

BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION AT ESSENTIAL HOSPITALS

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KEY FINDINGS

- Behavioral health and primary care integration is an important way to reach vulnerable populations by increasing access, reducing stigma of behavioral health issues, and increasing efficiency for care providers.
- There are many different ways to integrate behavioral health and primary care services. Care models should be chosen according to provider settings, patient populations, and available resources.
- Key considerations for integrating care include leadership buy-in, effective staffing, outcomes tracking, and adequate financial structures.

**UNDERSTANDING
BEHAVIORAL HEALTH**

Nearly one in four adults in the United States will experience at least one behavioral health disorder in a given year. This includes mood disorders, anxiety disorders, substance abuse disorders, eating disorders, impulse control disorders, psychotic symptoms, adjustment disorders, and often times a combination of two or

more.¹ Comorbidities among those with behavioral health conditions also extend to physical health, as a reported 68 percent of adults with a behavioral disorder have at least one physical condition.²

Evidence also shows that a significant portion of behavioral health conditions go untreated,³ often on account of stigma, lack of detection, or lack of access to effective care. Additionally, individuals suffering from behavioral health conditions sometimes seek treatment in inappropriate settings such as the emergency department (ED), which increases health care costs and fails to provide consistent, long-term care for what is often a chronic condition.

The terms mental health and behavioral health are often used interchangeably in health care. While both of these terms refer to the mental or emotional rather than the physical state of health and well-being, behavioral health has a broader definition, as it includes substance use disorders and psychological distress along with serious mental illness (e.g., schizophrenia, major depressive disorder, bipolar disorder). Behavioral health integration programs for primary care settings are typically more inclusive and do not focus only on patients with severe mental illness. As

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such, this brief uses the more inclusive term of behavioral health when referring to a broad set of services and the narrower mental health term when referring to these services specifically.

BEHAVIORAL HEALTH AND PRIMARY CARE: A BRIEF HISTORY

More than 70 percent of primary care visits involve an underlying psychosocial issue, with depression alone ranking as the third most common reason for a health center visit.^{4,5} In the past, primary care settings have often been ill-equipped to handle these behavioral conditions among their patient population. However, with proper staff integration and training, an important and unique opportunity exists to increase efficiency, lower health care costs, and improve access. Integrating behavioral health and primary care provides a

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solution to disparities in behavioral health treatment while addressing the considerable interconnectedness of physical and behavioral health.

Integrated behavioral health and primary care programs can be traced back to the early 1970s. Through trials and pilot programs, health care providers began testing these models more frequently, and major literature on theory and practices started developing in the mid-1990s.⁶ Early work at the University of Washington in the late 1990s provided the first major study of depression in 18 primary care clinics with important results—collaborative care more than doubled the effectiveness of depression treatment in primary care settings.⁷ Over the next several years various other programs and reports emerged, highlighting similar advantages and successes of integrated care. Implementation of the Affordable Care Act (ACA) in 2010 advanced the field with a substantial shift toward integrated care and medical homes.

THE ACA'S IMPACT ON BEHAVIORAL HEALTH SERVICES

The ACA outlines a variety of additional services that will now be available for individuals with mental

health and substance use disorders. The law makes mental and behavioral health treatment one of 10 essential benefits required in new insurance policies. Specifically, it intends to achieve the following:

- improve upon existing coverage regulations for the treatment and management of mental health and substance use disorders, including prescription drugs and rehabilitation services
- expand access to mental health preventive services
- create additional incentives to coordinate primary care and mental health and substance use services

- enhance community-based services for individuals with a mental health or substance use disorder
- advance workforce initiatives to improve the overall mental health and substance use system, including investing in education and training for health care providers and loan repayment programs

For years now, the health care industry has slowly been working to transform overall care delivery, shifting from fragmentation and care siloes to a more integrated and collaborative system. The ACA, with its call for greater access and

Our Work on Behavioral Health Integration

America's Essential Hospitals recognizes the complexity and importance of addressing behavioral health issues, particularly as they relate to improving care for our nation's most vulnerable patients. This brief follows a series of articles on behavioral health integration programs within essential hospitals, as listed below:

