

Behavioral Health Integration **Compendium**

PRESENTED BY THE BHI COLLABORATIVE



BEHAVIORAL HEALTH INTEGRATION COMPENDIUM

THIS BEHAVIORAL HEALTH INTEGRATION COMPENDIUM

represents information believed to be current best practices, but it is not intended as legal, financial, medical, or consulting advice.

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



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Part 1:
**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 and implement behavioral health integration (BHI) in order to achieve the goal of optimal, whole-person care.



Chapter 1: Compendium Basics

Our aim is to provide accessible, detailed information on the steps required to integrate behavioral health care, which includes mental health and substance use disorders (SUD), into your practice and to provide links to resources should you desire further, more specific information.

As part of this effort, the AMA has also developed detailed guides specific to [workflow](#), [pharmacological intervention](#), [substance use disorders \(SUD\)](#), and [suicidal ideation and prevention](#). So, while the compendium will guide your practice through the initial steps and considerations regarding the integration of behavioral

health, the How-to Guides will provide specific knowledge and actionable resources in some of the most requested areas of 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 (BH) 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 [Collaborative's website](#).

A note about using the BHI Compendium

Different pathways may be taken to integrate behavioral health into primary care, pediatrics, obstetrics and gynecology, or other specialty care. The Collaborative recognizes the importance of meeting practices 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.





Part 2:
**BHI Basics
and
Background**

Chapter 2: BHI Definitions



WHAT IS BEHAVIORAL HEALTH (BH)?

Throughout this Compendium, behavioral health (BH) will refer to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care will refer to the prevention, diagnosis, and treatment of those conditions

WHAT IS BEHAVIORAL HEALTH INTEGRATION (BHI)?

BHI is widely accepted as the result of primary care (or other care settings) and behavioral physicians and other clinicians, working together with patients and families, using a systematic approach to provide patient-centered care

WHY IS BHI IMPORTANT?

One in five adults is living with a significant mental health or substance use disorder.

Additionally, one in eight women report symptoms of depression after giving birth.ⁱ Stigma, system fragmentation, and shortages in BH clinical resources and qualified mental health 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 behavioral health integration (BHI) into primary care.ⁱⁱ

Mental health disorders also impact approximately one in five of America's youth, which can cause significant challenges at home, school, and/or in their community. Additionally, suicide is the second leading cause of death among those ages 10 to 24.ⁱⁱⁱ However, only 10%

of U.S. children and adolescents ages 3 to 17 receive any treatment or counseling from a mental health professional.^{iv} Further, psychiatric disorders impacting children and adolescents are estimated to have an annual treatment cost of around \$40 billion.^v

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

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

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

There are many specific benefits to incorporating behavioral health services into primary and specialty care, including but not limited to:

PROMOTING OVERALL HEALTH:

Integrating behavioral health into primary care acknowledges the importance of physical and mental health to whole person health

CLOSING TREATMENT GAPS:

Coordinating physical and behavioral health care helps close the gap between the prevalence of these issues and the number of people receiving treatmentⁱⁱ

ENHANCING ACCESS:

Aside from providing greater access to long-term monitoring and management to individuals affected, services can often be accessed more easily when behavioral health is integrated into primary careⁱⁱ

REDUCING STIGMA:

Delivery of behavioral health services in a primary care setting may reduce the reluctance some individuals feel about seeking care at a facility that delivers only behavioral health services. Community outreach, care coordination, and mental health promotion by organizations that promote total patient care can reduce stigma and discrimination^v

For examples of how clinicians can be leaders in destigmatizing seeking and/or receiving treatment for people with mental health conditions, watch the Collaborative's webinar, "[Physicians Leading the Charge: Dismantling Stigma around Behavioral Health Conditions and Treatment.](#)"

REDUCING RISK OF SELF-HARM AND SUICIDE:

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 (suicide) in the United States^{vi,vii}

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.](#)

INCREASING POSITIVE OUTCOMES:

The majority of patients with behavioral health 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 communityⁱⁱ

IMPROVING PATIENT SATISFACTION:

Integrated care is more convenient for the patient. It also more effectively addresses their entire well-being, which leads to a sense of higher-quality care and greater satisfaction^{viii}

INCREASING PHYSICIAN AND OTHER CLINICIAN SATISFACTION:

An indirect result of more effective treatment for BH and other chronic conditions is the positive impact integration can have on care team satisfaction and well-being^{ix}

PROMOTING LONG-TERM VALUE:

Treating behavioral health issues in primary care settings is cost-effective in the long termⁱⁱ

Chapter 3: Introduction to Potential Approaches to BHI



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 most beneficial to patients with mild-to-moderate depression and/or anxiety as well as those receiving treatment for substance use disorders in the primary care setting.^x

In pediatrics, BHI has been widely used to help address a large number of behavioral issues, such as parent-child conflicts and attentional and organizational issues. Integration of behavioral health care within primary care can also be effective for patients with chronic health conditions such as obesity, diabetes, hypertension, or chronic pain (with or without a substance use disorder).

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



WATCH-OUT:

Not all BHI models of care are ideal for meeting the needs of patients with complex mental health issues (e.g., bipolar disease, schizophrenia, unstable psychosis, etc.) or for those who require urgent referral for psychiatric care and/or inpatient 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*.

UNDER COORDINATED CARE ARE LEVELS 1 AND 2:

In the middle of the BHI spectrum is **co-location**, in which the behavioral health specialist is physically located in a primary care clinic, or the primary care physician or other clinician is physically located in a mental health or substance use disorder treatment setting. The distinguishing feature here is *physical proximity*.

