need to educate your patients more effectively about lifestyle and behavioral issues. Training curricula often teach strategies for patient engagement, motivational interviewing, and action plan creation with patients.

Example of a Suggested Workflow for a Small Private Practice

The workflow illustrated below assumes that the practice has already established external relationships with other specialties and that they have aligned on and coordinated BH efforts.

As noted previously, different roles may take on different responsibilities throughout the workflow.

STEP	DESCRIPTION
Confirmation of Eligibility and Benefits	Prior to the patient visit, eligibility is verified, and patient benefits are confirmed.
Patient Arrives for Scheduled Appointment	Patient presents with chief complaint(s) and medical assistant asks patient about any BH concerns.
Screening for BH	BH screening performed (incorporated as a part of the office visit).
Positive Indication for BH Need	Positive screen (indicating depression, substance use, etc.).
Discussion with Patient	PCP discusses the diagnosis/status with the patient and recommends BH services and treatment.
BH Coordination and Collaboration of Care	Care manager meets with the patient and collaborates with treating practitioners for the episode of care (based on severity and risk). If applicable, care manager provides patient education about available resources.
Care Oversight	PCP continues to oversee the patient's care, including prescribing medications, treating medical conditions, and making referrals to specialty care.



CALLOUT:

A “warm handoff” can occur either virtually or in-person, when the PCP, medical assistant, or nurse directly introduces the patient to a BH clinician at the time of care. One example of what this might look like is where the medical assistant rooming the patient learns through conversation or screening tools that the patient needs a more in-depth assessment. Ensuring a prompt connection with the BH clinician helps minimize the risk that the patient will not receive needed care. A staff member may also schedule a follow-up appointment for the patient, so the responsibility for scheduling that appointment is not placed on the patient.



TIP:

Workflows differ based on clinical diagnosis, severity, practice type, and available clinical resources.

Creating a BHI Training Manual

As your practice expands its offerings and adopts new ways of working, you may find it beneficial to create a training manual to help onboard new and existing team members.

Training manuals can include information on workflows, protocols, policies and procedures, and information on the history, culture, and vision of the organization.

SAMPLE OUTLINE OF A TRAINING MANUAL

Organizational Background

- Organization history, mission, and vision
- Information on the integration model (current and ideal)
- Description of roles and responsibilities

BHI Model Information

- BHI terms and definitions
- Sample script and handouts for introducing the model and BH clinicians to patients
- Team meeting descriptions and types
- Workflow descriptions
- Smart phrases for the EHR
- Screener forms
- Coding and billing procedures
- Information scheduling, appointment types, and duration
- Health system (internal) and community (external) resources
- Recommended references (articles, books, and websites)

Information for Clinicians

- BH interventions and treatment modalities
- Descriptions of the differences between integrated care provided by an integrated BH clinician and specialty MH clinicians
- Documentation requirements and examples



TIP:

Conducting orientation for members of the integrated care teams helps to foster a supportive partnership for success. [The BHI Orientation Checklist](#) provides recommendations on what to include and how to structure a successful orientation.

Practice Spotlight

A Case of Successful Implementation into Workflow

An ob-gyn practice in Massachusetts recognized mental health as a critical component of quality perinatal care and sought to integrate MH screening, assessment, intervention, referral, and follow-up into their practice workflow.

To do so, they enrolled in the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms program. MCPAP for Moms delivers evidence-based trainings and toolkits with guidance on how to screen, assess, and treat MH conditions in perinatal care settings. In addition, MCPAP for Moms' team of psychiatrists, who have expertise in perinatal mental health, provides consultation to physicians and other clinicians.

Soon after the practice participated in training and integrated these processes into their workflow, a patient presented for care and screened positive for depression at 14 weeks gestational age. The practice called MCPAP for Moms and, guided by expert psychiatric consultation, the ob-gyn was further equipped to discuss treatment options, connect the patient to a therapist, and prescribe an antidepressant.

For more case studies in successful implementation, watch the BHI Collaborative's "[BHI in Practice: Establishing Efficient Workflows](#)" and "[Integrating Perinatal Mental Health Care into the OB Practice](#)" webinars.



MOVING FORWARD:


For a tool to assist you in designing workflows, see the [Workflow "How-To" guide](#).

Chapter 10: Partnering with Patients, Families, and Caregivers



Engaging Patients, Families, and Caregivers

It is important that care teams explain the “why and how” of integrated care to patients, families, and caregivers by:^{xl}

- Expressing commitment to whole-person care and the impact mental health can have on physical health and vice versa
- Triaging patients to the appropriate level of care while managing the patient’s needs in the interim
- [Using appropriate and helpful language](#) to introduce BH clinicians in ways that help address the patient’s confusion or fears about their situation or meeting someone new
 - *Note: Some practices find it helpful to refer to the BH clinician/care manager as a “BH consultant” to avoid confusion with specialty MH care services*
- Offering hopeful, encouraging, understanding, reassuring, and acknowledging comments and avoiding dismissive or blaming comments
- Educating patients about their clinical situation and care, involving families and caregivers as appropriate to age, developmental stage, and circumstance
- Describing the screening process and explaining the results (Note: In pediatrics, screening starts early for promotion, prevention and early identification)
-  Ensure families that the intent of BH screening is not to “find something wrong” but rather focused on promotion of [healthy mental and social-emotional development](#) and prevention of future MH challenges
- Helping patients understand the commitment of the primary care team and BH clinicians to whole person care and address any concerns they may have with their care or barriers to receiving it
- Identifying the patient’s insurance coverage status to help them understand associated costs and explore options if needed
- Educating patients on what constitutes a BH emergency and who to contact based on their specific needs

Best Practices to Partner with the Patient, Family, and Caregiver^{xli}

In order to create a comfortable environment for the patient, consider the following:

