CREATING A CULTURE OF WHOLE HEALTH

Recommendations for Integrating Behavioral Health and Primary Care



EUGENE S. FARLEY, JR.
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Multi-Method Findings Aligning the Literature, Interviews, Focus Groups, and a National Leader Summit

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EXECUTIVE SUMMARY

Fragmentation in healthcare delivery presents multiple, significant barriers that prevent the creation of a culture of health. This fragmentation is most clearly demonstrated through the artificial separation of "mental" health from "physical" health. This separation plays out in numerous ways throughout communities and in our families, but almost always comes back to a need for intentional integration at all levels to achieve a foundation for better health.

In service to improving outcomes, decreasing costs, and enhancing the experience for all in a culture of health, integrating behavioral health and primary care is one solution that holds great promise. While predominately a healthcare strategy, integration of care attempts to address the comprehensive needs of patients, families, and communities in whatever setting is most appropriate for the person. However, at its fullest extent, integrating care goes beyond the walls of a clinic where clinicians from different backgrounds and different clinical cultures come together to collaborate around patient care. It is in our communities where we must end the distinct and separate histories and management of mental health from physical health; we need to change the dialogue to focus on whole and inclusive health for all people.

Despite an abundance of evidence demonstrating the connections between mind and body, a disconnect remains between behavioral health and primary care. One must ask, if integrating care is such a promising solution, what prevents it from happening?

To better understand and elucidate the barriers to integrating behavioral health and primary care, we gathered perspectives from more than 70 key informants and conducted two focus groups to expand upon findings from a literature review, and developed recommendations to advance efforts for integrating behavioral health and primary care. The interviews were distilled into a preliminary report and presented to a convening of leaders in Washington, DC, for the National Leader Summit on Integrating Behavioral Health and Primary Care, August 2015. Leaders worked for two days using facilitation and small group activities to further define topics from the preliminary report into more concise recommendations for targeted audiences to advance the integration movement.

As highlighted throughout this document, the resulting recommendations are prioritized, actionable and, in some cases, interdependent. This report goes well beyond discussing the barriers that have stilted progress and offers specific recommendations in six key areas to accelerate efforts toward optimizing integration of care.

70
key informants

2
focus groups



developed recommendations



national leader summit

INTRODUCTION

Parks are often filled with paths of beaten down grass where people have chosen to walk where there was no sidewalk. These paths, probably started by one person deciding it was the easiest way to get to her destination, likely wore down over time due to more and more people making the same decision; one person's shortcut became an entirely new path. Was this a failure in design? Did the park lack a necessary path that was then created by people to get to where they needed to go? While such questions may not have consensus answers, they highlight "desire lines," paths created by people as a route to their destination. "Desire lines" may be helpful when we think about improving health and healthcare.

We have a design problem in healthcare.

Like a favored and newly trodden path that abandons the engineered sidewalk, people seek care in a single setting. Multiple paths make it more challenging to reach the destination due to complexity, unavailability or lack of visibility. For example, while the sidewalk for mental healthcare traditionally leads to the specialty mental health system, patients' "desire lines" are bringing them to primary care. Similarly, physical healthcare is often needed but unavailable in mental health settings. As stated in the Institute for Medicine's book, Primary Care: America's Health in a New Era, "Mental health care cannot be divorced from primary medical care, and all attempts to do so are doomed to failure. Primary care cannot be practiced without addressing mental health concerns, and all attempts to do so result in inferior care."[1]



A culture of health could be enabled by closing the artificial division between mind and body and focusing, instead, on health and wellness that addresses comprehensive, whole person care.[2,3]

> The integration of *physical and mental* healthcare at the community level could provide whole-person care that is flexible, personalized, and seamless.

There is no wrong path or no wrong door in a properly constructed system; and whether people understand their health needs as emotional, behavioral, or physical, their needs can be addressed without stigma in a comprehensive fashion. In a system supporting a culture of health, the desired path is available, accessible and affordable and should lead to no wrong door.

In 2015, the Robert Wood Johnson Foundation commissioned the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado School of Medicine to explore and articulate recommendations to advance integrated behavioral health and primary care as one strategy to support a culture of health. To this end, the Farley Center led a series of activities:



- Review pertinent **literature**;
- Conduct **key informant interviews and focus groups** to collect expertise regarding integrated behavioral health and primary care;
- Convene a **national leader summit** to identify barriers and facilitators of full-scale adoption of integrated behavioral health and primary care;
- **Formulate prioritized recommendations** for RWJF and other stakeholders describing systematic changes to advance clinical, operational, financial, training, and policy opportunities for integrated care to help achieve a culture of health.

This report presents topic areas that emerged from steps one, two, and three, organized into sections that include a series of prioritized recommendations. Each section has its own recommendations; however, it is important to note that sections are not independent from one another. The figure above demonstrates the interdependence of identified barriers that together represent opportunities to advance integrated care. The icons are used in this report as one way for readers to keep track of the total picture while attending to particular issues.

While integrated care at the community level does not guarantee a culture of health, this assessment assumes that under proper conditions, it could be a high-impact strategy. To create a culture of health, it is possible that new desire lines for integrated care are needed. Patients, families, and communities have identified a need for integrating behavioral health and primary care. Where such care has emerged, it appears to improve health and healthcare and contain costs.[4,5] This report is intended to be an actionable catalyst to accelerate substantive change, minimize barriers, and offer promising solutions to move integration forward. This report is meant to further encourage the national movement that has emerged on integrating behavioral health and primary care.

METHODOLOGY

Literature Review

The literature review on behavioral health and primary care integration, conducted in collaboration with a librarian at the University of Colorado Health Sciences Library, examined both peer-reviewed and grey literature. This was not a systematic review or a meta-analysis, but a scan to provide context for the key informant interviews. We gathered literature published from 2000 to 2015 using the following search terms: organization, administration, policy, policies, state government, provincial government, federal government, national government, agency, health policy, models, programs, integrated behavioral health, integrated primary care, integrated health, mental health, primary care, delivery of healthcare, delivery of integrated care, barriers, access, and health services accessibility. Thematic analysis of the literature informed development of the key informant interview and focus group guides. See Appendix A for the literature review bibliography.

Key Information Interviews and Focus Groups

A multidisciplinary research team with content expertise around integration conducted the key informant interviews and focus groups. The project team worked with partners at the RWJF and members of the Agency for Healthcare Research and Quality (AHRQ) National Integration Academy Council (NIAC) to identify the first wave of key informants. Using a snowball sampling technique, we added additional key informants to the interview list. We invited key informants to participate via email. Up to three invitations were sent before excluding the individual from the sample. Eighty-seven key informants were initially invited to interview; five declined participation and five did not respond. We completed a total of 77 key informant interviews, as well as two focus groups (n=12). Participants for focus groups were recruited from a federally qualified health center and an integrated academic residency practice proximate to the research team. From these settings, we included behavioral health trainees and family medicine residents who work in integrated behavioral health and primary care settings.

All interviews and focus groups were recorded and transcribed. These data, with interviewer notes, were analyzed using an inductive thematic content approach.[6] Our qualitative analyses explored barriers to integration, recommendations for management, and funding opportunities to improve integration. Appendix B lists key informants, and Appendix C contains the interview and focus group guides.

National Leader Summit on Integrating Behavioral Health and Primary Care

A subset of key informant interviewees subsequently attended a working meeting in Washington, DC: our *National Leader Summit on Integrating Behavioral Health and Primary Care*. Ten additional experts, including RWJF staff, participated in the Summit. In total, 57 people attended the two-day event, representing multiple disciplines with varied degree of content expertise in integration. All summit participants received preparatory information, including a report comprised from the key informant interviews, focus groups, and literature review articulating identified barriers and recommendations. Participants were assigned to facilitated workgroups and tasked to develop and refine recommendations for advancing integrated behavioral health and primary care. A list of Summit participants is included in Appendix D.

DEFINITIONS

This project and report adopt definitions from the AHRQ Lexicon for Behavioral Health and Primary Care Integration.[7] These definitions are provided below to ensure consistency across project participants, readers, and stakeholders.

Integrated Behavioral Health. The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.

Mental Health Care. Broad array of services and treatments to help people with mental illnesses and those at particular risk of developing them—to suffer less emotional pain and disability and live healthier, longer, more productive lives. Although often defined separately, substance abuse services sometimes are regarded as part of mental health care.

Chemical Dependency/Substance Use Care. Services, treatments, and support to help people with addictions and substance abuse problems of all kinds suffer less emotional pain, family and vocational disturbance, and physical risks and live healthier, longer, more productive lives. Sometimes included under "mental health care."

Behavioral Health Care. A very broad category often used as an umbrella term for care that addresses behavioral problems bearing on health, including patient activation and health behaviors, mental health conditions, substance use, and other behaviors that relate to health. In this sense, behavioral healthcare is the job of all kinds of care settings, and is done by clinicians and health coaches of various disciplines or training, including but not limited to mental health professionals. It is a competency of clinics, not only of individuals.

For more on the AHRQ Lexicon, including specific parameters for integration, see Appendix E.



ORGANIZING THE MOVEMENT

Integration of behavioral health and primary care requires not only organizational restructuring but also a substantial cultural shift. Across the country stakeholders across the community are leading this charge towards change. In fact, this alignment of cause has led many to work together towards a shared agenda. Said differently, integration has truly become a movement, and all movements need organization to scale; all movements require organization and planning for iterative change.

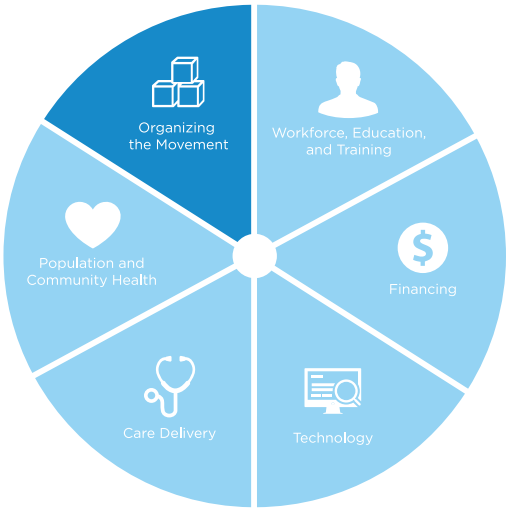
Central to the notion of a movement is the need to clearly establish what is and is not within the parameters of the movement. Integrating behavioral health and primary care is no different than other movements in that it needs organization to align all the disparate innovators dispersed across the country. Without establishing certain tenets of organization, efforts to integration will remain disconnected and have isolated impact. Organizing the movement requires the collective stakeholders in healthcare to come together on certain key elements, which when agreed upon, can help lead towards scaling, generalizability, and collective impact. To begin, there needs to be consensus on the definition of integrated care and technical assistance to operationalize concepts.