LEVELS 3 AND 4 FALL UNDER CO-LOCATION:

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

LEVELS 5 AND 6 ARE VARIATIONS OF INTEGRATED CARE:



CALLOUT:

A “warm handoff” can occur either virtually or in-person, when the primary care physician (PCP), medical assistant, or nurse directly introduces the patient to a behavioral health specialist 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 specialist 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.

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
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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 need; 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 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}

Models of care 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 mental health care, some practices may expand their model of care to offer a broader range of behavioral health services.



TIP:

When choosing a model of care, do not allow the process of selecting a model to become a barrier for action. Whatever the initial approach, it can later be modified based on experience.



CALLOUT:

Many states are developing [Pediatric Mental Health Care Access Programs](#) or [Child Psychiatry Access Programs](#) to provide child psychiatry consultation services to pediatric primary care providers. In addition, this consultation model has also been applied to address maternal depression and related behavioral disorders. For more information, see the [Resources section under Introduction to Potential Approaches to BHI](#).

Integrated Models of Care

Although there are a number of BHI models to choose from, only a few 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 behavioral health problems in primary care
 - The cornerstone to 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 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](#).

Integrated Models of Care (Cont.)

While there is more evidence of effectiveness for the CoCM than there is for other models, practices need to start with integration in a way that works best for them.

Alternative models of care may be a better fit for your practice and patient population.

- If your practice has a sizable clinic population that would make implementing the CoCM difficult, the **Primary Care Behavioral Health (PCBH) Model**, otherwise known as the Behavioral Health Consultant Model, is an alternative to consider^{xiii}
 - In the PCBH Model, the BH consultant, who may be a PsyD, PhD, master's level clinician, LCSW, or CRNP certified or trained in behavioral health, typically sees an individual patient for a limited time and a limited number of visits. 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 primary care physician and other members of the team

- If your practice manages persons with substance use disorders 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^{xiv}
 - SBIRT is an evidence-based approach to improve the care for these individuals and can be used to address other mental and behavioral health conditions as well
 - A clinical encounter, be it in a primary care practice, emergency room, trauma center, or other community setting, is an opportunity to intervene early when an individual is at risk for substance use disorders and before more serious consequences occur
 - Partnerships need to be facilitated to ensure timely access to treatment for referred patients

For more detailed information on caring for patients with substance use disorder in primary care, see the [SUD How-To Guide](#).



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:

- Virtual brief behavioral health (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 on when it is appropriate to leverage telehealth technologies, watch the Collaborative's webinar, "[Keys to Success: Implementation Strategies for Virtual Behavioral Health Integration](#)."



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](#).

Practice Spotlight

A Case in Child and Adolescent Psychiatry Access

There is a widespread shortage of child and adolescent psychiatrists in the United States, with only 9,000 to serve more than 91 million children and adolescents, for a ratio of more than 10,000 children per child and adolescent psychiatrist. Most mental illnesses begin in childhood, and early diagnosis and treatment can improve an individual's behavioral health, quality of life, and longevity. Primary care pediatricians have a critically important role in identifying and treating children's mental and behavioral health care needs but often do not feel adequately prepared to do so.

[The Massachusetts Child Psychiatry Access Project \(MCPAP\)](#) 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 behavioral health issues. The most high-risk and complex cases are referred to specialists.

Eighty percent of well-child visits with primary care pediatricians in the MCPAP program result in a behavioral health screen, making BH 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 mental health care into pediatric primary care through telehealth services at state or regional levels. Additional federal funding was allocated to this program in 2021 to expand to other states and regions.



Part 3:
Getting Started



Chapter 4: Making the Case: Establishing the Value of BHI



The Importance and Impact of an Integrated Approach

Practice leadership is a prerequisite to BHI, and without it, integration is unlikely to succeed. Sharing the evidence-based outcomes of BHI with leadership will allow them to see the importance 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 providers more confidence to fully support their patients' needs and their ability to effectively manage their overall health. Collectively, this reduces the dependence on primary care providers while increasing satisfaction on both sides.

The American Psychiatric Association's [Practice and Billing Toolkit](#) offers sample provider 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 Collaborative's webinar, "[Beating Physician Burnout with Behavioral Health Integration.](#)"

Making the Case

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

The impact of these illnesses can be substantial and creates a significant burden for the individuals living with them, their families, 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 behavioral health care and accessing treatment, watch the Collaborative's webinar, "[Advancing Health Equity through BHI](#)."

According to the Center of Excellence for Integrated Health Solutions, as many as 40% of all patients seen in

primary care settings have a mental illness,ⁱⁱ and given that mental and physical health problems are often interwoven, as many as 70% of primary care visits stem from psychosocial issues.^{xv} While patients may initially present with a physical health complaint, data suggests that underlying behavioral health issues are often triggering these visits.^{xv}

Data released by the Centers for Disease Control and Prevention demonstrates the need for integrated care is more evident than ever before. This data found people are experiencing three times the symptoms of anxiety disorder (25.5% vs. 8.1%) and four times the prevalence of depressive disorder (24.3% vs. 6.5%) than those reported in the second quarter of 2019, with racial and ethnic minorities and essential health care workers being more impacted. In addition, there was almost an 18% increase in suspected overdose submissions when comparing the weeks prior to and following the commencement of state-mandated stay-at-home orders.^{xvii}

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 behavioral health issues do not receive the care they need.ⁱⁱ



TIP:

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

For more information on telehealth implementation and services, see the various resources from Collaborative members such as the [AMA](#), [APA](#), [AACAP](#) and [AAP](#), in the *Resources* section under [Making the Case: Establishing the Value of BHI](#).