- **Start Early:** Share early in the relationship the importance of addressing both physical and mental health. Let patients know they should feel free to bring up any questions or problems during the visit.
- **Look Out for Red Flags and Risk Factors:** Understand and look for the warning signs of mental illness and substance use; listen to patient, family, and caregiver concerns; and connect them to MH clinicians and specific resources. Additionally, understand risk factors for children and families in regard to caregiver health and well-being, social drivers of health, and risks for toxic stress. Follow up with the patient and initiate warm handoffs with the care manager if needed.
- **Directly Involve the Patient in Their Care:** Educate the patient about what to expect, including why certain assessments are performed. Encourage them to describe how they are feeling as compared to prior visits and to share any concerns they may have about potential medication side effects.
- **Focus on Destigmatization:** When having conversations, make sure to use [non-stigmatizing language](#) that is appropriate for the patient's background and is developmentally appropriate. Certain groups, such as older patients and certain cultural groups, view mental and behavioral health care as taboo. As an example, framing conversations based on symptoms rather than illness (feeling bad or down instead of depressed, feeling scared or worried instead of anxiety) may help.
- **Demonstrate Cultural Humility:** Cultural humility refers to an orientation toward caring for one's patients that is based on: self-reflexivity and assessment, appreciation of patients' expertise on the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning.^{xii}
- **Incorporate Trauma-Informed Care:** A history of trauma and traumatic stress can affect a patient's functioning and increase the risk and severity of BH conditions. Approaching care with an awareness and understanding of trauma enables you to create a safe environment, foster resilience and reduce the risk of re-traumatization. For more information on how to incorporate trauma-informed care into your practice, watch the BHI Collaborative's "[Addressing Childhood Trauma Through Trauma-Informed Care](#)" webinar.
- **Provide Resources:** Make resources available in waiting rooms and exam rooms. These could be fact sheets, guides, pamphlets, and/or brochures about behavioral health, local support groups, and services. Seeing these resources may give your patient the nudge they need to raise concerns they may have about their behavioral health. These are most helpful when targeted to specific patient populations.
- **Maintain Confidentiality:** Provide a comfortable and private area for discussion:
 - If the patient is a child, provide areas for parent(s)/caregiver(s) to discuss their concerns both with and without the child present
 - If the patient is an adolescent or teenager, provide separate areas for the patient to discuss their concerns both with and without parent(s)/caregiver(s) present
 - For more information on how to safely integrate patient care while preserving patient privacy, watch the BHI Collaborative's "[Privacy and Security: Know the Rules for Communication of Behavioral Health Information](#)" webinar.

- **Consider Motivational Interviewing:** [Motivational interviewing](#) is a method that helps people enhance their own motivation for change and is applicable when working with patients who are faced with making any BH decision or change. When utilizing this method, follow the "RULE" approach:^{xiii}
 - *Resist* telling the patient what to do: Avoid telling, directing, or convincing them what a "right" path may be
 - *Understand* their motivation: Gain an understanding of their values, needs, abilities, motivations, and potential barriers to changing behaviors
 - *Listen* with empathy: Offer understanding and support for their values, needs, abilities, motivation, and potential barriers to changing behaviors
 - *Empower* them: Work with the patient to set achievable goals and identify techniques to overcome barriers

Offered for a fee to both licensed and non-licensed clinicians, consider UMASS Chan Medical School's [Certificate of Intensive Training in Motivational Interviewing](#).

For guidance on implementing motivational interviewing in pediatric settings, visit the AAP resource "[Motivational Interviewing Video Resources - Implementing Mental Health Priorities in Practice](#)."

Framing the Work for the Community

In addition to engaging patients one-on-one, consider what details you might want to communicate about your commitment to whole-person care externally.

These details can be shared directly by your practice staff, through your organization's website, and through patient handouts.

- How BHI services your practice's strengths-based, whole-person care approach
- The intersection of medical issues such as chronic pain or diabetes and behavioral health
- Benefits of seeing a BH clinician in your primary care practice
- Differentiation between specialty outpatient counseling (having a handful of community referrals ready in case patients request that option)
- Care team photos and bios
- Services offered
- Languages spoken or offered via interpreter
- Potential for out-of-pocket costs depending on insurance

MOVING FORWARD:

For further information on shared decision-making, motivational interviewing, and other engagement strategies, please visit the BHI Collaborative's "[Key Steps to Engaging Patients in Psychosocial Interventions](#)" webinar.

Chapter 11: Measuring Progress



BHI is a constantly evolving process.

As such, it is important to measure practice performance and progress on goals at regular intervals and to modify your approach when needed.



Measuring Value in Integrated Care Models^{xvi}

To maximize the impact of your measurement efforts, consider prioritizing measures that align with your practice and stakeholders' definitions of value. As introduced in Chapter 3: Establishing the Value, value can be measured in a variety of ways, including but not limited to:

VALUE DRIVER	EXAMPLES OF RELEVANT MEASURES
Clinical Outcomes, Quality and Safety	Patient assessment scores (PHQ-9, GAD-7, etc.) Adherence to therapy and/or medication
Access to Care	Availability of warm handoff Referral completion rate
Patient, Family, and Caregiver Experience	Patient-reported confidence and satisfaction with care Patient-reported ease of using telehealth platform
Clinician Experience	Engagement and satisfaction with work Burnout (e.g., Mini-Z)
Financial and Operational Impact	No-show rate New patient acquisition

Operationalizing Measurement

Once you've aligned on your priority measures, take inventory of the data you're already collecting and the resources at your disposal to determine a realistic starting point.

You might be collecting more data than you realize, especially if you have an EHR system, use patient registries, or participate in mandatory reporting.

Questions to consider as you audit your measurement capabilities:

- What data are we already collecting? *Examples may include Healthcare Effectiveness Data and Information Set (HEDIS) or Partnership for Quality Measurement (PQM)™ measures*
- What analysis tools do you have access to through your EHR? Your IT department? Via an external consultant? *Regardless of what tools you're using, the most important thing is consistency in how and where data is recorded*

Once you've established your existing data capabilities, identify who in the organization has the access and necessary skills to execute data collection and analysis (e.g., build fields in EHR and run reports).