ORGANIZING THE MOVEMENT

Defining Integrated Care

Creating a new approach to healthcare requires simultaneously developing new rules and definitions. For most new fields or scientific developments, there is a process by which the field, discipline, or approach is clearly defined and explained. For behavioral health and primary care integration, this definition has been elusive because integration may be interpreted differently depending on who you are, where you are, and what you do. The process for achieving a consensus definition is multifactorial but the outcome is unifying.

Consistently defining what is and is not integration has proven to be a significant barrier for advancing and scaling successful approaches. Multiple stakeholders describe a challenge of consistently redefining integration in their respective communities. Problems associated with defining behavioral health are an additional concern. Despite various tools developed to help define integration, such as the Agency for Healthcare Research and Quality's Lexicon for Behavioral Health and Primary Care Integration and SAMSHA-HRSA's Center for Integrated Health Solutions definition, many key informants and leaders describe a need for more. Lacking is the information on how to apply a definition to certification, quality, and measurement of behavioral health and primary care integration.



Recommendations:

- Develop a comprehensive guide suited for federal agencies, foundations, payers, and other stakeholders to define, standardize, and operationalize integrated behavioral health and primary care as a basis for providing technical assistance.
- Create an audit tool that can be used to assess integrated settings including criteria and components necessary to operationalize integrated care.

Technical Assistance

Consistently, stakeholders report a profound need for technical assistance at multiple levels to achieve integration. There is a lack of knowledge as to how to help transform delivery systems that integrate primary care and behavioral health. As more states, practices, and communities work to integrate, there will be an increased need for varied types of technical assistance to support integration at multiple levels. For example, individual practices may seek clinical support to address workflow and team building, while states may need assistance for transforming policy and payment options. Existing technical assistance centers focus on pieces of improving integrated work (e.g., SAMHSA-HRSA's Center for Integrated Health Solution, Institute for Healthcare Improvement), however they are not generally available for public access, limit focus to clinic-level integration, and are not coordinated in their efforts to make a stronger collective impact nationally.

Recommendations:

» Invest in a national technical assistance center focused on state health policy to provide direct consultation and support to local communities on work related to behavioral health and primary care integration. For example, the technical assistance center could address federal, state, and local policies and regulations to revise and harmonize differences and assist local entities in overcoming these barriers to enable patient-centered integrated behavioral health care. Collaborative efforts would engage and include stakeholders at varying stages or levels of the policy development and implementation: local and state government and policy makers, Medicaid and Medicare agencies, Federal agencies, and Federal policy makers.





WORKFORCE, TRAINING, & EDUCATION

The United States is fortunate to have a large healthcare workforce of both behavioral health and medical clinicians, but there is consensus that the requirements of the rapidly changing healthcare delivery system are exposing workforce shortages that impede full implementation of integrated models of care. Expanding the behavioral and medical clinician workforce will be insufficient without also addressing identified workforce deficiencies. This is likely to frustrate rather than accelerate integrated care efforts. A workforce that is well-prepared through education and training is absolutely central to making integrated care the norm for all people with mental, emotional, and behavioral conditions, including children, adolescents, and aging populations with co-morbid chronic conditions.

WORKFORCE, TRAINING, & EDUCATION



The Current Workforce

There is widespread agreement that the current clinical workforce lacks sufficient diversity, geographic distribution, and opportunity for inter-professional and intra-professional education and development. There is an immediate opportunity to create professional development programs to enable psychologists, social workers, counselors, nurses, physician assistants, physicians, and others to join and lead the movement to integrate care. One challenge will be to unite these groups around shared vision since each has its own philosophy and competencies that would need adaptation to meet core requirements of integrated care.

WORKFORCE ASSESSMENT

Workforce assessments, conducted to better understand the capacity and competencies needed for integrated care delivery, will provide valuable data to aid in scaling integration efforts.

Recommendations:

» Establish or designate and invest in an entity to analyze specific integration workforce needs and capacity for states or localities. Describe the current and long term distribution of the workforce necessary to provide integrated care, with special attention to diversity and geographic proximity to populations being served.

» Develop assessment tools to measure the competency of the integration workforce at a community, practice, and provider level to assure consistency across care delivery sites and to measure progress improvement in systems and delivery of care.



STANDARD DEVELOPMENT

Critical competencies are known for behavioral health, primary care, subspecialty care, and more general inter-professional collaboration.

Recommendations:

» Create standards at both a practice and provider level for providing integrated care in accordance to an agreed upon definition of integration. These standards should be consistent with developed competencies.



CLINICIAN RE-EDUCATION

Behavioral health and medical clinicians and clinical faculty trained in prior decades may lack the knowledge and experience to practice in evolving interprofessional care settings.

Recommendations:

» Provide training endorsed by national professional organizations for licensed practicing healthcare professionals on the recognition and intervention of mental and behavioral health issues.

» Tie training requirements to updating credentials to practice, such as board certification or state licensing.

» Invest in a professional development program for the existing clinician workforce that delivers the foundational curriculum using adaptive educational approaches at local levels. Partners with existing educational entities including community colleges and professional societies.

» Establish and disseminate best practices for incorporating the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) in integrated care delivery.



The Future Workforce

Next generation clinicians will have the advantage of not having to "un-learn" habits and will possess an innate comfort with the information technologies that underlie both education and integrated care. The formation of professional identity can be sculpted to expect integrated care. There is some urgency to adjust and augment how next generation clinicians are educated to match the roles that practices, patients, and communities will be expecting them to fill.

Shared multi-professional, multi-disciplinary, and complementary curricula are foundational to preparing the future workforce for integrated care. These curricula will sustain core competencies in various fields of knowledge and service while adding new knowledge, attitudes, and collaborative skills of integrated care. These curricula must connect directly to all levels of healthcare delivery including primary care and subspecialty care, ambulatory and institutional care for all types of patients. Curricula must emerge from the current foundation of evidence and incorporate the duty and skills of continuous learning to improve integrated care. This is a tall order that calls for a revival of healthcare professionalism and an organizational framework capable of convening and directing relevant experts to produce the desired curricula in a relatively short timeframe. The next generation needs these advanced curricula to be properly prepared to meet the needs of people awaiting integrated care.

COORDINATE WORKFORCE INVESTMENTS

The moving of healthcare delivery toward integrated care depends upon coherent, coordinated investments that would benefit and be made more efficient if guided by an oversight organization.

Recommendations:

» Create an oversight organization committed to establishing the healthcare workforce people need. Such an organization would require a broad scope of action, crossing disciplinary and professional boundaries, and would benefit from strong patient voices and public participation.

PROFESSIONAL EDUCATION

Nurses, physicians, pharmacists, and all health clinicians spend vast hours committed to attaining knowledge and expertise regarding physical illnesses, including recognition of signs and symptoms to formulate diagnoses and determining management, treatment, or even cures. Considering the preponderance of behavioral and mental health issues and the human and financial costs of insufficient care, expanded mental and behavioral health education is sorely needed to train a broader array of professionals who will meet the public need.

Recommendations:

- Increase demand from nursing, medical, and pharmacy school certifying boards that all students are prepared to address mental and behavioral health issues, no matter what the field. Insist educational requirements on mental and behavioral diagnoses and interventions receive parity in value as physical diagnoses, including the strong message that mental and behavioral health disorders may have as severe morbidity and mortality as many physical disorders.
- Stimulate scholarly and clinical activities through grants, scholarships and faculty support to encourage interest in research, clinical care, and entrance into fields that enhance and embrace behavioral and mental health.
- Organize team-based care in emergency, ambulatory, and hospital-based settings in a way that all residents are prepared with the competencies required to appropriately triage and care for patients and families with behavioral health problems.
- Design and scale competencies for behavioral health providers working in primary care and partner with local colleges and professional societies to adapt these competencies to curricula that could be endorsed by relevant national licensing and board certification authorities.
- Organize and invest in a small workgroup to explore the inclusion of explicit education and training in integrated care with the entities now producing the clinician workforce. Organize technical assistance provision to advance inclusion of education and training.

CENTERS OF EXCELLENCE

Fundamental to development of a workforce that meets the needs of an evolved, integrated healthcare system are clinical settings where integrated care is modeled, studied, improved, and then replicated across the nation. These clinical settings, termed Centers of Excellence, should include diverse care settings (e.g., within an urban underserved community or a remote rural area) and have plans for recruitment of underrepresented learners and faculty, as well as interprofessional team development. Monitored activities may include: team function, patient outcomes (qualitative and quantitative), degree of community participation, consideration of social determinants, and workforce parameters such as recruitment and retention.

Recommendations:

- Enhance funding, through a competitive application process, for currently successful integrated care models (e.g., those found from the AHRQ Guidebook of Professional Practices for Behavioral Health and Primary Care Integration) to create five to seven highly functioning integrated settings across the nation that serve as both care and learning centers. Create regional centers of excellence that are accessible to local organizations as training and educational sites and are informative about the local environment and policies.

Community Education

A major barrier to whole person health is the lack of a widespread, shared understanding of the basis, frequency, and manifestations of mental, emotional, and behavioral problems. There are opportunities to marshal the capacities of families and resources within communities to work together with redesigned clinical systems to recognize and respond to people with mental, emotional, and behavioral problems. Just as the professions have different mental models, so do communities. Gaining the benefits of integrated care depends also on an educated public.



ENHANCE PUBLIC URGENCY

Day in and day out, the media reports deadly violence in our communities and our schools, drug overdose mortalities, and suicides, as our prisons and homeless shelters fill up with our untreated mentally ill. Unseen by the news cameras are millions, a quarter of the population, who never realize their life dreams due to undiagnosed and untreated depression, anxiety and other mental disorders.