Identifying Integration Value

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 benefitsⁱ
- Deliver care more efficiently and effectivelyⁱⁱ
- Increase confidence and competence in addressing behavioral health issues^{ix}
- Connect more efficient care with increased number of patients who can then be billed for servicesⁱⁱ
- Increase in ability to earn pay-for-performance rewards based on reduction costs, patient satisfaction, and improved outcomes



PATIENTS

- Establish greater value in complete, comprehensive care, leading to healthier and more satisfied patients^{viii}
- 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 primary care physicians and other clinicians through maintained relationships
- May reduce overall health care costsⁱⁱ,
- More well equipped to fulfill one's roles in work, relationships, and other daily activitiesⁱⁱ
- Added support for families and caregivers of patientsⁱⁱ



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

Fair Compensation for Services and Justification for Additional Team Members

Compensation for integrated care, particularly behavioral health services in primary care settings, commonly relies on fee-for-service (FFS) payment; however, there are several ways to review, report, and track the value of behavioral health integration, including:ⁱⁱ

CAPACITY:

face-to-face time spent with patients out of the total time available

PRODUCTIVITY:

count of visits provided vs. projected

PAYMENT:

average payment for behavioral health services across all payers

COST:

average cost of behavioral health visits across all physicians and other health care professionals



CALLOUT:

While today FFS is the most commonly used method of payment for behavioral health 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 [APM Overview](#) from the Center for Medicaid & Medicare Services.

Practice Spotlight

A Case in Successful VBC Implementation

Oak Street Health (OSH), a nationwide system of primary care centers for Medicare-eligible adults, was interested in tracking their success based on sustaining optimal enrollment and positive patient experiences.

Within their value-based care practice model, OSH identified specific metrics to track the fidelity of this model, with the ultimate goal being to optimize actions shown to have the greatest impact on value. The metrics they aligned on included optimal patient enrollment, model effectiveness, universal screening, and repeat screening, using the [PHQ-9](#) as a specific data point.

As a result of universal depression screening (PHQ-9) of around 5,000 patients, roughly half have met the criteria to benefit from a BH program. Of those 2,500 individuals, about 1,000 have participated in a BH program and shown improvement in their PHQ-9. The OSH care model, which takes a whole person approach to mental and physical health and relies on the collaborative care model, has proven to show a six to one return on investment. This has allowed OSH physicians and other clinicians to prioritize patient outcomes over the total number of visits. Optimal enrollment and member retention allow OSH to engage patients over time and know their total cost of care. Of over 25,000 eligible patients (based on model criteria), OSH has treated more than 6,000. OSH has also demonstrated decreases in utilization of emergency room and inpatient stays for this cohort. The goal of the program is to demonstrate a year-over-year reduction in medical costs similar to the study results. Thus far, OSH is on trend to reduce medical costs by year two of enrollment for patients in the behavioral health program.

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

A Case in Successful FFS Implementation

When Northwestern Medicine began the process to integrate 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 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.

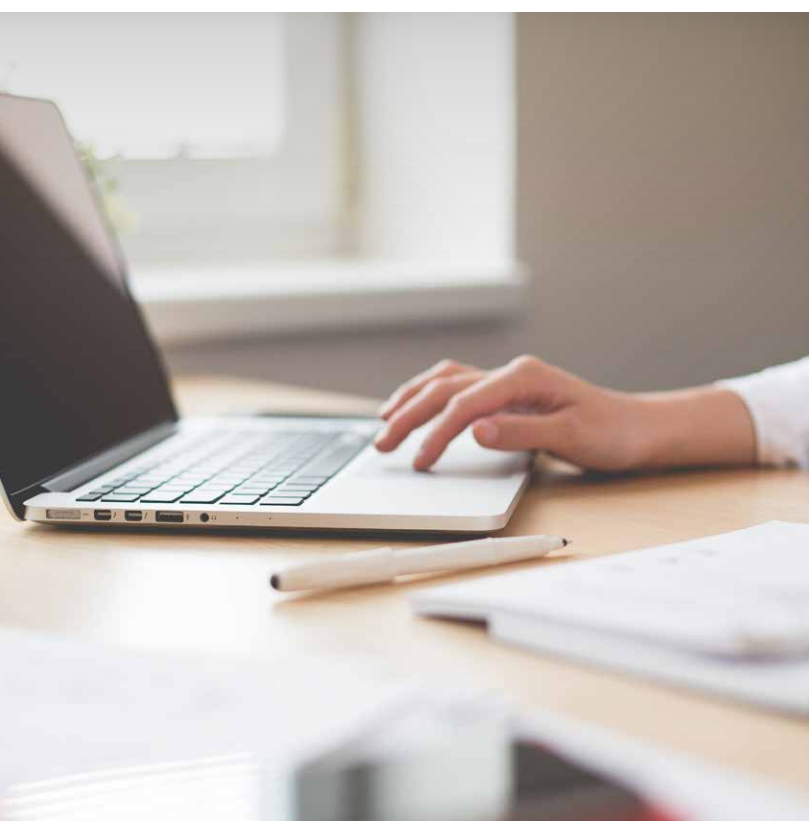
Their experience with the automated billing and coding process, which has now been expanded to 11 clinics, has identified gaps in documentation prior to claim submission, enables the team to appropriately allocate resources, and ultimately ensures patients are receiving clinically appropriate care.

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



MOVING FORWARD:

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



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 as well as 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 and measures 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 with 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](#), [EPDS](#), etc.?
- Do you have partnerships in place for timely referrals?

If you answered “yes” to any of these, you have already begun to integrate BH into your practice.



MOVING FORWARD:

There are various [self-assessment tools](#) available to help you better understand your practice's readiness for implementation.

Chapter 6: Establishing Goals and Metrics of Success

Set Goals: Progress over Perfection

Integration of behavioral health 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.