Questions to consider as you develop a measurement plan:

- Who will run the report? How often?
- Where will you store the data to ensure HIPAA compliance?
- What will you use this data for? How will clinical teams use it at the point of care?
- Whom will you share it with and how often?



TIP:

BH team updates should be on the agenda at regular team meetings. This gives the entire team the opportunity to evaluate progress, explore ways to collectively make processes better, increase and improve communication, and keep the focus on providing the best care to patients.

Knowing the Milestones of Progress

Being able to recognize successful integration of behavioral health in your practice is important. While often different for each practice, successful organizations are those who are able to:

- Advocate for a mission and vision focused on integrated care
- Build a sustainable staffing structure for integrated care
- Create a team-based culture
- Structure the organization for delivering integrated care
- Optimize physical workspace for providing integrated care
- Organize health information technology to support integrated care
- Manage the structure and timing of integrated care delivery
- Utilize communication tools and practices that facilitate integrated care
- Utilize clinical practices of integrated care teams

Practice Spotlight



Leveraging the EHR for BHI in an Independent Pediatric Practice

When the team at [Pediatric Associates of Mt. Carmel](#) embarked on a search for a new EHR system, they were looking for a flexible solution that could adapt to the evolving needs of an independent practice caring for children and adolescents.

As a first step in their search, they turned to colleagues in the AAP's Section on Administration and Practice Management ([SOAPM](#)) listserv for recommendations. They found that a smaller-scale EHR system designed for independent pediatric practices would better suit their needs, avoiding the risk of overcomplicating workflows. While forgoing “bells and whistles,” they identified several key functionalities crucial to delivering excellent care.

These tools included customizable templates for their child and adolescent psychiatrist and therapists, all housed within the same EHR to allow for centralized recordkeeping across the care team. The system also enabled internal messaging between clinicians, allowing the PCP to flag follow-ups for the MH team and vice versa. Additional tools featured within the EHR helped to manage sensitive or private information, including a section for private notes and a portal allowing parents and caregivers to access certain information while maintaining patient confidentiality.

While some EHR systems offer digitally integrated screening tools, the team opted for a cost-effective approach that leveraged their existing workflow. Staff administer paper screeners with scores recorded and scanned into patient charts for easy reference. This method was already something that worked for them, and they continue to find it efficient for recording and tracking scores over time.

The simplicity and effectiveness of their new EHR fostered quick uptake, and the team at Pediatric Associates of Mt. Carmel has been able to seamlessly share information, facilitating early intervention and truly comprehensive care.



MOVING FORWARD:

The National Council for Mental Wellbeing's [Comprehensive Healthcare Integration \(CHI\) Framework](#) offers guidance for measuring progress in “integratedness,” demonstrating the value produced by progress in integrated service delivery and providing initial and sustainable financing for integration.

Resources and Tools



RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
FOUNDATIONAL ELEMENTS				
Chapter 1: Key Terms and Building Blocks	Lexicon for Behavioral Health and Primary Care Integration (2023 Revision)	The Lexicon is a set of concept and definitions developed by experts to provide a practical definition of BHI as implemented in practice settings	Agency for Healthcare Research and Quality (AHRQ)	https://integrationacademy.ahrq.gov/products/ibh-lexicon/2013-lexicon
Chapter 2: Potential Approaches	The Six Levels of Collaboration/Integration	Six levels of collaboration/integration are organized by Coordinated, Co-Located, and Integrated in this table. The core description, key differentiators, strengths, and weaknesses of each level are explained.	SAMHSA-HRSA Center of Excellence for Integrated Health Solutions	https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?dof=375ateTbd56
	CoCM Information and Details	This website provides further information and detail on CoCM specifically, including free training.	American Psychiatric Association (APA)	https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
	Collaborative Care Implementation Guide	This guide is an introduction to the process of implementing CoCM, from the crucial first step of understanding what it is to monitoring outcomes once it is in place.	Advanced Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/resource/collaborative-care-implementation-guide/
	Pediatric Collaborative Care Implementation Guide	This guide is for multidisciplinary, primary care teams seeking to improve care access and behavioral health outcomes for children and adolescents through implementing Collaborative Care.	Advanced Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/wordpress/wp-content/uploads/2023/06/Pediatric-CoCM-Implementation-Guide_Final-Reduced-Size.pdf
	SBIRT Model of Care	For more information on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model of care, this change guide assists PCPs and other clinicians in integrating care for patients with unhealthy alcohol and/or drug use into routine medical care.	National Council for Mental Wellbeing	https://www.thenationalcouncil.org/resources/implementing-care-for-alcohol-other-drug-use-in-medical-settings/
	SBIRT Website	This website provides guidance to integrating SBIRT in pediatric primary care settings.	American Academy of Pediatrics (AAP)	https://www.aap.org/sbirt

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
FOUNDATIONAL ELEMENTS				
	The Integrated Care Podcast	Experts discuss timely topics in the world of integrated care.	Collaborative Family Healthcare Association (CFHA)	https://www.integratedcarenews.com/podcast/
	Collaboration with Primary Care in Pediatrics	This website contains additional materials to assist physicians, other clinicians, and policymakers interested in developing Collaborative Care models.	American Academy of Child & Adolescent Psychiatry (AACAP)	https://www.aacap.org/AACAP/Clinical_Practice_Center/Systems_of_Care/Collaboration_with_Primary_Care.aspx?hkey=4bab0731-cc26-48d9-b3be-062a3bab4250
	A List of Resources by Focus Area	This website contains multiple resources related to BHI, organized by assessing organizational readiness, building the business case, and workforce development.	SAMHSA-HRSA Center of Excellence for Integrated Health Solutions	https://www.thenationalcouncil.org/integrated-health-coe/resources/
	Telehealth and Behavioral Health Integration	This page aims to provide practical information and resources for using telehealth technologies as well as available research evidence, including peer-reviewed outcomes data and experiences.	Agency for Healthcare Research and Quality	https://integrationacademy.ahrq.gov/about/integrated-behavioral-health/telehealth
	Perinatal Mental Health State-Based Model	This website describes MCPAP for Moms, a state-based model that provides training, psychiatric consultation, and referrals to care for obstetric, pediatric, primary care, and psychiatric clinicians serving pregnant and postpartum patients.	Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms)	https://www.mcpap.com/About/McPAPforMOM.aspx
	Child Psychiatry Access Programs	Access this site for information on child psychiatry access programs across the nation.	National Network of Child Psychiatry Access Programs	https://nncpap.org/
	Pediatric Mental Health Care Access (PMHCA) Technical Assistance Program	Access this site to learn more about connecting with PMHCA programs for teleconsultation, education, and support.	American Academy of Pediatrics	https://www.aap.org/en/patient-care/mental-health-initiatives/pediatric-mental-health-care-access-pmhca-program/
	Maternal and Child Health Initiative	Reference this site for information on the Maternal and Child Health Bureau, which aims to promote behavioral health and well-being in these two populations.	Health Resources & Services Administration Maternal and Child Health	https://mchb.hrsa.gov/maternal-child-health-initiatives/mental-behavioral-health

RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
FOUNDATIONAL ELEMENTS				
Chapter 3: Establishing the Value	Business Case for the Integration Behavioral Health and Primary Care	Refer to the Business Case Equation for BH Integration on page 3	SAMHSA-HRSA Center of Excellence for Integrated Health Solutions	https://www.thenationalcouncil.org/wp-content/uploads/2021/04/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf?dof=375ateTbd56
	Evidence Base for Collaborative Care	This website makes the case for establishing CoCM through a variety of lenses.	Advanced Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/evidence-base-for-cocm/
	Why Practice Collaborative Care? PCP Perspective	A one-pager that summarizes the benefits of CoCM from the PCP perspective.	Advanced Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/resource/why-practice-collaborative-care/
	Comparing Payment Models for RHCs and FQHCs	Refer to the table on pages 17–19 to compare CoCM, General BHI, and Psychiatric CoCM in terms of requirements and payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).	Centers for Medicare & Medicaid Services	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
	Primary Care Innovations and PCMH Map by State	Utilize the map available on this site for brief descriptions of PCMH's activity across each state.	Primary Care Collaborative	https://www.pcpc.org/initiatives/state
	APMs Overview	Reference this site for an introduction to and overview of Alternative Payment Models.	Centers for Medicare & Medicaid Services (CMS)	https://qpp.cms.gov/apms/overview
	Innovation Models at State Levels	Utilize the map available on this site for information on innovation models run at the state level.	Centers for Medicare & Medicaid Services (CMS)	https://innovation.cms.gov/innovation-models/map
	Payment Model Reform Foundational Resources	Access this site for a collection of fact sheets, reports, infographics, white papers, and more to understand payment model reform.	Health Care Payment Learning & Action Network	https://hcp-lan.org/foundational-resources/

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
FOUNDATIONAL ELEMENTS				
	AMA STEPS Forward™: Creating the Organizational Foundation for Joy in Medicine™	This module includes an interactive calculator to calculate the projected costs of physician burnout related to turnover for your organization.	American Medical Association (AMA)	https://edhub.ama-assn.org/steps-forward/module/2702510
	The Practice and Billing Toolkit	Sample tools and resources from pioneer practices who have implemented the Collaborative Care Model (CoCM) and are billing for services delivered in the model.	American Psychiatric Association (APA)	https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-CoCM-Practice-and-Billing-Toolkit.pdf
	Telehealth Implementation Playbook	Reference this document for further information on incorporating telehealth into your practice.	American Medical Association (AMA)	https://www.ama-assn.org/system/files/ama-telehealth-playbook.pdf
	A Toolkit for Building and Growing a Sustainable Telehealth Program in Your Practice	Reference this toolkit for information on developing and implementing a telehealth strategy in family practice.	American Academy of Family Physicians (AAFP)	https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
	Telehealth Tips for Pediatricians	Access this resource for resources and trainings to implement telehealth in your pediatric practice.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/practice-management/care-delivery-approaches/telehealth/
	APA's Telepsychiatry Toolkit	Access this resource for information on telepsychiatry history, training, practice/clinical, reimbursement and legal issues from leading psychiatrists.	American Psychiatric Association (APA)	https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit
	AACAP's Telepsychiatry Toolkit	Reference this toolkit for video presentations covering topics relevant to developing and expanding a telepsychiatry practice with children and adolescents.	American Academy of Child & Adolescent Psychiatry (AACAP)	https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/toolkit_videos.aspx
	Accelerating and Enhancing Behavioral Health Integration Through Digitally Enabled Care: Opportunities and Challenges	Reference this resource to further explore opportunities and limitations to incorporating technology to advance BHI.	American Medical Association (AMA)	https://www.ama-assn.org/system/files/bhi-return-on-health-report.pdf

RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
FOUNDATIONAL ELEMENTS				
Chapter 4: Financial Sustainability	BHI Collaborative's Billing and Coding 101 Webinar	For more information regarding billing and coding, see this webinar.	American Medical Association (AMA)	https://www.ama-assn.org/practice-management/sustainability/behavioral-health-integration-webinar-series-billing-coding-101
	Financial Modeling Workbook	This tool helps organizations model and estimate BHI revenue and expenses as well as evaluate practice parameters to better understand their financial impact.	Advancing Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/financial-modeling-workbook/
	Decision Support Tool and Billing Modules	A tool designed to help clinician organizations sustainably finance integrated care, along with companion billing modules with guidance for optimizing financing strategies.	National Council for Mental Wellbeing's Center of Excellence for Integrated Health Solutions	https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/
	Behavioral Health Coding Resource	Refer to this PDF for key codes to use when administering BH screening, treatment, and/or preventative services.	American Medical Association (AMA)	https://www.ama-assn.org/system/files/behavioral-health-coding-resource.pdf
	Codes for Services Under Medicaid	Refer to this PDF for details on services, codes, and rates for community and private BH centers.	Mississippi Division of Medicaid	https://medicaid.ms.gov/wp-content/uploads/2014/03/
	BHI Medicare Fact Sheet	This PDF offers an overview of the billing and coding requirements under CoCM.	Centers for Medicare & Medicaid Services (CMS)	https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf
	Coverage for CoCM Codes	Reference this PDF for information on both commercial and Medicaid payers with approved coverage for CoCM codes.	American Psychiatric Association (APA)	https://www.psychiatry.org/getmedia/c2b57396-00a3-4d46-90db-7bf3414014d3/Coverage-Psychiatric-CoCM-Codes-Payers.pdf
	Opportunities to Integrate BH Care Through Medicaid Managed Care	Access this PDF for details on models, codes, and state differences for Medicaid payment.	Center for Health Care Strategies, Inc.	https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
FOUNDATIONAL ELEMENTS				
	Screening and Assessment Services Overview	Access this PDF for advice to ensure you're coding and billing properly for all BH services you're providing.	American Academy of Family Physicians (AAFP)	https://www.aafp.org/fpm/2017/1100/fpm20171100p25.pdf
	Screening Fact Sheet	Refer to this PDF for an explanation of the difference between Developmental and Emotional/Behavioral screening, which often causes confusion.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/coding_factsheet_developmental_screeningtesting_andEmotional_Behaviorassessment.pdf
	Primary Care Behavioral Health (PCBH) Funding FAQs	Visit this site for an overview of how PCBH programs are funded.	Collaborative Family Healthcare Association	https://members.cfha.net/page/PCBHFAQFunding
	Quick Guide on Bundled Payments for Behavioral Health Integration Services	This PDF provides information on BHI codes.	Advancing Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/wordpress/wp-content/uploads/2023/11/Quick-Guide-CMS-BHI-CoCM-2022.pdf
	Quick Guide on Bundled Payments for Behavioral Health Integration Services: Federally Qualified Health Centers and Rural Health Clinics	This PDF provides information on BHI codes covered by FQHC and RHC practices.	Advancing Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/wordpress/wp-content/uploads/2023/11/Quick-Guide-CMS-FQHC-RHC-2023_0.pdf

RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
GETTING STARTED				
Chapter 5: Assessing Readiness	Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration: Two Major Self-Assessment Tools	Access this PDF to utilize two major self-assessment tools: The Partnership Checklist and the Executive Walkthrough.	SAMHSA-HRSA Center for Integrated Health Solutions	https://www.thenationalcouncil.org/wp-content/uploads/2020/01/OATI_Overview_FINAL.pdf?dof=375ateTbd56
	Mental Health Practice Readiness Inventory	Access this PDF to determine level of readiness and identify areas where your practice may need to focus efforts.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/PracticeReadinessInventory.pdf
	Site Self-Assessment Survey Facilitation Guide	Access this PDF for a self-assessment tool to evaluate progress toward integration.	Maine Health Access Foundation (MeHAF)	https://waportal.org/resources/mehaf-facilitation-guide
Chapter 6: Establishing Goals and Metrics of Success	Measurement-Based Care in the Treatment of Mental Health and Substance Use Disorders	Includes recommended validated rating scales and a user-friendly list of tools for measuring adult and pediatric outcomes.	Meadows Mental Health Policy Institute	https://mmhpi.org/wp-content/uploads/2021/03/MBC_Report_Final.pdf
	Collaborative Care Outcomes Data	Reference this resource for an assessment on Collaborative Care outcomes.	Concert Health	http://concerthealth.com/hubfs/Collateral/Concert%20Collaborative%20Care%20Outcomes%20Data_Final.pdf

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
GETTING STARTED				
Chapter 7: Assembling and Aligning the Team	Defining Care Team Roles & Relationships	This booklet contains information about the Collaborative Care Services (CoCM) approach to BHI.	Medicare Learning Network, Centers for Medicare & Medicaid Services	https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf
	BHI Collaborative's Assembling the BHI Care Team: Roles & Responsibilities webinar	This webinar shares tips on how to identify practice needs, train care team members, and assign roles and responsibilities in a streamlined way.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/assembling-bhi-care-team-roles-and-responsibilities
	Identifying Local Resources	Through FindHelp.org, information regarding locating and accessing local BH resources is provided by entering only a ZIP code or location.	Findhelp.org	https://www.findhelp.org/
	Identifying National Resources	This link contains additional resources and helplines available to physicians and patients.	Substance Abuse and Mental Health Services Administration (SAMHSA)	https://www.samhsa.gov/find-help/national-helpline
	Resources for Mental Health Services	This PDF contains further resources for key MH services.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/KeyMentalHealthServices.pdf
	Addressing Mental Health Concerns in Pediatrics: A Practical Resource Toolkit for Clinicians	This collection provides access to content, forms, screening and assessment resources, and videos for first-line advocates for mental health.	American Academy of Pediatrics (AAP)	https://publications.aap.org/toolkits/pages/mental-health-toolkit?autologincheck=redirected
	Pediatric Mental Health Minute Series	This website contains quick yet in-depth videos to improve knowledge and skills for caring with children and youth with MH disorders.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/patient-care/mental-health-minute/
	Guide for Promoting Child and Adolescent Behavioral and Mental Health in Primary Care	This PDF is a compilation of practical MH information geared toward child and adolescent health care clinicians.	Virginia Mental Health Access Program	https://vmap.org/wp-content/uploads/2022/06/VMAP-Guidebook_6.7.22-2.pdf
	Children's Mental Health	This website provides information on children's mental health.	Centers for Disease Control and Prevention (CDC)	https://www.cdc.gov/childrenmentalhealth/index.html
	RethinkVape.org	This website shares facts on the dangers of vaping.	Eastern Virginia Medical School	https://rethinkvape.org/

RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
IMPLEMENTATION				
Chapter 8: Establishing Assessment and Treatment Capabilities	BHI Collaborative's BH Screening as a Part of Ongoing Care Webinar	This webinar explores the use of BH screening tools in MH assessment and monitoring, highlighting their application in pediatric, OB/GYN, and geriatric care.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/behavioral-health-screening-part-ongoing-care
	The Primary Care Psychiatric Interview	This document focuses on the importance of the initial psychiatric interview in primary care, emphasizing its role in setting the future course of visits and treatment.	John Onate, MD, Glen L. Xiong, MD, Robert McCarron, DO	https://hnc.org.au/wp-content/uploads/2017/11/The-Primary-Care-Psychiatric-Interview.pdf
	A Guide to Primary Care Management of Mental Health and Addiction-related Risks and Functional Impairments	The purpose of this tool is to support PCPs (family physicians and primary care nurse practitioners) in reducing harm in adult patients (18+) who exhibit signs, symptoms, or behaviors suggestive of an MH condition.	Centre for Effective Practice	https://cep.health/media/uploaded/CEP_MHA_V1.pdf
	ASQ Toolkit	The ASQ toolkit is organized by the medical setting in which it will be used: emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics.	National Institute of Mental Health (NIH)	https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/adults-asq-toolkit
	AAP/AFSP Blueprint for Youth Suicide Prevention	This educational resource aims to support pediatric health clinicians and other health professionals in identifying strategies and key partnerships to support youth at risk for suicide.	American Academy of Pediatrics (AAP) and American Foundation for Suicide Prevention	https://www.aap.org/suicideprevention
	Stanley-Brown Safety Plan	This document is a structured safety plan template designed to help individuals identify warning signs, coping strategies, support networks, professional contacts, and measures to make their environment safer during a crisis.	Stanley-Brown Safety Planning Intervention	https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf
	Mental Health Tools for Pediatrics	The aim of this compilation is to help you determine what tools might be most appropriate for each stage of screening, evaluating, and treating pediatric MH needs.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf

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IMPLEMENTATION				
	Bright Futures Toolkit: Commonly Used Screening Instruments and Tools	This document details the AAP's protocol for routine screenings in pediatric visits, offering a guide to various assessment tools without endorsing any, and reminds health professionals to consult instruction manuals and respect copyright laws when using these tools.	American Academy of Pediatrics (AAP)	https://publications.aap.org/toolkits/resources/15625/?autologincheck=redirected
	Screening Tool Finder	The Screening Tool Finder can help you identify tools to screen or assess for child development, perinatal depression, social drivers of health, and more.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/
	Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit	The GLAD-PC Toolkit helps PCPs put the GLAD-PC guidelines into effect.	The REACH Institute	https://thereachinstitute.org/guidelines-for-adolescent-depression-primary-care/
	Addressing Mental Health Concerns in Pediatrics: A Practical Resource Toolkit for Clinicians, 2nd Edition	This toolkit is designed to empower pediatric care clinicians at delivering comprehensive MH care and has been condensed to deliver a streamlined collection of tools most relevant to pediatric practice in a new online format as part of the AAP Toolkits collection.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/catalog/categories/mental-health-resources/addressing-mental-health-concerns-in-pediatrics-a-practical-resource-toolkit-for-clinicians-2nd-ed/
	Pediatric Psychopharmacology for Primary Care	The revised and updated third edition of this best-selling resource provides PCPs with practice-tested, condition-specific treatment recommendations for various mental and psychiatric disorders or behavioral problems in children and adolescents.	American Academy of Pediatrics (AAP)	https://publications.aap.org/aapbooks/monograph/692/Pediatric-Psychopharmacology-for-Primary-Care
	The REACH Institute Trainings	REACH uses state-of-the art, interactive methods grounded in the science of behavior change to teach effective methods for helping children and adults who suffer from mental and emotional health challenges.	The REACH Institute	https://thereachinstitute.org/training/
	BHI Collaborative's Addressing Childhood Trauma Through TIC Webinar	The webinar discusses integrating trauma-informed care into comprehensive health strategies, with a focus on recognizing and managing trauma throughout life.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/addressing-childhood-trauma-through-trauma-informed-care-tic

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LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
IMPLEMENTATION				
	BHI Collaborative's Addressing BH in Primary Care: Non-Pharmacological Services & Treatments webinar	The webinar showcases physicians sharing strategies for identifying and managing behavioral health within primary care settings, including practical, non-pharmacological approaches.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/behavioral-health-and-primary-care-non-pharmacological-services
	Case Studies of Health Information Technology for BHI	These AHRQ Academy case studies are real-world examples of health systems and group practices that have adopted Health IT tools for integrative purposes	Agency for Healthcare Research and Quality (AHRQ)	https://integrationacademy.ahrq.gov/expert-insight/success-stories
	Perinatal Mental Health Toolkit	This toolkit includes a summary of perinatal MH conditions, patient screening tools, algorithms, and educational resources for clinicians, patients, and families.	American College of Obstetricians and Gynecologists (ACOG)	https://www.acog.org/programs/perinatal-mental-health
	Team Building & Workflow Guide	This document can be used to help guide you through the workflow and align on a plan.	Advanced Integrated Mental Health Solutions (AIMS) Center	http://aims.uw.edu/sites/default/files/ClinicalWorkflowPlan.pdf
Chapter 9: Preparing the Team and Establishing Workflow	A Process for Integrating Mental Health Care into Pediatric Practice	For examples of various workflows in pediatrics, see this document.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/Algorithm_Integration_of_Mental_Health_Care_Into_Pediatric_Practice.pdf
	Maternal Mental Health State Resources	Perinatal Psychiatry Access Programs support clinicians in assessment and treatment of perinatal MH conditions. For a list by state, visit this website.	Lifeline4Moms	https://www.umassmed.edu/lifeline4moms/Access-Programs/network-members-us/
	Maternal Mental Health National Resource	Medical clinicians who treat pregnant and postpartum patients can use PSI's Perinatal Psychiatric Consult Line for questions about MH care.	Postpartum Support International	https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/
	The Partnership Checklist	Utilize this Partnership Checklist to determine if a partnership is necessary to achieve the desired outcomes for the integration program in your practice or organization.	SAMHSA-HRSA Center of Excellence for Integrated Health Solutions	https://www.thenationalcouncil.org/wp-content/uploads/2022/01/OATI_Tool1_Partnership_checklist.pdf