Healthcare leaders faced with these sobering circumstances have an opportunity to guide the nation with a new vision by presenting the overwhelming evidence of the human and financial costs that can be averted through access to care to the public. This blind spot in our health system, our failure to recognize and treat mental health disorders early and effectively, is causing loss of life and of life's potential. Leaders must create a sense of urgency among our powerful health, education, and social institutions to recognize and respond to those of us struggling with behavioral health issues and who remain in the shadows due to shame and stigma.

By integrating access to behavioral health with physical health in care environments across the nation, mental and behavioral health can be de-stigmatized and accessible. Care providers must become more knowledgeable and comfortable helping people gain insight and decrease perceived humiliation associated with behavioral health issues they confront.

Recommendations:

- Create "Speakers Bureaus" and forums at major academic medical centers, national meeting plenaries, communities, schools and social agencies to share high level data regarding the human and financial costs of behavioral health issues. Call for a fundamental shift that equips and builds capacity for our health system to reclaim the loss of life and livelihood reorganizing health systems and building integrated primary care and mental health provider teams.
- Educate all professionals with public contact: police and the justice system, fire fighters and other first responders, and school teachers and counselors regarding the ABCs of mental health recognition, referral information, and intervention techniques.
- Create community assessments for integration. Leverage local data to aid the community on ways of telling of their stories through infographics, maps, etc.



FINANCING

One of the major barriers for integrating behavioral health and primary care is financing. Due to multiple historical artifacts that result in behavioral health being treated as a separate benefit that warrants separate payment, finding new and alternative payment models that sustainably support the concept of team-based, whole person care is challenging. Reforming how we pay for healthcare to better integrate behavioral health and medical care will benefit the patient, but also the system in achieving lower cost and improved outcomes.

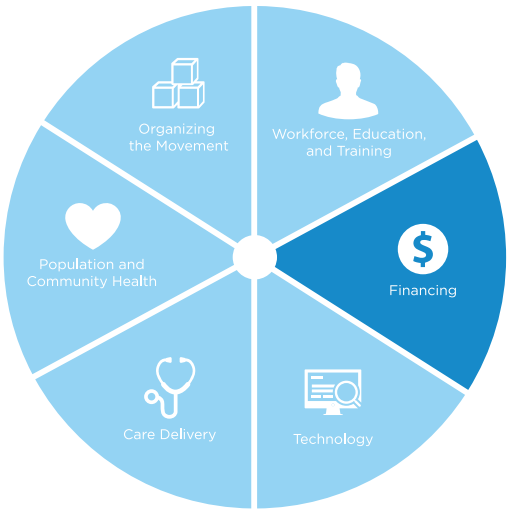
FINANCING

Payment Transformation: Establish a Framework for Alternative Payment Methodologies

In order to transform integration through payment reform, an aspirational direction is needed for financing integrated, whole person, team-based delivery of healthcare. However, due to the variability in readiness across the healthcare marketplace, there is no single pathway through which integrated care is operationalized. Accordingly, identifying incremental steps that align behavioral health and medical care payment models—pointing in the direction of the ultimate goal--has great utility for payers, providers, patients and their families, who will benefit from more seamless, efficient, and cost effective care. This movement toward value-based care is demonstrated by the Center for Medicare and Medicaid Services (CMS) who has created a value framework, to move from volume-based payments to more value-based payments.

As we move away from the current fragmented fee for service (FFS) payment model, the following incremental strategies are options that lead toward the desired goal for financing integrated care delivery supported by integrated payment for services. To be clear, there will remain a need for specialty mental health delivery that may have a different payment model, and will also incorporate quality and clinical measures to ensure that care improves people's health. However, for the purpose of supporting integration of behavioral health in primary care, the payment models we describe below are focused on the primary care setting.

A framework for establishing alternative payment methodologies to support the integration of behavioral health and primary care services, considers the community in which the practice operates and



incorporates variation in the local health care marketplace (e.g., payer mix, workforce, socio-demographics of patient panel). These various payment approaches should reinforce the concept of the team and not the individual provider, therefore enhancing the likelihood of integration's success. The following strategies can be considered in establishing an alternative payment methodology:

- Include a Per Member Per Month (PMPM) for behavioral health in primary care as part of a fee-for-service + PMPM strategy
- Establish a framework for creating financial models for primary care population-based payment (PBP) with behavioral health

Determine a Per Member Per Month (PMPM) for Behavioral Health Within a Fee-for-Service System: FFS+PMPM



Many states, commercial health plans, employers, and government payers are paying for the integration of behavioral health into primary care by adding a PMPM to their existing FFS payment for primary care. Currently, the vast majority of behavioral health services are paid for through FFS. However, when FFS is still the predominate payment mechanism, it artificially forces behavioral health to operate and be paid in its own silo, often resulting in a co-located model where the behavioral health provider's schedule is full of billable appointments, limiting the types of behavioral health services available and accessible to patients.

Recommendations:

- Establish the appropriate PMPM payment for integrated services that considers the community in which the practice operates and variation in the local healthcare marketplace (e.g., payer type, healthcare workforce, socio-demographics of patient panel, etc.).
- Provide technical assistance to determine the appropriate PMPM payments, including: actuarial assistance to determine PMPM for a given patient population and assessment of services to be included, and practices and providers who are eligible.
- Develop and disseminate tools, resources, and best practices to track expenditures within the PMPM that:
  - Ensure accountability for services
  - Describe governance (e.g., determining who sets payment, what factors are included in setting payment) and patient attributions
  - Cover coordination of care services and other resources offered in the medical neighborhood/community
  - Cover services that allow for enhanced communication access (e.g., secure e-mail and telephone consultation) and fall outside of face-to-face visits
  - Recognize case mix differences in the treated patient population (e.g., severe and persistent mental illness)

BUILD A FINANCING MODEL FOR PRIMARY CARE POPULATION-BASED PAYMENT (PBP) WITH BEHAVIORAL HEALTH

Payment models that are grounded in FFS pose challenges in terms of their ability to incentivize alignment, integrate team-based care, and reward value versus volume. To this end, the creation of new payment models that are non-encounter, non-volume based allow for better primary care and behavioral health integration and drive better care at lower cost. Accordingly, payment models that integrate behavioral health into a risk-adjusted, primary care, global payment are needed. As Medicare swiftly moves toward value-based payment models such as Primary Care Medical Homes and Accountable Care Organizations, integration of behavioral health into these models is timely and warranted.

Recommendations:

- Design technical assistance for determining the services that should be included in alternative payment methods, the providers who are eligible to deliver the services, and the appropriate payment given the local healthcare marketplace.
- Develop and disseminate in depth case studies, best practices, and standardization on how to operationalize behavioral health integration into primary care for public and commercial payers. Outline best practices for population health management strategies to include non-visit based services (e.g., asynchronous communication, telehealth, mobile apps).
- Create tools, resources, best practices, and technical assistance to track expenditures within the PBP that:
  - Ensure accountability for services
  - Describe governance (e.g., determining who sets payment, what factors are included in setting payment) and patient attribution
  - Cover coordination of care services and medical neighborhood/ community resources
  - Cover services that allow for enhanced communication access (e.g., secure e-mail and telephone consultation) and fall outside the face-to-face visit
  - Recognize case mix differences in the treated patient population (e.g., severe and persistent mental illness)



Building the Business Case

A stronger business case for integration is needed to educate stakeholders about the potential of payment models that support integration of behavioral health into primary care. Different target audiences respond to different data, converted into language that resonates with their priorities. Employers and health plans require return on investment (ROI) estimates while consumers require information that addresses their concerns about affordability, accessibility, and quality of care.

Recommendations:

- Create a comprehensive guide or tool kit that highlights the different payment models that support integrated care with targeted messages for different audiences. Include an analytic tool that estimates the return on investment (ROI) for payers and practices to help scale the adoption of the payment model.
- Develop a communication plan for behavioral health integration ROI and impact of different payment methods tailored for patients, providers, and payers.

Support and Connect Local Initiatives Around Payment Reform

All healthcare is local, and when local leaders within communities are engaged in driving payment reform, buy-in across various stakeholders within the community is significantly enhanced. A strategy is needed to connect payment reform innovations with other innovators and communities just beginning to integrate. Often funders and investors can be catalysts to bring together employers and payers, and encourage them to push for payment reform. Piloting new models may be the start that many communities need to initiate innovative approaches to care.

Recommendations:

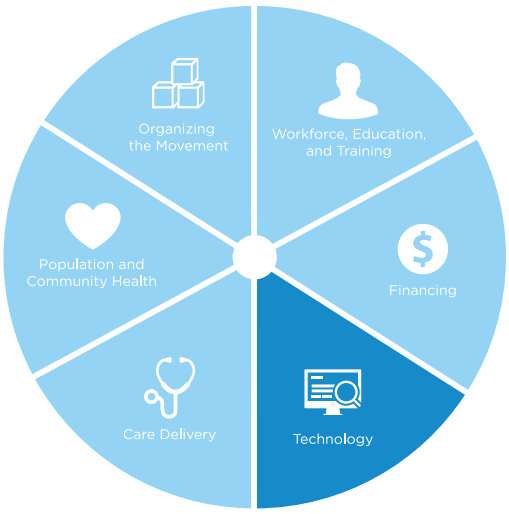
- Create a payment and innovation center that can collect and organize information about payment reform efforts. Organize various state and local payment reform efforts for behavioral health integration into a single location that can be utilized by various stakeholders across the country. This center could arrange the various innovations according to state, payer, approach to behavioral health integration, and outcome or findings. An additional function of the center could be to provide technical assistance or play “matchmaker” to various individuals throughout the country interested in taking a payment model and applying it elsewhere.
- Fund experimental payment models and sites or support existing communities where payment innovation is occurring to assess specific elements of the payment model that support integration and can be scaled elsewhere. Local, state, and national funders should consider supporting innovative payment models and evaluating their outcomes.



TECHNOLOGY

Meaningful exchange of information between all members of the care team, the patient, and patient's family, and across the continuum of care underlies all efforts to integrate behavioral health. Data are foundational, and it is often the use of technology that can help facilitate communication and access to meaningful data that can help people achieve their personal health and wellbeing goals.

TECHNOLOGY



Change Constraints on Behavioral Health Data

Even in places where technology can enable the exchange of behavioral health data, it is not being used to its full capacity. Extreme privacy practices around behavioral health are often driven by misunderstandings, inconsistent legal interpretations, lack of education of clinical and administrative staff, and conservative legal interpretations by provider organizations, all leading to the inability to coordinate and integrate care. There are several recommendations that enhance the sharing of behavioral health data with the end goal of data integration with the community and among providers, all upholding legal frameworks of privacy.