TIP:

If an EHR is not an option for your organization or practice, standalone software solutions are available that can help facilitate the delivery of critical informatics support needed for successful integration of a variety of mental health conditions.

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 behavioral health 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.

Identify Metrics of Success

Whether a single practice or multiple provider 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 reimbursement. [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 progress of behavioral health integration, 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
- Appointment adherence
- [Patient assessment scores](#) (PHQ-2, PHQ-9, C-SSRS, GAD-7)
- Hospital admission (reduced visits to emergency department)
- 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)



MOVING FORWARD:

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

- Improvement Rate – Number and proportion of patients seen for treatment for 70 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 5 points and to a final total score of less than 10 (Target 50%, Acceptable 35%)
- Consultation Rate – Among those in treatment for 70 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%, Acceptable 60%)
- Change in Treatment Rate – Among those in treatment for 70 days or greater who did not improve, proportion who had a change in treatment (Target 75%, Acceptable 60%)

Chapter 7: Aligning the Team



Anatomy of the Team

In a physician-led, team-based behavioral health model of care, the entire team—the primary care physician, behavioral health specialist, nurses, medical assistants, psychiatric consultant, etc.—*works together* to provide collaborative 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 (FQHC) or Rural Health Clinics (RHC) 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 provider and the needs of their population when determining if there is a need for an on-site, on-call or virtual BH specialist, 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:

- Talk to the patient/family and hear their concerns about BH
- Implement screening and monitoring tools for mental health disorders, make the diagnosis and/or determine the level of severity, initiate treatment, and [manage medications](#)
- Supervise the hands-on work of the behavioral health specialist and collaborate in frequent case conferences with the team to identify patient needs and opportunities for improvement

Medical assistants or nurses:

- Assess patients' mental health needs by actively listening to patient responses and reviewing responses to screening questions on the pre-visit questionnaire
- Flag any concerning responses to the primary care physician and/or BH specialist

Behavioral health specialists/care coordinators:

- Participate in pre-clinic huddles; monitor symptom severity, treatment adherence, and side effects; report results to the primary care physician and/or the consulting psychiatrist
- Provide lifestyle counseling to address anxiety, depression, sleep disturbances, weight loss/gain, exercise, and smoking cessation, and identify social-service needs
- Use motivational interviewing, problem-solving therapy, behavioral activation, and grief support:
- For practices managing patients with addiction, behavioral health specialists can support patients' addiction treatment, dosing, and recovery in

- consultation with the primary care physician
- For pediatrics specifically, participate in shared visits for children and youth, provide support to parents, communicate with childcare providers, teachers, and school guidance counselors
- *Note: The BH specialist may be a psychologist, licensed social worker or nurse, or another individual trained in mental health/SUD, health education, or lifestyle counseling*

Consulting psychiatrists:

- Assist with case conferences to review challenging cases of patients with behavioral health conditions
- Collaborate with the primary care physician and/or behavioral health care manager about diagnosis and treatment planning
- Support knowledge transfer to help primary care physicians understand how to care for people with mental health and [substance use disorders](#)
- Increase acumen of primary care team through means such as brief didactics and case review to improve not only the patient being discussed but also to better inform approaches to future patients who may present with similar issues and diagnoses

Note: The psychiatrist is available to consult in-person or virtually with the behavioral health specialist and the primary care physician on the management of patients.



TIP:

Creating a vision statement can be an effective way to establish alignment amongst the team and overall commitment to BHI. The [AIMS Center's Creating a Shared Vision for Collaborative Care resource](#) provides a useful guide on how to create a vision statement, ways to make it operational, and how to further iterate.

CALLOUT:

For smaller practices or those in areas with limited resources, a behavioral health specialist 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 Collaborative's webinar, "[Effective BHI Strategies for Independent Practices](#)."



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.