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IMPLEMENTATION				
	Get Trained in the Collaborative Care Model	Psychiatrists, PCPs, and BH care managers can receive free training in the Collaborative Care Model.	American Psychiatric Association (APA)	https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained
	Short Courses in Primary Care Behavioral Health	UMass Chan Medical School offers short courses and training for a fee on selected Behavioral Health and Primary Care topics.	UMass Chan Medical School	https://www.umassmed.edu/cipc/webinars-short-courses/short-courses/pcbh-short-courses/
	BHI Collaborative's Integrating MH Care into the OB Practice Webinar	This webinar details a practicing OB-GYN integrated MH screening, assessment, treatment and follow-up into the obstetric practice, with helpful tools and resources available to physicians and primary care teams.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/integrating-mental-health-care-ob-practice
	Core Competencies for Integrated Behavioral Health and Primary Care	This resource details a method for developing core competencies, involving interviews, literature review, and analysis of relevant competency sets, followed by integration, categorization, and refinement based on expert feedback.	SAMHSA-HRSA Center of Excellence for Integrated Health Solutions	https://www.thenationalcouncil.org/wp-content/uploads/2020/01/Integration_Competencies_Final.pdf
	Preparing the Workforce for Behavioral Health and Primary Care Integration	This article details how organizations prepare clinicians to work together to integrate BH and primary care.	Journal of American Board of Family Medicine	https://pubmed.ncbi.nlm.nih.gov/26359471/
	Collaborative Family Healthcare Association	The Collaborative Family Healthcare Association (CFHA) is a multi-guild member association whose goal is to make integrated care the standard of care across the United States and beyond.	Collaborative Family Healthcare Association (CFHA)	https://www.cfha.net

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	International Foundation for Integrated Care	The International Foundation for Integrated Care (IFIC) is a non-profit network dedicated to advancing the science, knowledge, and adoption of integrated care across the world by connecting a diverse range of stakeholders including academics, researchers, and healthcare professionals.	International Foundation for Integrated Care (IFIC)	https://integratedcarefoundation.org
	Academy for Integrating Behavioral Health and Primary Care	AHRQ seeks to build a centralized resource hub to provide the tools and materials to advance the field of integration, and to promote a collaborative environment for dialogue and discussion among leaders across behavioral health, and primary healthcare arenas.	Agency for Healthcare Research and Quality (AHRQ)	https://www.ahrq.gov/cpi/about/otherwebsites/integrationacademy.ahrq.gov/index.html
	LGBT Training Curricula for Behavioral Health and Primary Care Practitioners	The first training curriculum specifically designed to help both administrators and clinicians address the various aspects of providing effective substance use treatment to LGBTQIA+ individuals.	SAMHSA-HRSA Center for Integrated Health Solutions	https://www.samhsa.gov/behavioral-health-equity/lgbtqi/curricula
	Rural Services Integration Toolkit Integrating SUD and OB/GYN Care	This toolkit identifies evidence-based and promising models and resources that will benefit rural communities seeking to implement services integration programs.	Rural Health Information Hub	https://www.ruralhealthinfo.org/toolkits/services-integration
	Project ECHO at AAP	Project ECHO is a tele-mentoring program designed to create communities of learners by bringing together health care clinicians and experts in topical areas using didactic and case-based presentations, fostering an “all learn, all teach” approach.	American Academy of Pediatrics (AAP)	https://www.aap.org/projectecho

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	National Rural Adolescent and Child Health (NRACH) ECHO Training Center	This training center helps ensure that children and adolescents who live in rural and frontier communities have access to pediatric MH services and quality pediatric care.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/practice-management/project-echo/national-rural-adolescent-and-child-health-nrach-echo-training-center/
	Mental Health Education and Training	This resource provides links to video series and telehealth resources, AAP online courses, EQIPP courses, AAP Live and Virtual Education Courses, Project ECHO, and Motivational Interviewing Video Resources - Implementing Mental Health Priorities in Practice.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/patient-care/mental-health-initiatives/mental-health-education-and-training/
	Project TEACH in NY	Project TEACH in New York is a state-funded initiative that strengthens the capacity of pediatric PCPs to deliver MH care to children and families with mild-to-moderate MH issues through consultations, training, and referrals.	Project Teach (NY)	https://projectteachny.org/resources/
	Integration Training Resources	For direct training manuals on integration and important steps along the way, utilize the manuals provided from the U.S. Department of Veteran Affairs.	U.S. Department of Veteran Affairs Veterans Integrated Service Network (VISN)	https://www.mirecc.va.gov/cih-visn2/foundations.asp
	BHI Collaborative's Overcoming Obstacles Implementation Strategies for Virtual Behavioral Health Integration Webinar	In this webinar, physician experts provide guidance on how to virtually support the behavioral health of patients.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/behavioral-health-integration-webinar-series-virtual-bhi
	Steps for Integrating Behavioral Health into Primary Care	For more information regarding necessary and helpful steps to integration of behavioral health in primary care, access this website.	American Medical Association (AMA)	https://edhub.ama-assn.org/steps-forward/module/2702747