Recommendations:

- Create resources, templates, and technical assistance and educational strategies to improve access to data for patients and other providers on how the Health Insurance Portability and Accountability Act (HIPAA) can serve as a facilitator for more robust integration, rather than a predominate barrier. Focus on data sharing and the rights a patient has to his or her data.
- Develop a multilevel plan to help create and disseminate the types of materials outlined above:
  - At a national level, the various professional societies could be convened to create a joint statement about behavioral health integration and data sharing; federal agencies within HHS could also consider more aligned interpretation of HIPAA.
  - At a state level, specific innovations that facilitate behavioral health integration could be collected and shared with other states.
  - At a local level, clinics, health departments, and mental health centers could create and share educational briefs around behavioral health and data sharing.
- Perform an environmental scan on effective use of technology for innovative behavioral health programs. To advance technology strategies around behavioral health, there first needs to be a better understanding of what's working and what trends are being observed. To accomplish this, a research and dissemination agenda should be developed that highlights innovations where things are working and where attitudes and behaviors (culture) have changed significantly around behavioral health. Once this information has been collected, new studies can be proposed that better help explain changing attitudes and behaviors related to privacy/sharing.



Fundamentally Re-think How We Are Using Technology to Support Behavioral Health Integration

Despite having a plethora of technologies in support of behavioral health, the consistency and quality of these data are not up to the same standards as that of medical data. One area often mentioned as a barrier for changing this is the lack of behavioral health providers' inclusion with the Health Information Technology for Economic and Clinical Health (HITECH) Act. Including mental and behavioral provides within HITECH, would create a certification vehicle to ensure electronic health record products used in behavioral health settings could capture the right types of information (e.g., quality reporting, coordination, sharing information, recording) and provide meaningful use incentives. Further, this would help enhance the quality of behavioral health data within healthcare communities. To this end, rethinking how technology is leveraged, independent of HITECH, may be helpful in advancing better behavioral health integration.

Recommendations:

- Develop a more rational and elegant approach to consent management from a technical and a policy perspective. Currently technology is about storing the behavioral health consent (e.g., consistent with most clinics' policies and compliance recommendations); however, the consent process should be more focused on how the behavioral health data can be accessed during a clinical encounter, regardless of setting. From a policy perspective, consent approaches are often inconsistent. State level conveners could prioritize supporting consistency.
- Create tools and templates to better use technology to support asynchronous communication among providers and create appropriate payment supports to accomplish this function.



Connect, Share, and Learn What Works to Enable Better Behavioral Health Integration

Innovations using technology are happening all over the country; however, there does not appear to be a unifying entity that can bring together these innovations to allow the broader healthcare community to connect, share, and learn around behavioral health integration.

Recommendations:

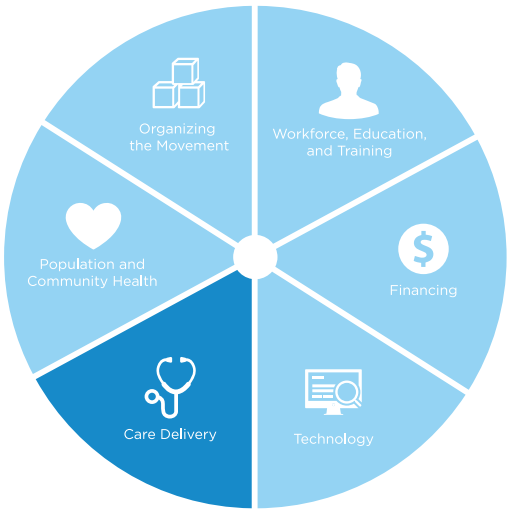
- Build a national network of health information professionals. While many health information professionals and professional groups are focused on this topic, no cohesive group has convened around a set agenda. Through the creation of a public/private group of various health stakeholders, the development of technical/use standards that help define a data model and underlying roles for information sharing can be created. These standards could be applied at the national, state, and local levels.
- Evaluate whether standards around behavioral health are being met through various health-related initiatives.
- Organize tools and resources necessary for technical assistance, building off a broad spectrum of use cases that range from clinical (e.g., e-consults) to risk-based (e.g., analytics available to other parties).
- Develop shared models and enhance health information technology functionality and data standards for behavioral health. In support of more robust integrated behavioral health, models must be created that can be adopted across systems. As it stands, there are no consistent ways, at multiple levels, for interested parties to share data models that increase behavioral health integration.



CARE DELIVERY

While we continue to investigate mechanisms for effective delivery of integrated care in the primary care setting, we must recognize the evidence that exists and realize that support for integration continues to grow. Integrated care is thriving in scattered hubs of innovation and in early adopter practices, but has not yet been systematically adopted as the standard of care in primary care practices. Building on exemplary practices that have data to demonstrate improved care delivery, there is an opportunity to scale new approaches in order to reach a greater majority of the primary care population. We can no longer afford to overlook or leave untreated those who present to primary care settings with behavioral health conditions. Scaling innovative care delivery will require strategies for implementation, spread, and sustainability, offering an opportunity to focus more fully on prevention and early intervention in addition to treatment and management.

CARE DELIVERY



Establish and Share the Best Available Evidence Around Behavioral Health and Primary Care Integration

Evidence in support of integrated care delivery falls into discrete categories – clinical, operational, and financial. During the continuum of care delivery these systems overlap and interact, thus should not be considered in isolation. Evidence may also be defined or perceived differently by various stakeholders. To reconcile these differences, we apply David Sackett's definition for Evidence Based Practice (EBP): "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."8 However, defining what constitutes the evidence base for behavioral health and primary care integration remains a challenge. We suggest that first we establish a foundational base of evidence for integration, beginning in these areas: clinical treatment, prevention/early intervention, and implementation. In order to begin to advance the evidence base for integration, the following is needed.

Recommendations:

- Establish a set of standards describing best evidence for behavioral health and primary care integration, using existing resources such as the AHRQ Lexicon7, The 5 R's: An Emerging Bold Standard for Conducting Relevant Research in a Changing World9, and Sackett's definition8 Through this process, a minimal set of standards could be set.
- Develop mechanisms for reviewing and updating the evidence, and define areas of sufficiency and gaps prioritizing new research based on evidence gaps.
- Conduct rapid cycle learning for more immediate application and spread of integrated care. Examples of this may include:
  - Building infrastructure, capacity and multi-modal strategies through forums for learning and dissemination such as specific tracks at conferences that focus on supporting a practice or system at any stage of integration.
  - Disseminating practice and community level data with use of visuals: maps, graphs, videos, and appropriate language for ease of use and consistent messaging among diverse stakeholders.
  - Developing and tailoring resources, such as a practical playbook to implement integrated care based on organizational readiness.
  - Offering technical assistance from a neutral technical assistance provider who can share evidence, resources and connections to practices and individuals to guide implementation.
  - Creating a network of practice assistance organizations to come together around a shared agenda for assisting with integration.
- Develop a standardized and validated "functional scale" to unite medical and behavioral health professionals in the service of improving patient functioning as opposed to focusing only on symptomatic improvements.
- Disseminate evidence for best practices to encourage adoption and implementation. This could be accelerated by creating a multidisciplinary panel similar to the United States Preventive Services Task Force (USPSTF) to help promote better evidence and recommendations to stakeholders in the field.



Moving Upstream: Prevention and Health Promotion

Recognizing the critical importance and urgency to better address mental health through prevention, more clinical interventions and programs should "move upstream" and attempt to improve health conditions prior to problems emerging. The definition of prevention will broadly include behavioral health needs (not just the prevention of physical health problems and conditions). Health promotion will address wellness and optimize function (e.g., how can people thrive and live to the fullest of their capacity?). Clinical providers will screen and address social determinants of health, engaging communities beyond the healthcare system to identify existing problems that are amenable to a prevention strategy. Community resources and stakeholders that are involved at a community level will be part of the team creating needed solutions. Additionally, we need to think about measures of health outcomes differently to include productivity, lost school days or academic performance, and indicators of resiliency. This will allow us to develop and track appropriate measures of prevention.

Recommendations:

- Promote screening tools to include the identification of at-risk populations (e.g., screening for adverse childhood experiences, toxic stress, and social deprivation) as well as tracking of universally adopted prevention measures (e.g., functional scale/s across the lifespan).
- Include interventions for prevention and early intervention (e.g., screening, treatment, management, follow-up) as an essential health insurance benefit with appropriate payment models in support of integrated teams.
- Address additional payment barriers to supporting prevention (e.g., the current requirement for a patient to have a diagnosis to bill for a service in the FFS environment; paying for technology-enabled interventions provided outside the clinic)
- Create a financial checklist that allows practices to see what prevention services are financially supported or not, to help understand the enablers and barriers for practicing prevention.
- Explore the use of technology for prevention and early intervention and create a repository of promising technologies that support prevention and behavioral health wellness (e.g., patient portals and text-based counseling).
- Explore how prevention and health promotion can help overcome disparities in health outcomes.



POPULATION & COMMUNITY HEALTH

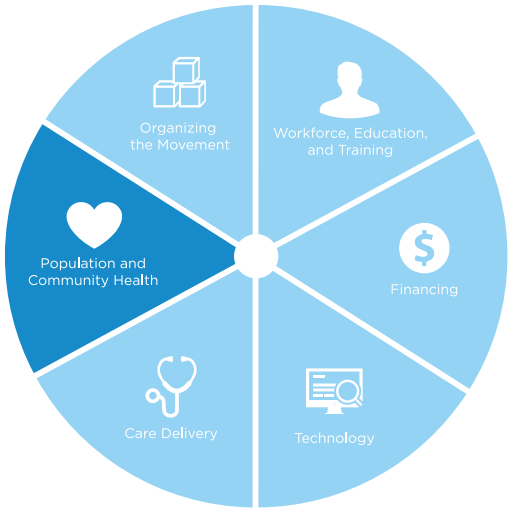
Integrating behavioral health into primary care requires far more than just a clinical intervention or even a series of steps in the clinical realm. Understanding that social determinants and environmental conditions have perhaps the strongest and most enduring influence on whole health, integrated care must recognize and include a broader scope of environments to affect health and well-being. Measures taken within, among, and across communities will provide context and support to facilitate integration and create opportunities to shift cultural expectations for physical and behavioral health to be experienced and addressed together. Within communities where people live, learn, work, pray, and play, we have a natural capacity to function in a state of wholeness without artificial fragmentation or compartmentalization of actions that are purely physical or behavioral. We need first to better understand needs at a community level and the social conditions that impact health on an individual or family level. We will then be better prepared to offer culturally appropriate care to individuals and build demand among people and populations for integrated approaches to health. We might first frame questions to guide information gathering. For example, what are the messages around integration that resonate most at the community level? Who will be accountable for behavioral health in a community? How can a sense of urgency for whole person care be created or inspired?