Establishing a Successful Partnership

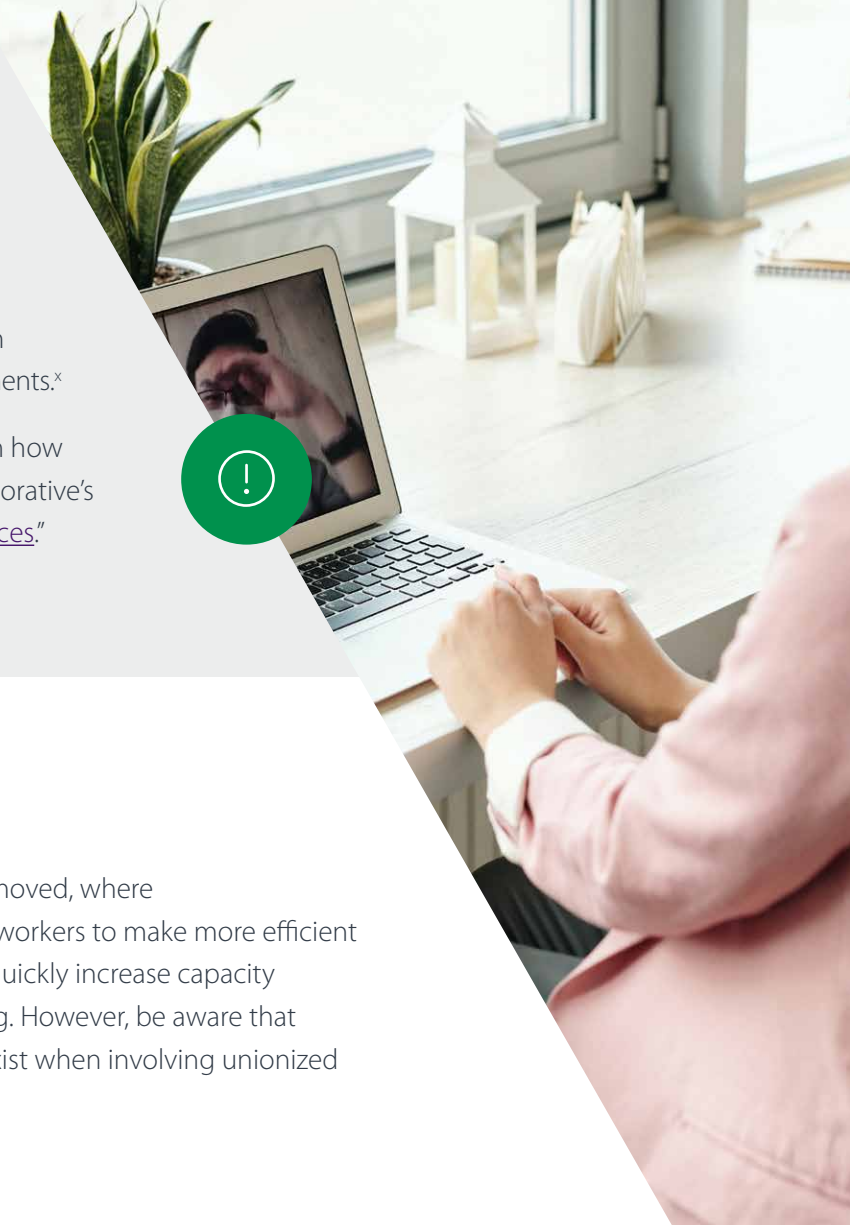
Successful partnerships are characterized by effective *collaboration, communication, and coordination* between psychiatrists, BH specialists, primary care physicians and other clinicians, and the patient and patient's family (where applicable). Continuing education, reminders, and training opportunities for team members, including the behavioral health specialist, nurses, and medical assistants, will help the care team continue to build their skill set and more fully apply their behavioral health knowledge in their daily interactions with patients.



MOVING FORWARD:

Identify team members, physicians, and other clinicians with whom to partner to better align your team.

For more information on care team roles and relationships, see the Medicare Learning Network's [Behavioral Health Integration booklet](#).



Part 4: Implementation



Chapter 8: Designing Workflow



Preparing for and Designing an Updated Workflow

When a patient requires a behavioral health 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 specialist? [Create processes and protocols for the entire care team](#) to recognize their roles and when the behavioral health specialist should become involved. Also, ensure each team member knows which aspects of patient follow-up are their responsibility and which belong to the behavioral health specialist. This should be reflected in shared practice protocols under the physician's leadership.

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/family about any BH concerns
Screening for BH	BH screening performed (incorporated as a part of the office visit)
BH Positive Indication	Positive screen (indicating depression, substance use, etc.)
Discussion with Patient	Physician discusses the diagnosis/status with the patient and/or caregivers 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	Physician continues to oversee the patient's care, including prescribing medications, treating medical conditions, and making referrals to specialty care

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



CALLOUT:

[Workflows](#) differ based on clinical diagnosis, severity, practice type, and available clinical resources.

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. Apply a “population” perspective to gain understanding of the behavioral health needs of children, youth, and adults in the community. This could be as simple as incorporating discussion into a weekly team meeting or huddle.

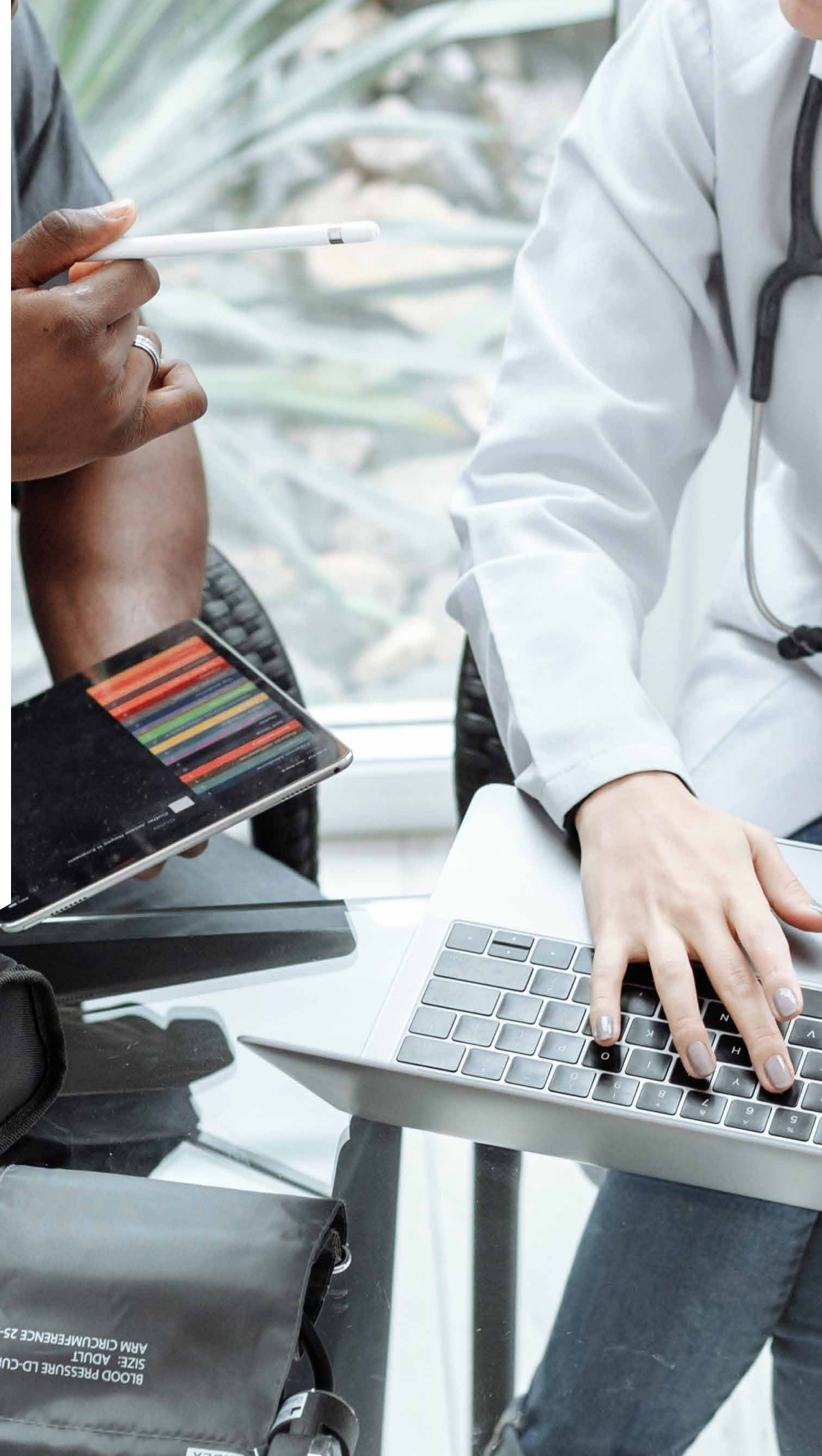
Take steps to:

- Inventory community mental health and addiction resources
- Develop or strengthen relationships with mental health advocates, schools, human service agencies, mental health and substance use treatment specialists, and developmental specialists
- Collaborate on system-focused initiatives such as filling gaps in needed services and care coordination and developing community protocols for managing psychiatric emergencies and overdoses
- Address stigma by discussing it openly within your practice and with your community partners



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 mental health 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 mental health 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 Collaborative’s webinar, [“BHI in Practice: Establishing Efficient Workflows.”](#)



MOVING FORWARD:

For a tool to assist you in designing workflows, see the [AMA’s BHI Workflow Plan](#).

Chapter 9: Preparing the Clinical Team



Steps to Prepare the Care Team

Successful integration of BH 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:^{xx}

- 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 primary care physician, psychiatrist, and/or BH specialist 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 non-judgmental, 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 clinicians 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 the Collaborative Care Model, see the APA's free [online training program](#).



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 creating an action plan with patients/caregivers.

Implementing Team-based Behavioral Health Integration^x

Know how and when to perform mental health assessments:

- Team members who will be conducting pre-visit planning and rooming patients should be trained on how to perform a mental health screening using a validated questionnaire, such as the Patient Health Questionnaire-2 (PHQ-2) and/or the Patient Health Questionnaire-9 (PHQ-9)^{xxi,xxii}
- 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 mental health conditions should prompt a behavioral health assessment and, potentially, a behavioral health referral. For a patient who is experiencing one or more of these stressors, the front-line clinician may recommend that the behavioral health specialist 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 and family/caregiver understand why a behavioral health 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 behavioral health assessment and care are provided "in addition to" their usual care



MOVING FORWARD:

For additional training resources, see the Department of Veterans Affairs' Center for Integrated Healthcare [training manuals](#).

Chapter 10: Partnering with the Patient



Engaging Patients and Caregivers

It is important that care teams explain the “why and how” of integrated care to patients and family/caregivers by:^{xviii}

- 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 physicians and other clinicians in ways that help address the patient’s confusion or fears about their situation or meeting someone new
- Offering hopeful, encouraging, understanding, reassuring, and acknowledging comments and avoiding dismissive or blaming comments
- Educating patients about their clinical situation and care, involving parents, families, guardians, or caregivers as appropriate to age, developmental stage, and circumstance (for more information on promoting social-emotional health among [young children and teens](#))
- Describing the screening process and explaining the results (*Note: In pediatrics, screening starts early for promotion, prevention and early identification*)
- Helping patients understand the commitment of the primary care team and behavioral health specialists to whole person care and address any concerns they may have with their care or barriers to receiving it
- Educating patients on what constitutes a behavioral health emergency and who to contact based on their specific needs

Best Practices to Partner with the Patient^{xviii}

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

- **Start Early:** Let your patients (and/or their parent(s), caregiver(s), etc.) know early in the relationship of the importance of addressing both physical and mental health. Let patients/caregivers know they should feel free to bring up any questions or problems during visits
 - **Look Out for the Red Flags and Risk Factors:** Understand and look for the warning signs of mental illness and substance use, listen to patient and caregiver concerns, and connect them to mental health specialists and specific resources. Additionally, understand risk factors for children and families in regard to caregiver health and well-being, social determinants 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 along with the family (if appropriate) 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
 - **Provide Resources:** Make resources available in waiting rooms and exam rooms. These could be fact sheets, guides, pamphlets, and/or brochures about behavioral health and 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 Collaborative’s webinar, “[Privacy and Security: Know the Rules for Communication of Behavioral Health Information.](#)”
 - **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 behavioral health decision or change. When utilizing this method, follow the “RULE” approach:^{xxiii}
 - *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



MOVING FORWARD:

The American Academy of Pediatrics offers [best practices in patient communication](#) that apply to children and families, and adults.

Chapter 11: Financial Sustainability: Billing and Coding



There is no one-size-fits-all financial model for BHI. Many practices primarily support their BHI efforts through fee-for-service (FFS) billing alone, utilizing relevant BHI codes and working directly with their local commercial health plans or self-insured employers. Some practices leverage their participation in alternative payment models (APMs) (or other value-based care contracts) to support their behavioral health integration efforts. There are many payment models to consider in addition to FFS, and no matter which you choose, the ultimate goal is sustainable delivery of high-quality care.