- **How to Integrate Behavioral Health with Primary Care:** a quality toolbox article on essentialhospitals.org that introduces behavioral health integration programs within four essential hospitals
- **How to Integrate Behavioral Health with Primary Care—Part 2:** a second article that builds on part 1 and focuses on cost of care, information sharing, and culture change

In addition to these articles, we conducted a webinar in May 2015 to discuss Santa Clara Valley Health and Hospital System's behavioral health and primary care integration program. Santa Clara, which serves 64,000 primary care patients, piloted a program using the IMPACT model (discussed in **UW Medicine's Behavioral Health Integration Program**) as a framework and presented results from the initial phase.

All of this work is part of our comprehensive behavioral health educational program that also includes presentations during VITAL (our annual conference) and a specific behavioral health focus during our 2015 Innovations Summit.

Often, vulnerable patients and underserved populations are most affected by this sporadic treatment model, as they have limited access to continuous behavioral health services for long-term management of their condition.

Improved integration of behavioral health and other services, has accelerated this process. As behavioral health services have traditionally been housed outside of the physical health care delivery environment, this phenomenon is particularly important in this area. Health care administrators and providers recognize the impact of behavioral health disorders on hospitals and specifically, the ED. Patients suffering from behavioral health issues often find themselves seeking treatment and episodic care from local EDs, contributing to rising health care costs, hospital readmission rates, and fragmented care. Often, vulnerable patients and underserved populations are most affected by this sporadic treatment model, as they have limited access to continuous behavioral health services for long-term management of their condition. The ACA addresses these concerns by requiring an expansion of preventive services and improvement in care coordination between primary care, inpatient, behavioral health, and community-based services for individuals with behavioral health disorders.

Since the ACA's implementation, essential hospitals across the United States have dedicated substantial resources to developing innovative programs aimed at accomplishing

the goals set forth by the law. As new practice models emerge it is important for providers and policymakers to understand their impact on patients, health systems, and their surrounding communities. America's Essential Hospitals is focused on helping health care providers and administrators learn about these different programs for improving behavioral health care for all patients, including our nation's most vulnerable (see Our Work on Behavioral Health Integration).

RESEARCH METHODS

Following our previous work on this topic, Essential Hospitals Institute—the research and quality improvement arm of America's Essential Hospitals—set out to better understand some of the key barriers and subsequent solutions to successful behavioral health and primary care integration.

We first conducted a literature review to assess the current landscape of behavioral health and primary care integration in the United States. Then, to understand how and to what degree of success that integration exists within our membership, we systematically reviewed essential hospital websites, Gage Award submissions from 2012 to 2014, and public grants databases.

Using this pool of program examples and the synthesized literature, we selected the following five member hospitals, each with a unique and diverse program, for evaluation:

- Harris Health System, Harris County, Texas
- Nassau University Medical Center (NuHealth), East Meadow, New York
- UMass Memorial Medical Center, Worcester, Massachusetts
- University of Texas Medical Branch, Galveston, Texas

- University of Washington, Seattle, Washington

We held a series of interviews with principal health care administrators at each hospital. Interviews were structured with a consistent eight-question guide and recorded.

This brief provides an overview of each organization's program, including barriers they experienced, outcomes, and some of the key factors of successful program implementation.

BEHAVIORAL HEALTH INTEGRATION MODELS

As health care systems and providers look to integrate behavioral health care, they will need to consider what model is most suitable for their community and clinical setting, patient population, and available resources.

In 1995, researchers at the University of Minnesota developed five categories of integration: minimal, basic at a distance, basic on-site, close partly integrated, and close fully integrated.⁸ Integration in these categories ranges from very little communication between providers to providers working as collaborative teammates.

Following that, Alexander Blount, EdD, a researcher from the University of Massachusetts Medical

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School, defined three main classes of integration: coordinated, co-located, and integrated.⁹ These models range from a referral system with routine provider communication to a single, collaborative treatment plan and care team.