POPULATION & COMMUNITY HEALTH

The following recommendations are common principles, driven by community need, which can better support the notion of behavioral health and primary care.

Active Participation of All People

To support more community buy-in for behavioral health integration, we desire more involvement of all people from grassroots to grass tops. This engagement and activation hinges on a power shift that allows individuals and families with behavioral health needs to be heard and to lead efforts and activities. Diverse and proportionate representation from community members, organizations, and leadership that genuinely represents the community is critical to build support, understanding, and demand for integration. Broad and focused participation will help achieve greater equity across the spectrum of public health outcomes. When engaging diverse representation, it should be recognized that we are asking communities and agencies at the local, state, and federal level to work together, share values, visions, objectives, and ultimately resources to achieve cohesive and comprehensive plans. This may depend on creating new models for cross-agency or cross-sector teams and seeking leadership from a dearth of experience. Analogously, we are asking behavioral health and doctors or medical providers to work together, realizing that most will be forging new ground and will need training and opportunity to build trust and collaborate to achieve successful teams. When new training experiences are needed, teaching and technical assistance is to be expected. As we seek out these new teams and approaches for care in shared settings, we should be cognizant of the value and need for technical assistance that will facilitate bringing teams across sectors together.



Recommendations:

- Create guidelines for agencies and organizations to involve people outside of the healthcare sphere, bringing a community voice into decisions on integration. Look to grassroots leaders, individuals, and families to drive and guide community change.
- Require funders and other investors to empower active participation with diverse representation in the development, implementation, and evaluation of community-based health programs. Include diverse populations representing the influx of refugees and immigrants as a frame of reference for mental and physical wellness that may differ substantially among ethnic groups.
- Provide guidance or national technical assistance to facilitate active participation in designing healthcare and community health initiatives with the end user in mind.

Data

Use and make accessible key data in real time; identify data to develop outcome-specific evidence at the desired personal, community, and population level for rapid cycle collection and feedback. The necessity for quality data is thematically integral across all areas for recommendations in this report. In this instance, an individual patient could be the first user of "person-level," then family, and finally the community need access to appropriate level data in order to own the information and realize implications for improving issues or problems related to health. In order to build systems that support integrated care, providers, administrators, community leaders, and policy makers will need to understand community and population level data relevant to health and social or environmental indicators of health.

Recommendations:

- Define and make public a set of metrics for wellbeing/behavioral health that shift the measurement of health from a frame of illness to wellness; include measures such as social connectedness and self-efficacy. Develop these data at individual, family, and community levels.
- Use existing real-time data to inform interdisciplinary links and areas for action between health systems and other public policy areas to develop targeted programs and policy changes to link behavioral health goals and outcomes to other systems such as criminal justice, violence prevention, education/graduation, environmental justice, and racial equity. Data could include emergency/mental health hotline calls, crime and domestic violence data, emergency department visits, school counseling visits, and more.
- Improve accessibility and presentation of community-level data with use of visuals—maps, graphs, and videos—and appropriate language for ease of use and consistent messages among diverse stakeholders.



Community Health Accountability

The role of community to support and strengthen health in peoples' lives is more important than ever. Recognizing opportunities and accountability, while creating a greater sense of community across sectors, systems, neighborhoods, and agencies is needed to support one another and achieve healthier populations.

Recommendations:

- Develop a definition of community that includes accountability, empowered people/residents, inclusion, and ownership for establishing an integrated system relevant and appropriate to the community.
- Describe community health accountability with tactical steps to take at every level—personal, family, community leaders, public officials, together with healthcare professionals.
- Create an accountability model that encourages shared accountability bringing together different sectors, e.g., require hospital administration to serve on one non-health community organization board.
- Define and incentivize ownership of behavioral health recognizing integration of behavioral and physical health. Identify who is committed to addressing issues and opportunities to overcome fragmentation at each level.



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APPENDICES

APPENDIX A

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APPENDIX B

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APPENDIX C
KEY INFORMANT INTERVIEWS AND FOCUS GROUP GUIDES

Key Informant Interview Guide:

1. You have been identified as a key informant based on your leadership and experience in the field of integrated behavioral health and primary care. I would like to begin our conversation today by you telling me a bit about yourself. Can you please state your name and say a couple of sentences about your professional background, and your work in the field of integrated care?

2. In your experience, what on the ground factors or issues pose a challenge to the success of integration? [micro level challenges/barriers]

- 2a. [Probe each barrier] What are your ideas for how to overcome these challenges?
- 2b. What needs to happen now?
- 2c. What needs to happen in the future?
- 2d. What stakeholders would need to be engaged to implement the steps necessary to overcome this challenge? What specific contributions would be needed from each of these stakeholders in order to overcome this challenge?

3. In your experience, what systems or policy level issues pose a challenge to the success of integration? [Probe: macro level challenge/barriers]

- 3a. [Probe each barrier] What are your ideas for how to overcome these challenges?
- 3b. What needs to happen now?
- 3c. What needs to happen in the future?
- 3d. What stakeholders would need to be engaged to implement the steps necessary to overcome this challenge? What specific contributions would be needed from each of these stakeholders in order to overcome this challenge?

4. Please share an example from your work when you felt integration worked well. This could include specific endeavors or places and systems that have cultivated integrated care.

- 4b. What factors made this work? What strategies were used to make these endeavors work?

5. Please share an example from your work of an instance when you felt integration did not work well.

    5b. What factors prevented success? What, if anything, would you have done to make this more successful?

6. Tell me about any other promising efforts to integrate care that you have heard about.

7. Organizations are interested in funding programs to advance the field of integration. If you were them, what would you spend your money on?

8. Who else would you suggest for me to talk with regarding integration efforts across the nation? (Collect name, organization, and contact information.)

9. These are all the formal questions I have for today. Is there anything that we missed that you would like to talk about regarding the state and future of integrated behavioral health and primary care?

Behavioral Health Trainees Focus Group Guide:

1. I would like to begin our conversation today by you telling me a bit about yourself. Can you please state your name and say a couple of sentences about your professional background, training, and work in the field of integrated care?

2. Prior to your experience at XXXXX, what was your training related to integrated behavioral health and primary care?

3. How did your graduate school training prepare you to work alongside medical professionals in a collaborative setting?

4. Were there specific qualities of the XXXXX training program that you were interested in?

5. How could psychology graduate programs improve such preparation?

6. Compared to those you would consider your peers in other training programs, how would you say your daily practice differs from their experience?

7. How would you say medical professionals enhance or hinder your daily practice?

8. Has your experience working with medical professionals changed your career trajectory? If so, how?

9. If you had the ability to infuse resources into your practice to improve integrated services, how would you spend your money?

Primary Care Residents Focus Group Guide:

1. Lets start out the conversation so we can get to know you a little better. Can we go around the room, state your name and residency year?
2. Prior to your residency experience, what was your training related to integrated behavioral health and primary care?
3. How did your medical school training prepare you to work alongside behavioral health professionals in a collaborative setting?
4. Were there specific qualities for the University residency program that you were interested in?
5. How could medical schools improve such preparation?
6. Compared to those you would consider your peers in other Family Medicine residency programs, how would you say your daily practice differs from their experience?
7. How would you say behavioral health professionals enhance or hinder your daily practice?
8. Has your experience working with behavioral health professionals changed your career trajectory? If so, how?
9. If you had the ability to infuse resources into your practice to improve integrated services, how would you spend your money?

APPENDIX D

NATIONAL LEADER SUMMIT PARTICIPANTS



Rebecca Baum, MD, is a member of the section of development and behavioral pediatrics at Nationalwide Children's Hospital and a clinical assistant professor of pediatrics at the Ohio State University College of Medicine. Her primary teaching and clinical activities involve young children and their families who are seen in Nationwide Children's Behavioral Medicine and Consultation Clinic. Dr. Baum's research interests include autism, attention deficit hyperactivity disorder, and quality improvement. She practiced primary care pediatrics in Pennsylvania before completing her fellowship in developmental and behavioral pediatrics at Nationwide Children's Hospital.



Virgina (Ginna) Trotter Betts, MSN, JD, RN, a psychiatric nurse and an attorney, is the former Commissioner of Mental Health and Substance Abuse Services for the state of Tennessee. She served as president of the NAMHSPD, and was a part of the HHS team that developed the first ever surgeon general's report on mental health. She has worked to improve overall health of populations through greater attention to behavioral health throughout the health care system and addressing the multiple, complex health needs of persons with mental health/ substance abuse disorders. Ms. Betts is a past president of the American Nurses Association. She is President and CEO of Health Futures, Inc.



Alexander (Sandy) Blount, EdD, is professor of clinical psychology at Antioch University of New England and professor of family medicine and psychiatry at the University of Massachusetts Medical School, where he directs the Center for Integrated Primary Care. Dr. Blount has been practicing as a clinician, trainer, administrator, author, teacher and consultant for 40 years; of which 20 years has been spent as a behavioral health clinician in primary care. He is a member of the National Integration Academy Council guiding the Integration Academy of the Agency for Health Research and Quality. He is past president of the Collaborative Family Healthcare Association, a national multidisciplinary organization promoting the inclusion of mental health services in medical settings; and he is past editor of Families, Systems and Health, the Journal of Collaborative Family Healthcare.



Whitney Bowman-Zatzkin, MPA, MSR, is a passionate community builder and a devoted healthcare advocate whose MPA focused on health policy. Director of the Flip the Clinic, a project of the RWJ Foundation to reinvent the clinician-patient interactions in healthcare and find the things that work in a system often thought of as broken, she got her start in healthcare 15 years ago managing a medical practice. She led the Great Challenges Program at TEDMED, curating conversations across an online community of 411,000+ members to encourage the exploration of health's toughest issues. Her publications highlight work on primary care practice models, health data, and disaster preparedness.