WATCH OUT:

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

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



TIP:

As many health plans and insurers are encouraging models of care that incorporate the use of a consulting psychiatrist 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 mental health condition.^x

BHI Billing Under Medicare

[Medicare pays for integrated BH services](#) provided to patients,^{xxv} including assessments, monitoring, and care planning performed by clinical staff, as well as psychiatric collaborative care services.^{xxvi}

BHI Billing Under Medicaid

Medicaid is the single largest payer for mental health services in the United States and is increasingly [playing a larger role in the reimbursement](#) of substance use disorder services.^{xxvii} The Centers for Medicare & Medicaid Services are responsible for implementing laws passed by Congress related to Medicaid, and the Medicaid program is funded by both the federal and state governments. The joint funding models allow each state the option to charge premiums and/or develop cost sharing. Providers 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, may require month-to-month collection based on Medicaid eligibility, or may require reporting the amount collected to the Medicaid program prior to claim payment. Note that most Medicaid recipients are children and adolescents (0-21 years) and do not have co-pays. Medicaid premiums and cost-sharing requirements differ by state, so check your state Medicaid program requirements for specific details.^{xxviii}

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 behavioral health services to their beneficiaries and employees.



CALLOUT:

The Medicare BHI codes are not limited to beneficiaries with certain behavioral health conditions; codes may be used to treat patients with any behavioral health condition (e.g., anxiety, depression, insomnia). Payment for these services requires that there be a presenting mental, psychiatric, or behavioral health 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.^{xxiv}



MOVING FORWARD:

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

Relevant Codes

The following are various Current Procedural Terminology (CPT®)/HCPC codes relevant to BHI.^{xix} While this list is not exhaustive, it can serve as an initial starting point:

Counseling Risk Factor Reduction and Behavior Change Intervention	<ul style="list-style-type: none"> Preventive Medicine <ul style="list-style-type: none"> 99401, 99402, 99403, 99404 (Individual) 99411, 99412 (Group) Behavior Change Interventions <ul style="list-style-type: none"> 99406-99407 Smoking and tobacco use cessation counseling visit 99408-99409 Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention (SBI) services
Psychotherapy	<ul style="list-style-type: none"> 90832, 90834, 90837 Psychotherapy (30, 45, 60 min) 90833, 90836, 90838 Psychotherapy when performed with E/M service 90853 Group Psychotherapy
Developmental/Behavioral screening	<ul style="list-style-type: none"> 96127 Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument 96110 Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument 96161 Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
Adaptive Behavior Services	<ul style="list-style-type: none"> Address deficient adaptive behaviors, maladaptive behaviors, or other impaired functioning secondary to deficient adaptive or maladaptive behaviors (e.g., instruction-following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care, daily living, personal safety) 97151, 97152 (Assessment) 97153-97158 (Treatment)
Health Behavior Assessment and Intervention	<ul style="list-style-type: none"> Focus on psychological, behavioral, emotional, cognitive, and interpersonal factors, and factors complicating medical conditions and treatments 96156-96171 (Individual, Group, Family)

Care Management	<ul style="list-style-type: none"> 99484 General Behavioral Health Integration Care Management 99492-99494 G2214 Psychiatric Collaborative Care Management
Inter-professional Digital Services	<ul style="list-style-type: none"> 99446-9, 99451 Professional-to-professional digital consultation, billable by the consulting psychiatrist 99452 Professional-to-professional digital consultation, billable by the primary care professional
Cognitive Assessment and Care Plan Services	<ul style="list-style-type: none"> 99483 Provided when a comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology, and severity for the condition Thorough evaluation of medical and psychosocial factors, potentially contributing to increased morbidity



MOVING FORWARD:

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

Chapter 12: Measuring Progress



Behavioral health integration 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 Modelsⁱⁱ

Value can be measured in a variety of ways, including but not limited to:

- Productivity: Increased access to behavioral health services, which can drive primary care physician efficiency
- Health outcomes: Improved patient health outcomes, including meeting quality measures, is consistent with successful integration
- Patient, family/caregivers, and care team satisfaction: Providing proactive, quality care to meet the patients' needs improves satisfaction
- Engagement: With a diverse skill set due to BHI training, behavioral health specialists can, and should, provide multiple kinds of visits such as helping patients with self-care, individual or group treatment, "warm handoffs" or other introductory visits, and group sessions to promote engagement

TIP:

Behavioral health team updates should be on the agenda at regular team meetings. This gives the entire team the opportunity to evaluate team 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 BH 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



MOVING FORWARD:

For additional information regarding benchmarking and established tools to measure success, watch SAMHSA-HRSA's Center for Integrated Health Solutions [Benchmarking Webinar](#).

A photograph showing a person in a purple lab coat pointing at a tablet held by another person. The scene is set in a clinical or office environment with a desk, a clipboard, and a stethoscope visible. A large purple diagonal overlay covers the left side of the image.