Building on both approaches, a 2010 Milbank Memorial Fund report presented a comprehensive framework depicting a wide spectrum of integration models (see Figure 1).¹⁰ Although the eight models are scaled from less to more integrated, they do

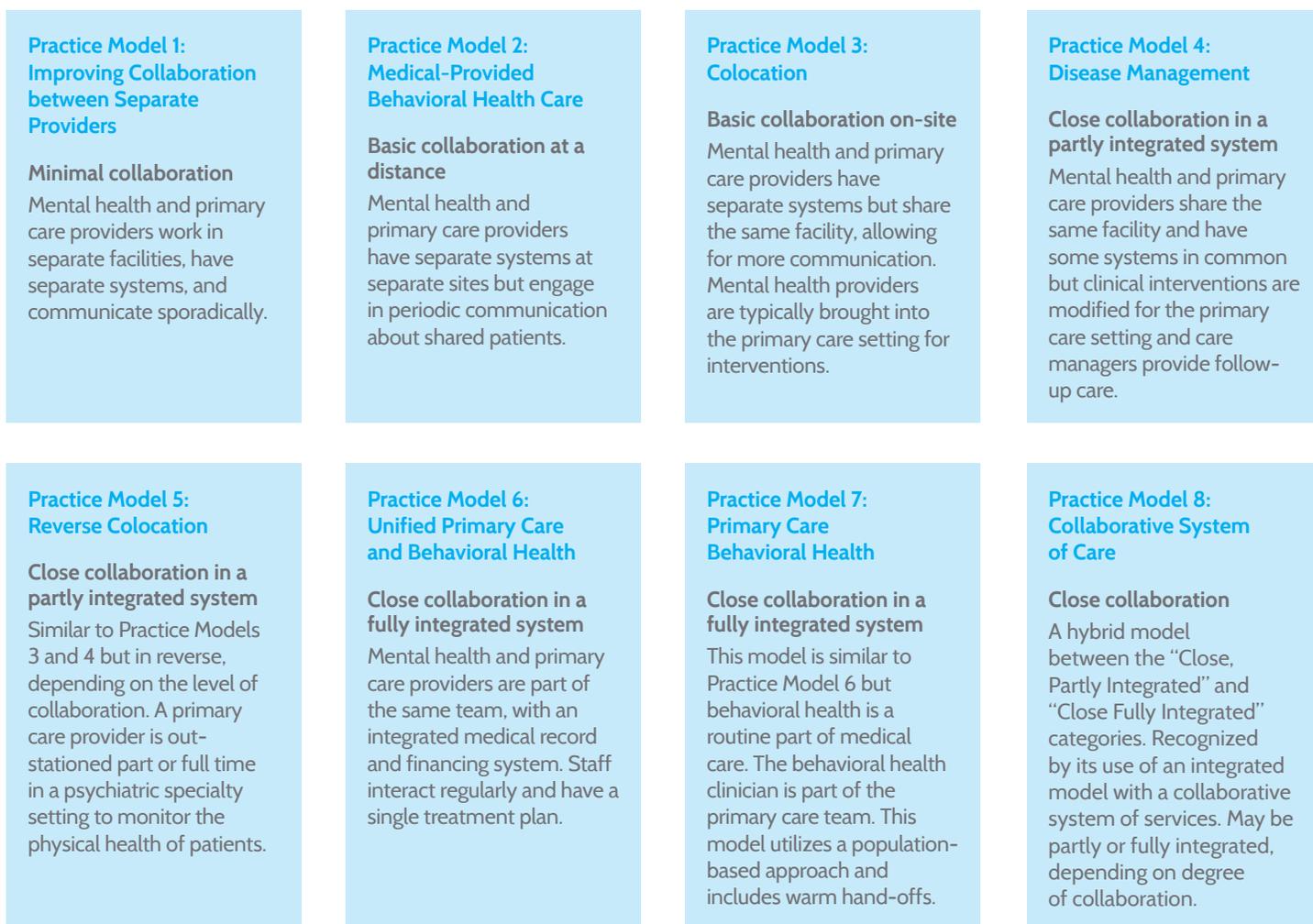
take the clinical setting in which they are implemented into consideration. Subsequently, certain models that may appear to have less integration may actually be optimal for a particular setting, depending on provider type, facilities, and patients served.