Courtney Cantrell, PhD, director of the North Carolina (NC) Division of Mental Health, Developmental Disabilities and Substance Abuse Services; is a clinical psychologist. She trained in the U.S. Air Force on the Behavioral Health Optimization Program model of integrated primary care, and has worked with Community Care of NC, designed to bring together primary care and carved-out behavioral health services across 26 NC counties. She also served as assistant director for behavioral health and I/DD for Medicaid, and spent six months working as a policy advisor for integrated care with the NC DHHS to ensure care integration for both the general population and for those receiving specialty care services.



Christopher Carroll, MSc, is director of Health Care Financing and Systems Integration for the Substance Abuse and Mental Health Services Administration. He also leads SAMHSA's strategic initiative on health care and health systems integration. He has more than 25 years experience in behavioral health with a background in mental and substance use services administration and financing, public health program implementation, organizational management, and behavioral health systems operations. Currently he works to maintain and manage relationships and programs with the DHHS officials, members of Congress, executives of other Federal and State agencies, professional organizations, international and non-governmental organizations.



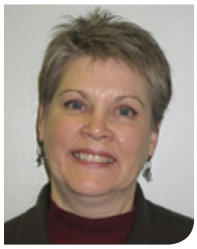
Teddy Chen, PhD, LCSW, is the director of the Mental Health Bridge Program at Charles B. Wang Community Health Center in New York City, which is part of the health center's primary health care system. It is a nationally recognized model that integrates mental health and primary health care services. Dr. Chen is a founding board member of the Chinese American Family Alliance for Mental Health in New York City - a support group for the family caregivers of people suffering from mental disorders. He is also a board member of the New York Coalition for Asian American Mental Health, an advocacy group to improve mental health services available to Asian Americans.

not pictured

Christine Cichetti, is a Senior Behavioral Health Policy Advisor with the Department of Health and Human Services/Office of the Assistant Secretary for Health.



Maribel Cifuentes, RN, is a senior program officer at the Colorado Health Foundation. Prior to joining the foundation, she was an instructor at the University of Colorado, Department of Family Medicine. She is the immediate past Deputy Director of Advancing Care Together, a practice redesign initiative seeking proper integration of primary and behavioral care for people with emotional and behavioral problems. Maribel is also the past Deputy Director of the Robert Wood Johnson Foundation's Prescription for Health program, another practice redesign initiative that was designed to improve the delivery and effectiveness of health behavior change services in frontline primary care practices.



Patricia (Pat) Cunningham, DNSc, APN-BC, immediate past president of the American Psychiatric Nurses Association, is the Associate Dean of Psychiatric Mental Health Nursing at Frontier Nursing University. She is a certified adult psychiatric/mental health clinical nurse specialist, a psychiatric family nurse practitioner, and a family nurse practitioner. Dr. Cunningham practices in an internal medicine teaching practice, integrating care for patients with co-morbid medical and mental health illnesses. She contributed to the development of the Doctor of Nursing curriculum, with an emphasis on the psychiatric/mental health advanced practice role. Her sholarly focus includes the integration of mental health in primary care.



Martha Davis, MSS, a senior program office at the Robert Wood Johnson Foundation, focuses her work on the root causes of violence, including child abuse and intimate partner violence. She works at strengthening families to create nurturing, healthy environments that promote the positive development of children. She was the co-founder and executive director of the Institute for Safe Families (ISF), a Philadelphia non-profit organization. For more than 18 years, she served as an adjunct faculty member of the Community College of Philadelphia, where she taught courses in behavioral health.



Dave deBronkart (e-patient Dave) is a stage IV kidney cancer survivor, patient high-tech marketer turned keynote speaker and policy advisor who evangelizes for patient empowerment, patient engagement, and patient-clinician partnerships. As a voice for patient engagement, he is a noted advocate and activist for healthcare transformation through participatory medicine and personal health data rights. He tries to help patients help themselves by encouraging them to own their medical data, helping them connect to fellow patients, and make medical care better. He is a leading voice in Washington for new federal regulations that require patients and families to have access to their EMRs.



Frank deGruy, MD, has been the Woodward-Chisholm professor and chair of the University of Colorado Department of Family Medicine since 1999. He's a member of the Institute of Medicine, has served as president of the Collaborative Family Healthcare Association (CFHA), chair of the national advisory committee for the RWJF's Depression in Primary Care Initiative and Systems of Care, and was president of the North American Primary Care Research Network. He serves on several national boards, is an active member of the National Network of Depression Centers (NNDC), is the chairman of the National Integration Academy Council, and was the senior scientist for Advancing Care Together – a Colorado program designed to better integrate primary care and mental health services.



Jonathan Delman, PhD, JD, MPH, has extensive knowledge of research, program evaluation, project management and group facilitation; and worked with Medicaid managed care companies and state agencies for more than 15 years. He has focused most of his work in the areas of behavioral health, psychiatric rehabilitation, measurement development, and community and consumer involvement in research, evaluation and policy. He developed effective approaches for young adults with serious mental illness to actively participate in policy, research and service. Jon is a person with lived experience of mental illness. He directs the program for recovery research at the Systems and Psychosocial Advances Research Center and is the principal at Resevoir Consulting Group, a consumer-run research and management consulting firm.



Andrea M. Ducas, MPH, is a Robert Wood Johnson Foundation program officer. She is especially involved with programs related to payment and delivery system reform, purchaser and consumer engagement, health care price transparency, community-driven health improvements, and strengthening health departments. Previously, she served as development and communications associate for a non-profit law and policy organization in NYC. As chief marketing officer of a .com, she developed and designed an online community to enhance the exchange of health information among medical professionals, enable patient feedback to promote practice improvement, and help patients find clinicians who can met their individual needs.



Mary Jane England, MD, professor of health policy & management at Boston University School of Public Health, launched her career as a child psychiatrist in 1964. She was the first commissioner of the Department of Social Services in Massachusetts, and president of the American Psychiatric Association. An expert on health care and mental health parity, Dr. England chaired the Institute of Medicine's (IOM) committee that produced the "Crossing the Quality Chasm" report about improving healthcare quality for mental and substance use conditions. In 2008 she chaired an IOM committee on parental depression and its effect on children and other family members. Dr. England continues to serve on Rosalynn Carter's Task Force on Mental Health at the Carter Center, and on the IOM board on Children and Families.



Elizabeth Fowler, BFA, is a multi-disciplined designer who brings a breadth of knowledge to the center in print, web, packaging and broadcast. She has experience in building companies from the ground up, and is passionate about bringing her clients success through creative problem solving and by anticipating what's on the horizon. She brings an organic quality to her work, which stems from her love of nature and the outdoors. She is committed to giving back to the community on both a local and global level.



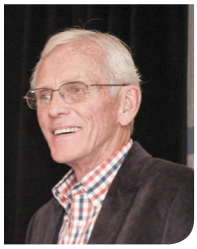
Emmy Ganos, PhD, is a program associate at the Robert Wood Johnson Foundation. She works on the foundation's efforts to advance a culture of health, where our economy is less burdened by excessive and unwarranted health care spending, and where the health of the population guides public and private decision making. Previously, she held research and teaching positions with the Medical College of Wisconsin in Milwaukee, working with undergraduate, graduate, and medical students. She also served as a manager of research and administration with the Donors Forum of Wisconsin, a professional membership association for grant makers and Wisconsin's premier resource for philanthropy.



Emma Gilchrist, MPH, is a program manager with the Eugene S. Farley, Jr. Health Policy Center. She received her masters of public health from the University of Michigan, and has been a project manager and evaluator for a variety of federal grants and state contracts focused on primary care and behavioral health integration.



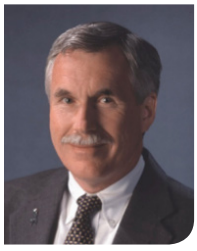
Patrick Gordon, MPA, Associate Vice President of Community Integration for Rocky Mountain Health Plans (RMHP), is accountable for an array of payment reform, health data exchange and behavioral health services integration initiatives in Western Colorado. He leads the implementation of the Medicaid Accountable Care Collaborative project. Patrick oversees the Medicaid, full benefit Medicare/Medicaid eligibles, and CHP+ programs supported by RHMP, as well as the CMS Innovation Center's Comprehensive Primary Care initiative. He also led several strategic initiatives for RMHP's stakeholders, including the Colorado Beacon community demonstration. Furthermore, he serves on the Colorado State Innovation Model (SIM) advisory board.



Larry Green, MD, a faculty member in the Department of Family Medicine at the University of Colorado, has spent most of his career developing family medicine and primary care, including health professions education; research policy; and uniting all the sciences and practice experience to guide the redesign of clinical care. University roles included practicing clinician for 22 years, residency director and chair. He is the founding director of the Robert Graham Center, a research policy center sponsored by the American Academy of Family Physicians; and he directed Advancing Care Together, a 5-year practice-based initiative dedicated to learning how to integrate primary care and behavioral health services on the ground in diverse settings. Currently he is focused on integrating mental health, public health, and primary care.



Kim Griswold, MD, MPH, RN, is a practicing family physician with research interests in serious mental health and cultural expressions and context of mental illness. She serves as the medical director of a newly developing Center for Refugee Survivors of Torture and Trauma in Buffalo, NY, and with her nurse practitioner colleague, coordinates an integrated clinic based in a behavioral health setting, and volunteers her time for refugee and immigrant populations seeking asylum. Dr. Griswold is keenly interested in preparing trainees to care for vulnerable populations.



Michael Hogan, PhD, served as commissioner/director of mental health in Connecticut, Ohio, and New York, and now works as a consultant/advisor in health and mental health care. He chaired the president's New Freedom Commission on Mental Health in 2002-2003, and was appointed as the first behavioral health representative on the board of The Joint Commission. He served on NIMH's National Advisory Mental Health Council as president of the National Association of State Mental Health Program Directors and as board president of NASMHPD's Research Institute. His current projects and priorities include development and implementation of Zero Suicide in Healthcare, assisting states with implementation of evidence based services, and advancing integrated care models.