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IMPLEMENTATION				
	Core Competencies for Behavioral Health Providers Working in Primary Care	Provides 8 core competencies and examples of each.	Eugene S. Farley, Jr. Health Policy Center	https://makehealthwhole.org/wp-content/uploads/2017/10/BHP-Core-Competencies.pdf
	National Guidelines for Behavioral Health Crisis Care	The toolkit provides sections for establishing, applying, and assessing crisis care in accordance with national guidelines.	Substance Abuse and Mental Health Services Administration (SAMHSA)	https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf
	Addressing Perinatal Mental Health Conditions in Obstetric Settings eModule	This online training educates obstetric care clinicians on MH screening, assessment, differential diagnosis, triage, referral, treatment, follow-up, and monitoring.	American College of Obstetricians and Gynecologists (ACOG)	https://www.acog.org/mentalhealth
	Guide for Integrating Mental Health Care into Obstetric Practice	The Guide is organized into 3 phases: plan, implement, and sustain, with 10 steps to integrate MH care into OB practice.	American College of Obstetricians and Gynecologists (ACOG)	https://www.acog.org/programs/perinatal-mental-health/integrating-mental-health-care-into-ob-practice-guide
Chapter 10: Partnering with Patients, Families, and Caregivers	Promoting Social-Emotional Health Among Young Children	Access this PDF for tips on how to interact with young patients to promote social-emotional health, specifically among young children.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/Tips%20to%20Promote%20SE%20Health%202023.pdf
	Implementing Mental Health Priorities in Practice: Strategies to Engage Patients and Families	This resource consists of videos demonstrating examples of patient encounters that encompass the most difficult conversation areas for various MH topics.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/patient-care/mental-health-initiatives/mental-health-education-and-training/
	Common Factors Approach: HEL ² P ³ to Build a Better Alliance	This document contains helpful considerations for communication methods when working with patients.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/mhtk2e_commonfactorsapproach.pdf
	Financial Modeling Workbook	For more information regarding financial modeling, see this website for access to a free resource.	Advancing Integrated Mental Health Solutions (AIMS) Center	https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook

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IMPLEMENTATION				
	Motivational Interviewing Resources	Clinical resources for learning how to implement motivational interviewing	Providers Clinical Support System	https://pcssnow.org/courses/motivational-interviewing-informative-links/
	Billing, Workflow, and Administrative Tools for Successful Implementation of CoCM	Illustrates billing opportunities based on clinical staffing	American Psychiatric Association (APA)	https://vimeo.com/440768429/a32276f6fe
	BHI Collaborative's Essentials of Patient and Family-Centered Behavioral Health Care for Older Adults Webinar	Experts walk through patient scenarios to highlight best practices in geriatric care and actions physicians and their care teams can take using BHI to provide quality, whole-person care to the patient, their family members, and their caregivers.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/essentials-patient-and-family-centered-behavioral-health-care-older-adults
	Integrated Behavioral Health Care for Older Adults	This resource provides primary care practices with actionable, evidence-based guidance on the nuances of integrated care for the BH needs of older adults.	American Medical Association (AMA)	https://www.ama-assn.org/delivering-care/public-health/integrated-behavioral-health-care-older-adults
	BHI Collaborative's Tackling the Youth Mental Health Crisis Webinar	Experts highlight key aspects of MH promotion, identification and intervention of MH challenges, healthy mental development and how physician practices can leverage integrated behavioral health to enable them.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/tackling-youth-mental-health-crisis
	BHI Collaborative's Engaging Patients in Psychosocial Interventions Webinar	Experts discuss the spectrum of brief psychosocial interventions (i.e., psychoeducation, motivational interviewing, and shared decision making), along with how best to use these to help address BH needs for both adult and pediatric patient populations.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/overcoming-obstacles-webinar-engaging-patients-psychosocial-interventions

RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
IMPLEMENTATION				
	BHI Collaborative's Privacy and Security: Communication of Behavioral Health Information Webinar	Experts provide key considerations regarding state BH/SUD rules and real-world insights as to how to safely integrate patient care while preserving patient privacy.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/privacy-and-security-communication-behavioral-health-information
	State-by-State Variability in Adolescent Privacy Laws	Experts summarize state laws and regulations on minor consent for the following: health services, substance abuse treatment, prenatal care, MH care, contraceptive management, immunizations, sexually transmitted infection management, human immunodeficiency viruses testing and treatment, dental care, and sexual assault evaluation.	American Academy of Pediatrics (AAP)	https://publications.aap.org/pediatrics/article/149/6/e2021053458/187003/State-by-State-Variability-in-Adolescent-Privacy?auto_logincheck=redirected
	Guidelines on Trauma-Informed Care	This includes resources from the AAP Pediatric Approach to Trauma, Treatment, and Resilience (PATTeR) project, provide information and guidance on implementing TIC in pediatric settings.	American Academy of Pediatrics (AAP)	https://www.aap.org/en/patient-care/trauma-informed-care/
	Mental Health Toolkit Handouts	Patient, family, and caregiver education handouts from Addressing Mental Health Concerns in Pediatrics: A Practical Resource Toolkit for Clinicians, 2nd Edition.	American Academy of Pediatrics (AAP)	https://publications.aap.org/patiented/pages/mental_health_handouts
	BHI Collaborative's Addressing Childhood Trauma Through Trauma-Informed Care (TIC) Webinar	Experts introduce trauma-informed care and how it can be incorporated within broader integrated care efforts. With a focus on the pediatric population, this webinar covers the developmental aspect of trauma, how to screen, treat and prevent trauma, and its impacts across the lifespan, highlighting key actions physicians can take to address trauma with their patients.	American Medical Association (AMA)	https://www.ama-assn.org/about/events/addressing-childhood-trauma-through-trauma-informed-care-tic

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IMPLEMENTATION				
Chapter 11: Measuring Progress	Effective Benchmarking in Integrated Care	Review this presentation.	SAMHSA-HRSA Center for Integrated Health Solutions	https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Effective-Benchmarking-in-Integrated-Care-9.10.18.pdf
	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Mental Health Care Surveys	The CAHPS Mental Health Care Surveys are designed to assess and improve patient experiences with BH, MH, and substance abuse services, offering supplemental items for the CAHPS Clinician & Group and Health Plan Surveys, along with the Experience of Care and Health Outcomes (ECHO) Survey, which is being revised to the Mental Health Care Survey for broader application across various care settings.	Agency for Healthcare Research and Quality (AHRQ)	https://www.ahrq.gov/cahps/surveys-guidance/echo/index.html

FOOTNOTES

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