It's important to note that most integration programs across the United States are the result of two or more different practice models. Individual programs rarely fall into one practice model category, as blended programs are more

common and often reflect the unique circumstances and populations served within each community.

Each of the five programs discussed in this brief are mapped to Milbank's framework of eight practice models. Our brief review of the available literature revealed this framework as being prominently used by health services researchers and behavioral health care providers today.

FIGURE 1: MILBANK MEMORIAL FUND BEHAVIORAL HEALTH INTEGRATION MODEL CONTINUUM¹¹



HARRIS HEALTH SYSTEM'S COMMUNITY BEHAVIORAL HEALTH PROGRAM

In July 2005, Harris County Health District established the Community Behavioral Health Program (CBHP), which is focused on expanding access to behavioral health services within community health centers. CBHP is based on a pilot program launched a year earlier that placed a psychiatrist in each of three community health centers. In addition to seeing scheduled patients at the centers, the psychiatrist was responsible for providing curbside consultations to primary care providers. The goal was to train primary care providers to provide moderate psychiatric interventions themselves.

The pilot program had initial success redirecting behavioral health services to primary care settings and away from the ED and outpatient specialty clinics focused on much more severe mental illness. So, the CBHP was created as an expanded program that serves 12 primary care clinics, one school-based clinic, one HIV clinic, and one homeless clinic.¹²

CBHP most closely resembles **Practice Model 4: Disease Management** under the Milbank framework. Mental health and primary care clinicians communicate regularly due to colocation and a single electronic health record (EHR) system.¹³ Mental health staff at each clinic typically includes therapists, social workers, caseworkers, and psychiatrists. While there is appropriate integration on a case-by-case basis, the care team does not systematically discuss each patient's care plan. Today, the CBHP conducts an estimated 65,000 visits annually for a highly complex patient population—more than 50 percent present with comorbid conditions. Patients are not required to have a

CURBSIDE CONSULTATIONS

An informal and unofficial consultation obtained from a health professional by either a lay person or a fellow health care professional.

Source: Segen's Medical Dictionary. (2011)

referral to be seen as long as they already have a primary care physician established at one of the 12 primary care clinics.

NASSAU UNIVERSITY MEDICAL CENTER'S INTEGRATED PRIMARY CARE PROGRAM

In 2009, Nassau University Medical Center (NuHealth) integrated its primary care program into an outpatient mental health clinic in response to a low rate of annual physicals among mental health patients. As part of this program, an attending primary care physician from the ambulatory care department works out of the clinic four hours per week (flexible as needed). This allows each patient to get an annual physical as well as any necessary follow-up, vaccinations, and mammography/colonoscopy screening.¹⁴ A nurse is also on staff at the health center to assist with primary care services and triage.

By placing a primary care provider in a specialty mental health setting this program employs **Practice Model 5: Reverse Colocation**. Due to the use of partial EHRs (paper charts are scanned into an online system), providers are able to access both physical and behavioral health information for their patients. The program also allows for some communication between the mental

health clinicians and primary care providers due to colocation. However, as noted earlier, the primary care provider is only located within the mental health setting for a limited number of hours per week, resulting in less frequent communication and care coordination.

UMASS MEMORIAL MEDICAL CENTER'S INTEGRATED PRIMARY CARE PROGRAM

Historically UMass Memorial Medical Center's family medicine department has had behavioral science faculty follow residents through patient interactions, promoting an integrated approach among staff. This evolved throughout the late 1990s to include collaborative consultations between primary care and behavioral health staff to address psychosocial issues. In 1999, a grant opportunity allowed the hospital to develop an additional training program through a postdoctoral fellowship in primary care psychology. The fellowship program expanded over the next few years, and UMass Memorial Medical Center began full-scale integration by 2004 with residents and fellows in each of three clinic sites (two of which are a part of the health system and the third a community health center).