Lauren S. Hughes, MD, is a family physician and deputy secretary for health innovation for the state of Pennsylvania. She was an RWJF Clinical Scholar at the University of Michigan prior to joining the Department of Health, where she pursued training in health services research. She volunteered in a federally qualified health center (AmeriCorps), worked at Iowa Senator Tom Harkin's office in Washington, D.C., and studied medicine and health systems in Brazil, Sweden, Tanzania, and Botswana. She has been a visiting scholar at the Robert Graham Center, ABC News Medical Unit in New York City, the Center for Medicare and Medicaid Innovation, and The Commonwealth Fund. Dr. Hughes' passions include studying the primary care workforce and innovations in primary care delivery.



Robert Joseph, MD, MS, is director of the Consultation-Liaison and Primary Care Behavioral Health Service, Cambridge Health Alliance. He's a faculty member of the Harvard Medical School and faculty advisor for the Harvard Center for Primary Care. He has spent 25 years providing consultation on inpatient general hospital services, and is the psychiatry lead for integrated mental health services across 12 academic primary care sites. Dr. Joseph is also the program director for the Fellowship Program in Psychomatic Medicine.



Roger G. Kathol, MD, CPE, president of Cartesian Solutions, Inc., is an innovative health strategist in the development of integrated programs and systems for patients with illness complexity, many with concurrent general medical and mental health/substance use disorders.™ He is adjunct professor at the University of Minnesota, and board-certified in internal medicine, psychiatry, and medical management. Dr. Kathol has consulted with >100 companies, organizations, and government agencies, both nationally and internationally. These partnerships allow him to contribute to the integration of medical and psychiatric service delivery and the application of payment models that allow sustainable care for health systems and healthcare stakeholders.



Parinda Khatri, PhD, is director of integrated care at Cherokee Health Systems – a comprehensive community healthcare organization in east Tennessee; and leads their integrated care implementation at a number of primary care sites. She is the training director of the psychology internship program there and principal investigator on several research projects. Dr. Khatri s member of the APA's presidential task force on PCMH and co-chair of the Patient-Centered Primary Care Collaborative's behavioral health special interest group. She serves on the behavioral health steering committee for the National Quality Forum. Her passions lie in training, recruiting and consulting about integrated care implementation.



Janhavi Kirtane, MBA, directs the Collaborative Health Network (CHN), a network designed to engage communities across the United States, and accelerate healthcare transformation initiatives. Janhavi has a wealth of experience in leading local community initiatives and forging innovative collaboration with stakeholders and organizations across the country. Previously she was director of the Beacon Community Program that demonstrated the vital role health information plays in supporting the triple aim in 17 communities across America. In this role she developed partnerships to advance knowledge-sharing among private organizations and other federal agencies, including the CMMI, ACL, HRSA, and the CDC.



Kathleen Klink, MD, is the family medicine liaison for the Department of Veterans Affairs. The VA's Choice ACT, signed into law a year ago, directs the VA to increase the number of GME residency positions at VA medical centers by up to 1,500 over a 5-year period. Dr. Klink is to assure that FM residency programs participate as fully as possible in these new training programs. Previously she was medical director at the Robert Graham Center with a focus on the primary care workforce, quality and access. Dr. Klink was also a Robert Wood Johnson health policy fellow in the office of Hillary Rodham Clinton where she participated in the U.S. Public health Service ACT, Title VII reauthorization bill.



Neil Korsen, MD, MSc, is a family physician/geriatrician with 18 years of practice experience, mostly in small Maine towns. He has worked for MaineHealth the past 15 years, an integrated delivery system in southern and central Maine. He is the medical director of their behavioral health integration program. Dr. Korsen is a member of the AHRQ National Integration Academy Council, an expert panel working to develop resources related to behavioral health integration in primary care; and he is principal investigator for the AHRQ Atlas of Integrated Behavioral Healthcare Quality Measures.



Mara Laderman, MSPH is a senior research associate at the Institute for Healthcare Improvement (IHI). She leads IHI's work in behavioral health, developing content and programming to improve behavioral health care in the United States and globally. In addition, as a member of IHI's innovation team, she researches, tests, and disseminates innovative content to advance IHI's work within the triple aim for populations focus area. Ms. Laderman received a master's of public health from the Harvard School of Public Health and a BA in Psychology from Smith College.



Karen Linkins, PhD, is co-founder and principal of Desert Vista Consulting. She specializes in systems transformation in the health, behavioral health, and human services fields through strategic planning, organizational development, evaluation and quality improvement. Dr. Linkins directs the Integrated Behavioral Health Project funded by the State of California that aims to spread integrated health care across the state and nationally through capacity building, training, and technical assistance. She works to develop strong partnerships across the safety net.

not pictured

Karen LLanos, MBA, is director of the Medicaid Innovation Accelerator Program (IAP), Center for Medicaid and CHIP Services at the Centers for Medicare & Medicaid Services. This program is designed to improve care, improve health and reduce costs by supporting state efforts to accelerate Medicaid innovations (developing resources and offering technical assistance). Previously at CMS, Karen was the senior policy advisor and technical director for initiatives related to quality measurement and improvement. Prior to joining CMS, Ms. LLanos was a health policy consultant to the New Jersey Division of Medical Assistance and Health Services and worked closely with state officials to improve the quality and effectiveness of its care management program.



Dayna Matthew, JD, a professor at the University of Colorado Law School and Colorado School of Public Health, brings an interdisciplinary approach to the study of health law. She co-founded the Colorado Health Equity Project, a medical legal partnership whose mission is to remove barriers to good health for low-income clients by providing legal representation, research and policy advocacy. She has practiced as a civil litigator both in Kentucky and Virginia. Presently she serves as special advisor to the director of the Office of Civil Rights for the Environmental Protection Agency, and she's also been named a 2015-2016 Robert Wood Johnson Health Policy Fellow.



Benjamin Miller, PsyD, is the Director of the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Department of Family Medicine. He is principal investigator on several federal grants, foundation awards, and state contracts related to the integration of comprehensive primary care and mental health, behavioral health, and substance use. He is actively involved in the governance of the Collaborative Family Healthcare Association, and leads the Agency for Healthcare Research and Quality's Academy for Integrating Behavioral and Primary Care project, as well as the highly touted Sustaining Healthcare across Integrated Primary Care Efforts (SHAPE) initiative. Dr. Miller is committed to changing policy to ensure sustainability of the integration of mental health and primary care.



Charlotte A. Mullican, BSW, MPH, is senior advisor for mental health research at the Center for Evidence and Practice Improvement (CEPI), Agency for Healthcare Research and Quality (AHRQ); where her interests include mental health and substance abuse. She serves on a variety of multi-agency committees/working groups, including the HHS Behavioral Health Coordinating Council subcommittee on the Integration of Mental Health and Primary Care, Suicide Prevention, the Patient-Centered Medical Home, and Mental Health and Health IT. She provides staff support to AHRQ director, Dr. Rick Kronick, and has served as medical officer on several mental health topics under review by the U.S. Preventive Task Force.



Linda Niebauer has spent most of her career coordinating communication efforts for a variety of primary care initiatives, including Prescription for Health, Advancing Care Together (ACT) and Keystone IV. She was among the early leaders in the development of practice-based research networks in her coordinating role with the Ambulatory Sentinel Practice Network and the State Networks of Colorado and Partners (SNOCAP). The past 10 years Linda has also contributed to strategic communication efforts with a small team at the University of Colorado Department of Family Medicine that includes producing a new publication called *Precipice* designed to pull together folks interested in changing the healthcare landscape.



Marci Nielsen, PhD, MPH, the CEO of the Patient-centered Primary Care Collaborative (CPCC), previously served as vice chancellor for public affairs and associate professor at the University of Kansas School of Medicine's Department of Health Policy and Management. She is a board member of the American Board of Family Medicine, and for the Center for Health Policy Development/National Academy for State Health Policy. She is a former board member of the Health Care Foundation of Greater Kansas City, TransforMED LLC and the Mid-America Coalition on Health Care. Dr. Nielsen holds an MPH from the George Washington University and a PhD from the Johns Hopkins School of Public Health, in the Department of Health Policy and Management.



Rebecca Noftsinger, is a Research Associate with Westat, and has over 25 years of experience in health care research and management. She served as Project Manager for AHRQ's Academy for Integrating Behavioral Health and Primary Care, and Task Lead for the Web-based Atlas task of AHRQ's Effective Quality Improvement and Evaluation in Mental Health – Primary Care Integration. She has served as Project Manager for The Wounded Warrior Survey, the Survey of Army Families, and Task Leader on a variety of behavioral health, health care and military projects, including knowledge dissemination and technical support projects, as well as survey projects. She has extensive experience as the Executive Director of nonprofit organizations including Free Clinics serving uninsured low-income populations, a Crisis Intervention Center, and as Education Director for a Foundation providing training for home dialysis technicians.



Caitlin O'Neill, MS, RD, is the Director of Community Transformation for Anthem's Enhanced Personal Healthcare Program. She comes to the field of practice transformation after having spent well over a decade working in behavioral and community- and practice-based research. Having worked as a quality improvement specialist in primary and specialty care, Cait is currently using her quality improvement and clinical experience to develop tools and resources to help Anthem's provider network transform into a patient-centered model of care. She has assisted a number of primary care organizations in acquiring National Committee for Quality Assurance (NCQA) certification, and she is currently working to help Anthem's primary care providers integrate behavioral health into their practices.



Christine Pace, MD, is a primary care physician who completed an addiction medicine fellowship. Her special interests are program development to enhance the integration of primary care and behavioral health services, and improving care for pregnant and postpartum women with opioid dependence. She is a consultant for the Massachusetts Department of Public Health's Bureau of substance abuse services. At Adult Primary Care at Boston Medical Center, she leads efforts to improve patients' access to behavioral health services. She also does clinical work at the Boston Public Health Commission's Opioid Treatment Program, where she co-founded a primary care clinic.



Vatsala Pathy, MPA, MA, is director of SIM in the office of Governor John Hickenlooper. Previously, she was the founder and managing director of Rootstock Solutions LLC, a healthcare consulting firm. She was also a senior program officer at The Colorado Health Foundation, where she was responsible for grant- making and initiative development to support healthcare delivery for low-income populations. She was also program officer at the CDC Foundation, where she served as a steward and manager of a number of national and international public health projects. Vatsala has extensive experience in state health policy research and program implementation with the Office of Colorado Governor Roy Romer, the Georgia Health Policy Center and Kaiser Foundation Health Plan of Colorado.