Part 5:
Resources & Tools

PART 5: RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 2: BHI BASICS AND BACKGROUND				
Chapter 3: Introduction to Potential Approaches to BHI	The Six Levels of Collaboration/Integration	The 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?daf=375ateTbd56
	CoCM Information and Details	This website provides further information and detail on the CoCM specifically, including free training.	American Psychiatric Association (APA)	https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
	SBIRT Model of Care	For more information on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model of care, this change guide assists primary care physicians and other clinicians in integrating care for patients with unhealthy alcohol and/or drug use into routine medical care.	National Council for Behavioral Health	https://www.thenationalcouncil.org/wp-content/uploads/2020/08/021518_NCBH_ASPTReport-FINAL.pdf?daf=375ateTbd56
	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

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 2: BHI BASICS AND BACKGROUND				
	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 providers 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/
	Maternal and Child Health Initiative	Reference this site for information on the Maternal and Child Health Bureau, which aims to promote mental 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
PART 3: GETTING STARTED				
Chapter 4: Making the Case: Establishing the Value of BHI	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?daf=375ateTbd56
	Comparing Payment Models for RHCs and FQHCs	Refer to the table on pages 17–19 to compare the 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.	CMS.gov	https://qpp.cms.gov/apms/overview

PART 5: RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 3: GETTING STARTED				
	Innovation Models at State Levels	Utilize the map available on this site for information on innovation models run at the state level.	CMS.gov	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/
	Tracking the Business Case: Costs of Physician Burnout	Access this site for an interactive calculator to calculate the costs of physician burnout 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/2020-04/ama-telehealth-playbook.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/
	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

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 3: 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/QATI_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
	MeHAF 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/sites/default/files/resources/MeHAF-Facilitation-Guide-Tool_190128.pdf
Chapter 6: Establishing Goals and Metrics of Success	Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration: Two Major Benchmarking Tools	Access this PDF to utilize two major benchmarking tools: The Administrative Readiness Tool (ART) for Primary Health Behavioral Health Integration and the COMPASS-Primary Health and Behavioral Health.	SAMHSA-HRSA Center for Integrated Health Solutions	https://www.thenationalcouncil.org/wp-content/uploads/2020/01/QATI_Overview_FINAL.pdf?dof=375ateTbd56
	Behavioral Health and Substance Use Quality Measures Portfolio	This site contains a portfolio of behavioral health measures for practices to track towards.	National Quality Forum	https://www.qualityforum.org/QPS/QPSTool.aspx
	Behavioral Health and Substance Use Quality Measures	Visit this site for information on the National Quality Forum's portfolio of behavioral health measures for practices to track towards.	National Quality Forum	http://www.qualityforum.org/ProjectDescription.aspx?projectId=86054
	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

PART 5: RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 3: GETTING STARTED				
Chapter 7: 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
	Identifying Local Resources	Through FindHelp.org, information regarding locating and accessing local behavioral health 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 mental health services.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/Sources_of_Key_Mental_Health_Services.pdf
PART 4: IMPLEMENTATION				
Chapter 8: Designing Workflow	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
	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 providers in assessment and treatment of perinatal mental health 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 providers who treat pregnant and postpartum patients can use PSI's Perinatal Psychiatric Consult Line for questions about mental health care.	Postpartum Support International	https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 4: IMPLEMENTATION				
Chapter 9: Preparing the Clinical Team	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.colleaga.org/sites/default/files/attachments/OATI_Tool1_Partnership_checklist.pdf
	Get Trained in the Collaborative Care Model	Psychiatrists, primary care providers 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
	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
	Steps for Integrating Behavioral Health into Primary Care	U.S. Department of Veteran Affairs Veterans Integrated Service Network (VISN)	American Medical Association (AMA)	https://edhub.ama-assn.org/steps-forward/module/2702747
	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
Chapter 10: Partnering with the Patient	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)	http://www.wvdhhr.org/rfts/pdf/social_emotional_tips.pdf
	Implementing Mental Health Priorities in Practice: Strategies to Engage Patients and Families	This resource consists of videos demonstrating examples of patient/family encounters that encompass the most difficult conversation areas for various mental health topics.	American Academy of Pediatrics (AAP)	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/introduction.aspx

PART 5: RESOURCES & TOOLS

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 4: IMPLEMENTATION				
	Mnemonic for Communication Best Practices	This document contains helpful considerations for communication methods when working with patients.	American Academy of Pediatrics (AAP)	https://downloads.aap.org/AAP/PDF/Mnemonic_for_Common_Factors_Communication_Methods_Help.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
	Motivational Interviewing Resources	Clinical resources for learning how to implement motivational interviewing	Providers Clinical Support System	https://pcssnow.org/education-training/training-courses/principles-of-motivational-interviewing-useful-for-primary-care-physicians/
Chapter 11: Financial Sustainability: Billing and Coding	Billing, Workflow, and Administrative Tools for Successful Implementation of CoCM	Illustrates billing opportunities based on clinical staffing	Advancing Integrated Mental Health Solutions (AIMS) Center	https://vimeo.com/440768429/a32276f6fe
	Billing & Coding 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
	Codes for Services Under Medicaid	Refer to this PDF for details on services, codes, and rates for community and private mental health centers.	Medicaid.gov	https://medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf
	BHI Medicare Fact Sheet	This PDF offers an overview of the billing and coding requirements under CoCM.	CMS.gov	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

LOCATION	TITLE	DESCRIPTION	ORGANIZATION	LINK
PART 4: IMPLEMENTATION				
	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)	Coverage for Psychiatric Collaborative Care Management (CoCM) Codes (CPT Codes 99492 – 99494)
	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
	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_developmentalscreening_testingandEmotionalBehavoraassessment.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://www.cfha.net/general/custom.asp?page=PCBHFAQFunding
Chapter 12: Measuring Progress	Using Benchmarking to Drive Successful Integration	Watch this CIHS and SAMHSA-HRSA Webinar on the use of benchmarking for information on how benchmarking can drive successful behavioral and primary care integration.	SAMHSA-HRSA Center for Integrated Health Solutions	https://www.youtube.com/watch?v=YqgnDbqRMDA&index=7&list=PLBXgZMLzqfTcBUREZpGi3zi3Yqu7uIDF

FOOTNOTES

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