Family medicine residents are required to complete 33 dual interviews with postdoctoral primary care psychology fellows and/or full-time psychologists as part of their residency program. Each of the two health system centers also employs full-time psychologists, social workers, nurse practitioners, and psychology trainees. When patients arrive at the clinic they receive information about all of the behavioral health services available to them and are made aware that patient information is shared among the care team.

We categorized this program as **Practice Model 7: Primary Care Behavioral Health**. By requiring both primary care and behavioral health clinicians to interact with patients simultaneously, the model is not only colocating services but also employing a collaborative team that treats patients as one functioning unit. All members of the care team are employed under the department of family medicine and communicate in a systematic manner to provide comprehensive care for patients, comprising both physical and behavioral health elements, as needed. Behavioral health providers often meet patients briefly during their initial visit, and warm hand-offs are used to transition patients between providers on the care team. Furthermore, the use of a single EHR system allows all providers to stay well-informed of their patients' overall health progress.

UNIVERSITY OF TEXAS MEDICAL BRANCH'S TELEHEALTH FOR SCHOOL-BASED MENTAL HEALTH PROGRAM

In 2004, University of Texas Medical Branch (UTMB) designed a program to improve access to mental health services for school-aged children and teens in Galveston, Texas. In the interest of doing so efficiently and at minimal cost, the program was built upon teen health centers already in place in Galveston schools. The decision was made to pilot telehealth services rather than deploy mental health specialists in the school clinics where they may be underutilized. The program was a collaboration between UTMB health policy and legislative affairs, the Galveston Independent School District, the teen health centers, and grants from the Annie E. Casey Foundation and Robert Wood Johnson Foundation.¹⁵

Students may self-present or be referred to the program by a teen health center staff member, school faculty member, or parents/guardians. Center staff triage new patients and determine the best level and provider of care for each patient. This includes determining whether the student should see a psychiatrist, psychologist, or social worker and how often the student should see that provider. On-site staff are trained to set up the telecommunications technology and video conferencing so it is available when needed. And at least one therapist is on-site to de-escalate any situations that may arise.

Outcomes from the pilot program showed that having behavioral health services on school campuses resulted in a direct increase in school attendance among students. This development was welcomed and valued by the partnering school district, which is reimbursed per head per day in class, and the program was expanded with additional space and facilities. There are currently three operational clinics with telehealth mental health services. Providers are primarily staffed by the hospital, though some are recruited through external sources to meet the needs of a diverse population.

UTMB's program is unique in its setting and delivery of behavioral health services. As such, it is challenging to align it to any specific practice model. The program most closely falls under **Practice Model 3: Colocation**, with specialty mental health services stationed in a setting typically devoted to primary care.

UNIVERSITY OF WASHINGTON MEDICINE'S BEHAVIORAL HEALTH INTEGRATION PROGRAM

University of Washington (UW) Medicine has benefited considerably from its proximity to UW Medical

WARM HAND-OFFS

An approach in which the primary care provider does a face-to-face introduction of a patient to the behavioral health specialist to which the patient is being referred.

Source: SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)

School's Advancing Integrated Mental Health Solutions (AIMS) Center. Since the early 1990s, the AIMS Center has conducted some of the earliest behavioral health integration studies, proving the advantageous effects of collaborative care on physical and behavioral health care.

In 1998, UW researchers conducted the IMPACT (Improving Mood: Providing Access to Collaborative Treatment) study, which was the largest depression treatment study to date. This randomized controlled trial demonstrated the benefits of collaborative care for depression and formed the foundation for the IMPACT model for integration of behavioral and primary care services. The key components of the IMPACT model are practicing collaborative care, providing a depression care manager for each patient, utilizing consulting psychiatrists, systematically measuring outcomes, and using a stepped care approach (adjusting treatment based on clinical outcomes according to an evidence-based algorithm).¹⁶

With the help of the AIMS Center and its unique IMPACT model, UW Medicine began its Behavioral Health Integration Program (BHIP) in 2012. BHIP incorporates behavioral health care managers and psychiatric consultants at 14 primary care clinics.