Alison Perencevich, MPH, program director at Grantmakers in Health (GIH), is responsible for the organization's behavioral health and integrative health work. Prior to joining GIH, Ms. Perencevich was a legislative assistant with the American Academy of Pediatrics' Department of Federal Affairs. Previously she was a program coordinator at the Bixby Center for Global Reproductive Health at the University of California, San Francisco. Ms. Perencevich received a bachelor's degree in neuroscience from Middlebury College and earned a master's of public health degree from Johns Hopkins Bloomberg School of Public Health.



Laurel Pickering, MPH, is a leader and visionary devoted to transforming healthcare. As president & CEO of Northeast Business Group on Health (NEBGH), Ms. Pickering has built an employer-led coalition of healthcare leaders and other stakeholders to empower members to drive excellence and value in healthcare and the patient experience. Nationally, Ms. Pickering chairs the board of directors of The Leapfrog Group, and serves on the board of National Quality Forum and National Business Coalition on Health. She chairs the board of directors of the NEBGH subsidiary, HealthPass, a health insurance exchange for small businesses, and is also on the board of Health Republic, a nonprofit health insurance plan in New York.



Harold Alan Pincus, MD, is a professor in the Department of Psychiatry at Columbia University's College of Physicians and Surgeons; and director of Quality and Outcomes Research at NY-Presbyterian Hospital. He is also the director of the Health and Aging Policy Fellows Program and senior scientist at the RAND Corporation. He led the national evaluation of mental health services for veterans and the redesign of primary care/ behavioral health relationships in New Orleans. Presently he co-chairs the Measurement Applications Partnership, which reviews and makes recommendations regarding all quality measures as part of the Affordable Care Act. For more than 22 years, he worked one night a week treating the severely mentally ill at a community clinic.



Andrew Pomerantz, MD, is the national mental health director for integrated services in the Veterans Health Administration and on the psychiatry faculty at Dartmouth Medical School. Prior to his psychiatry training, he was a primary care physician. He served as director of consultation/liaison psychiatry at the White River Junction VA, and then as chief of mental health and behavioral science. While there, he achieved national recognition for building an interprofessional team to integrate primary care and mental health, which became known as the "White River Model" of integrated care and became a national standard for the VA.



Josef Reum, MPH, PhD, is the principal in a collaborative consulting firm providing mindful approaches to complexity and individual excellence in the private, NGO, and philanthropic sectors; and a nationally recognized speaker on issues of policy and change in the health care environment. He served nine governors in six states, from Alaska to Massachusetts, in multiple agencies including commissioner for departments of mental health and developmental disabilities; highway safety czar; and fiscal policy advisor. He led a national trade association of local organizations improving the clinical quality of healthcare. Dr. Reum was a member of the first U.S. Disabled Ski Team, and holds nine silver medals in downhill skiing.

not pictured

Alexander Ross, ScD, is senior advisor on behavioral health in the Division of Nursing and Public Health, Bureau of Health Workforce at the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Service. Besides focusing on behavioral health workforce programs, Dr. Ross supports HRSA Bureaus and Offices fostering the integration of behavioral health and primary care. His work has included an emphasis on financing issues regarding behavioral health/primary care services and assuring that an appropriately trained health care workforce is available to meet the nation's needs. Previously he held positions at HRSA in the Office of Planning and Evaluation, the Bureau of HIV/AIDS, and the Office of Public Health Practice.



George Rust, MD, is professor of family medicine and community health and preventive medicine at Morehouse School of Medicine. He is the founding director of the National Center for Primary Care and Faculty Development program. He chairs the Atlanta Community Access Coalition. His passions include improving health care access, healthcare quality and outcomes for low-income and uninsured segments of the population, and developing training programs and health quality-outcomes research partnerships among Morehouse School of Medicine and networks of community and migrant health centers.



David Shillcutt, JD, is a health insurance specialist in the benefits and coverage division at the Center for Medicaid and CHIP Services. David's work at CMS focuses on the Innovation Accelerator Program, including physical and mental health integration and substance use disorders. David has also worked for the Substance Abuse and Mental Health Services Administration, where he was the lead for regulatory affairs, and for the Center for Disease Control's Center for Global Health as a presidential management fellow.



Shanna Shulman, PhD, a senior program officer at the Richard and Susan Smith Family Foundation, directs their health-related portfolio of grants and initiatives. Previously she directed the Boston Children's Hospital Center of Excellence for Pediatric Quality Measurement, where she led the development of quality of care measures for broad national use. She directed policy and research at the BCBS of Massachusetts Foundation, and was responsible for assessing cost, access, and health outcomes resulting from Massachusetts' landmark 2006 universal health care law. Dr. Shulman was senior researcher at Mathematica Policy Research in Cambridge, and directed large-scale, public health program evaluations.



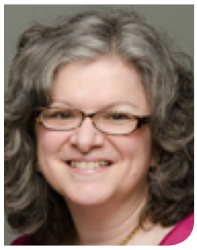
Kerri Sparling was diagnosed with type 1 diabetes at the age of seven. She is the creator and editor of the award-winning diabetes patient blog, **SixUntilMe.com** *Six Until Me* was one of the first globally-recognized patient advocacy voices, leading the charge for patient opinion leaders. In her role as a patient advocate, she sits on the board of directors for T1 Today, on the national steering committee for the Eugene S. Farley, Jr. Health Policy Center, she is an advisory board member of the Diabetes Hands Foundation; and has served as an advisor to Webicina, Diabetes Social Media Advocacy, Juvenile Diabetes Research Foundation International, You Can Do This Project, and Diabetes Advocates. Kerri works to bring the message of patient empowerment and diabetes advocacy forward.



Ron Stock, MD, MA, is a geriatrician/family physician/clinical health services researcher, and currently directs clinical innovation at the Oregon Health Authority Transformation Center. He has dedicated his career to improving the quality of healthcare for vulnerable populations with complex care needs, focusing on redesigning the primary care delivery system for vulnerable elders through an interdisciplinary team model. He has also provided technical assistance to the Oregon Comprehensive Primary Care Initiative and is a member of the IOM Best Practices Innovation Collaborative on Team-Based Care, most recently having participated on an IOM task force to explore the role of "patients on teams."



Jurgen Unützer, MD, is a psychiatrist and health services researcher and advised the president's New Freedom Commission on Mental Health. His focus is on innovative models of care that integrate mental health and general medical services, and on translating research on evidence-based mental health care into effective clinical and public health practice. He chairs the Departments of Psychiatry and Behavioral Sciences at the University of Washington, and directs the Division of Population Health. He also heads the AIMS Center dedicated to advancing integrated mental health solutions and the IMPACT Program that has supported the development, testing and implementation of an evidence-based program for depression treatment around the world.



Anne F. Weiss, MPP, is program staff director at the Robert Wood Johnson Foundation. Previously she served as senior assistant commissioner of the NJ Department of Health, where she directed the state's oversight of the quality of care delivered by health care providers and health plans, and was responsible for the state's hospital indigent care programs. Weiss also served as executive director of NJ's blue-ribbon health reform panel. She spent a decade in Washington, D.C. as professional staff to the U.S. Senate Committee on Finance and as a senior examiner with the office of management and budget. She also has served as a program analyst in the office of the assistant secretary for planning and evaluation.



Rachel Wick, MPH, is a program officer for Blue Shield of California Foundation's Health Care and Coverage program. She supports the foundation's work related to improving access to healthcare services for the underserved, and strengthening systems of care in California's safety net. Previously Ms. Wick was the director for policy, planning and special projects at the Consumer Health Foundation, a private health foundation in the Washington, D.C. region. She chaired the health working group of the Washington Regional Association of Grantmakers and served on the Greater Washington Workforce Development Funders Collaborative.



Shale Wong, MD, MSPH, is a pediatrician and professor of pediatrics at the University of Colorado, teaching child health, advocacy, and health care reform with focused interests in primary care and achieving health equity. She is education director for the Eugene S. Farley Jr. Health Policy Center and a senior program consultant to the RWJ Foundation. Dr. Wong co-founded CU LEADS, a program to promote leadership, education, advocacy, development, and scholarship for medical students; focusing on social determinants of health and developing community advocates through service, collaboration and public policy. She served as health policy advisor to First Lady Michelle Obama; and assisted in launching *Joining Forces* to improve health and wellness of military families. A lifelong dancer, she is inspired to advance health through the arts.

APPENDIX E
LEXICON DETAIL PARAMETERS

The Lexicon allows us to move past discussions about what is and what is not integration, and to pursue more meaningful dialogue around implementation and scaling. While the Lexicon has many parts to it, as seen in the full write-up, for the purposes of this guide, we establish the following elements associated with integration. Of note, it is expected that all practices will have different ways of implementing integration, so these parameters should be seen as existing on a range.

A practice team tailored to the needs of each patient and situation

- Behavioral health expertise and functions are readily available to the practice – with relationships in place – ready to be part of the care team at any time for any particular patient or population
- The behavioral health expertise is brought into the care team in the ways needed for each individual patient or in general for each target population
- The workflows and protocols are in place and used to actually operationalize the behavioral health participation and role in the team

Patient identification and care planning

- A method is in place and routinely used to identify patients who need or may benefit from integrated behavioral health
- Patients are engaged with clinicians in the creation of their care plan and making important decisions concerning the plan
- Primary care and behavioral health clinicians work from shared care plans developed for each shared patient, located in a single medical record that each can access

Systematic monitoring and adjustment of treatment plans if patients are not improving as expected

- A system including a registry or patient list is in use for monitoring participation in treatment and treatment response (for individual patients and to monitor the status of selected populations)
- Outreach is made to patients who do not follow-up
- The team quickly adjusts the care plan for patients who are not improving (e.g., not responding to initial treatment, exhibiting major side-effects, not engaged or able to carry out his/her part of the plan)
- Plans to build patient understanding of setbacks and what to do about them are established for patients who are substantially improved and no longer in active treatment

Organizational functions that support integrated behavioral health

- Share across the organization a vision for integrating behavioral health in primary care , along with supporting strategies, resource allocations, and leadership alignment
- Train the practice team to work together across disciplines to integrate care
- Support daily functions of integrated behavioral health throughout the clinical operational systems to include office processes and workflow.
- Make a plan for financial support for the functions of integrated behavioral health
- Plan to routinely collects, uses, and internally report practice-based data to improve outcomes and quickly learn from experience
- Take advantage of opportunities to demonstrate or educate patients and families about the value of integrated behavioral health as a general standard of care



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