Often these programs are spearheaded or championed by a single or small group of physicians who see the direct benefits of integration, such as improved efficiency and quality of care for their patients.

Primary care physicians in the clinics conduct routine screening for behavioral health disorders among patients, determine whether further assessment and diagnosis is required by behavioral health specialists and, when necessary, provide warm hand-offs to care coordinators within the same facility. The care team comprises a primary care physician, a care manager (i.e., nurse or clinical social worker), psychiatric consultants, and at times, additional mental health providers such as chemical dependency counselors.

Our analysis of BHIP leads us to categorize it as **Practice Model 6: Unified Primary Care and Behavioral Health** under the Milbank framework. This model consists of most of the elements of a fully integrated system, including colocation, a fully collaborative care team, a single treatment plan for each patient that includes both physical and behavioral health elements, and an integrated EHR system. In addition, members of the care team have established a systematic process to ensure continuous communication between primary care and behavioral health providers for each patient.

TIPPING THE SCALE TOWARD SUCCESS

In evaluating these five programs, we identified some of the most commonly faced barriers to implementation across the spectrum:

- leadership buy-in
- staffing and training
- measurement and outcome reporting
- funding and reimbursement

Leadership Buy-In

One of the greatest challenges in implementing new behavioral health and primary care integration programs is making structural and even ideological changes within the culture of an organization. Often these programs are spearheaded or championed by a single or small group of physicians who see the direct benefits of integration, such as improved efficiency and quality of care for their patients. To move this idea forward, providers must choose the appropriate care model that suits their clinical system and convince leadership to provide the necessary approvals and resources. To succeed in this fairly challenging task, providers should present an evidence-based clinical and financial rationale for integration that will enable leadership to make a more informed decision.¹⁷ This evidence-based rationale can include projected cost reductions, increased efficiency, reduced ED use, and increased access to behavioral health and primary care for vulnerable patients.

Additionally, it's important to appeal to other individuals involved in care delivery, including ancillary staff at health clinics and any other system employees who may be affected by the integration. Any potential changes in staff's day-to-day functions should be

thoroughly discussed and agreed upon by all stakeholders involved, as they are critical to program sustainability and operation.¹⁸

Staffing and Training

As two separate departments or programs are united into one cohesive group, additional hurdles arise around staff restructuring, training and education, and reconfiguring facility space. All of these factors are contingent on funding that may not be abundantly available. Essential hospital leaders also noted issues with billing, scheduling, and significant workforce turnover, the last one being a major obstacle in ensuring consistent care teams.

Systems such as UMass Memorial Medical Center are able to leverage training programs to cultivate integration, as family medicine residents and postdoctoral primary care psychology fellows are the cornerstone of the care teams in their health clinics. Other systems such as Harris Health employ their psychiatric residency program, also calling on an available staffing resource while educating young physicians. Workforce capacity and oversized caseloads can be another challenge, particularly in places where behavioral health staff are splitting their time among other

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services or facilities. UTMB cites this as a key reason for instituting telepsychiatry, as it cuts down on provider travel time, provides access to patients in remote locations, and alleviates space constraints in clinics. NuHealth operates with a specific focus on flexibility for the visiting primary care physician (scheduling visit frequency based on demand). This prevents high no-show rates and underutilized provider time, which could impact buy-in from other departments and leadership. Many programs, including UW's, use online training programs to ensure all staff can undergo standardized training for integrated care.

Measurement and Outcome Reporting

Just as evidence-based arguments are crucial to convincing leadership of the need for integration, outcomes evidence is also key to influencing policymakers and payers of the need to support integration. Known benefits of integration include patient and provider satisfaction, increased access to mental health services and primary care services, improved patient adherence to treatment, improved clinical outcomes, and increased cost effectiveness.¹⁹ However, providing evidence for these outcomes can be difficult,

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particularly at essential hospitals with their high volumes of complex patients and limited financial resources. Use of EHRs for tracking outcomes and carefully planned program evaluations can help address this issue; however, budget constraints are a key barrier.

Another challenge to quantifying the benefits of integration lies in considering increased access as an outcome measure. While increased access is an important measure, it can make cost-savings difficult to discern unless it is looked at proportionally and as an adjusted metric. Grant funding can be helpful in data collection and outcome reporting but does not provide a long-term solution to implementing a standardized system or protocol.

Validated mental health screening tools, such as the PHQ-9²⁰ and GAD-7²¹, are often used to track changes in patients' mental health status over time. For example, UW Medicine utilizes a web-based care management tracking system to showcase improvement in patient outcomes using PHQ-9 and GAD-7 scores. Similarly, Harris Health began tracking mental health outcomes using the PHQ-9. UMass was able to create its own survey based on these validated mental health screening tools. Alternatively, less conventional outcomes can still make a case for integration, such as increased school attendance at UTMB's school-based program and increased annual physicals at NuHealth.

Funding and Reimbursement

Some of the biggest and most consistent obstacles to integration are funding and reimbursement structures. Longstanding policies for payment, billing, and reimbursement do not always have the flexibility

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to accommodate the changes that integration brings to a health care setting. In order to keep up with changing models of care, payment reform is and will continue to be a necessary element for successful integration programs. Payment reform must also be paired with cultural and policy changes to have a widespread and sustainable impact on the way care is delivered.²²

UTMB began its integration work with grant funding and was able to replace that with school and hospital funds as the program gained traction. UTMB has also been working with the U.S. Department of Health and Human Services and Texas Board of Medical Examiners to ensure telepsychiatry is reimbursable through various payers. Under certain provisions, telemedicine is covered by Medicare, and several states have also been able to incorporate these services into Medicaid reimbursements. Third-party payers are a particular challenge and many states have, or are working toward establishing, mandates for telemedicine inclusion.^{23,24}

UMass participates in the Massachusetts Primary Care Payment Reform (MPCPR) Program, a Medicaid program supported by a State Innovations Model (SIM) grant from the CMS Innovation Center. SIM grants are offered to states and other entities working on new payment and service delivery models that will benefit

Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Under Massachusetts' model, practices receive a bundled payment based on their fee-for-service payments from the prior year, adjusted by risk, acuity scores, and quality scores. The bundled payment covers primary care services with the option to include some behavioral health services as needed.²⁵

NuHealth strictly uses internal hospital funding for both psychiatric and primary care services. Providers are able to bill directly to each of these separate departments within the hospital. However, funding continues to be a challenge for other indirect costs such as clinic space and supplies. Harris also bills separately to psychiatry and ambulatory care and is able to use Delivery System Reform Incentive Payment (DSRIP) Program funding for other program expenses and maintenance costs. The DSRIP is a Section 1115 state Medicaid waiver also aimed at supporting innovative delivery system reform.

UW supports its BHIP program through health system funds and a combination of public and private payers. Hospital staff are hoping that a proposed Medicare billing reform from the Centers for Medicare & Medicaid Services (CMS) will allow its care coordinators and psychiatric consultations to be reimbursable through Medicare in the future. This bill, H.R. 2759, was introduced in June 2015 and amends title XVIII of the Social Security Act to cover marriage and family therapist services as well as mental health counselor services under Medicare Part B, particularly among rural health clinics, federally qualified health centers, and hospice programs.²⁶

ESSENTIAL HOSPITALS CAN LEAD INTEGRATION, A KEY STEP IN HEALTH CARE IMPROVEMENT

Integrating behavioral health and primary care is an important part of improving the U.S. health care system. It can decrease costs and increase efficiency, enhance the patient and provider experience, and improve health at community and population levels. By continuing to push this integration forward, we can help mitigate any stigma associated with these services and bolster inadequate detection rates (i.e., poor screening) that often plague the behavioral health environment. At the same time we can improve our health systems in a socially and economically responsible manner.

As providers of care to vulnerable populations, essential hospitals are uniquely positioned to implement this kind of care. These hospitals are engrained in their community as a trusted and central resource for care. They can have a profound impact on equitable and efficient care delivery.

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