Strategies for Effective Behavioral Health Integration

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Defining Integrated Care

"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."

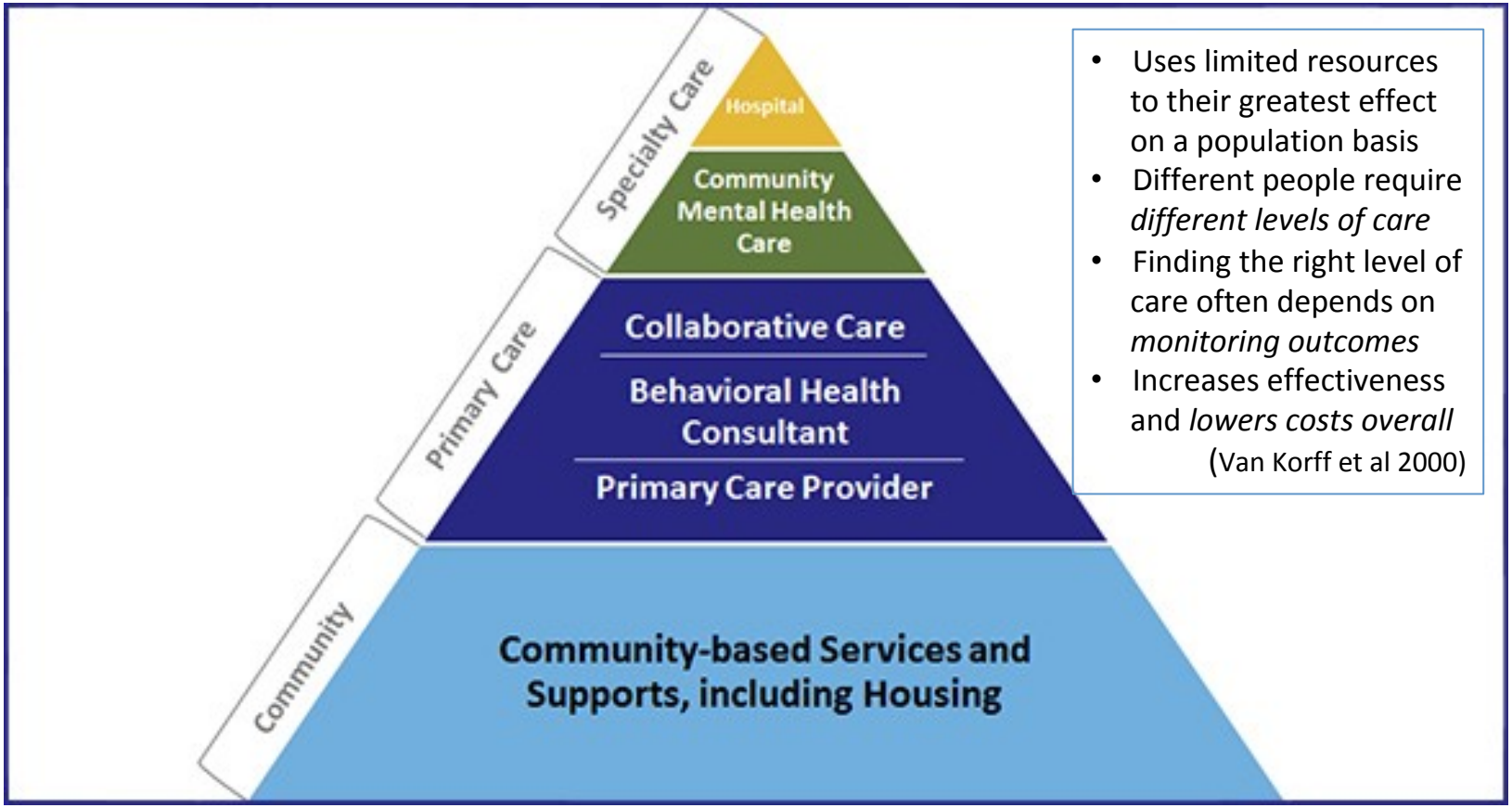
Peek CJ and the National Integration Academy Council. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: *Agency for Healthcare Research and Quality. 2013.*

SAMHSA Levels of Integrated Care

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

https://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare

Stepped Model of Integrated Care

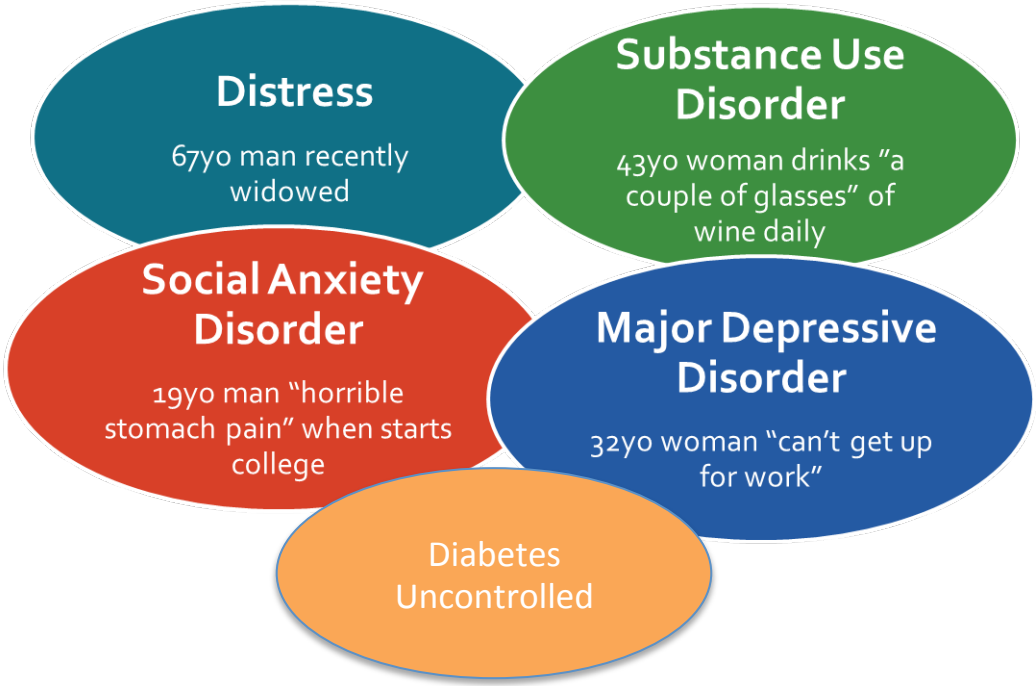


- Uses limited resources to their greatest effect on a population basis
- Different people require *different levels of care*
- Finding the right level of care often depends on *monitoring outcomes*
- Increases effectiveness and *lowers costs overall*

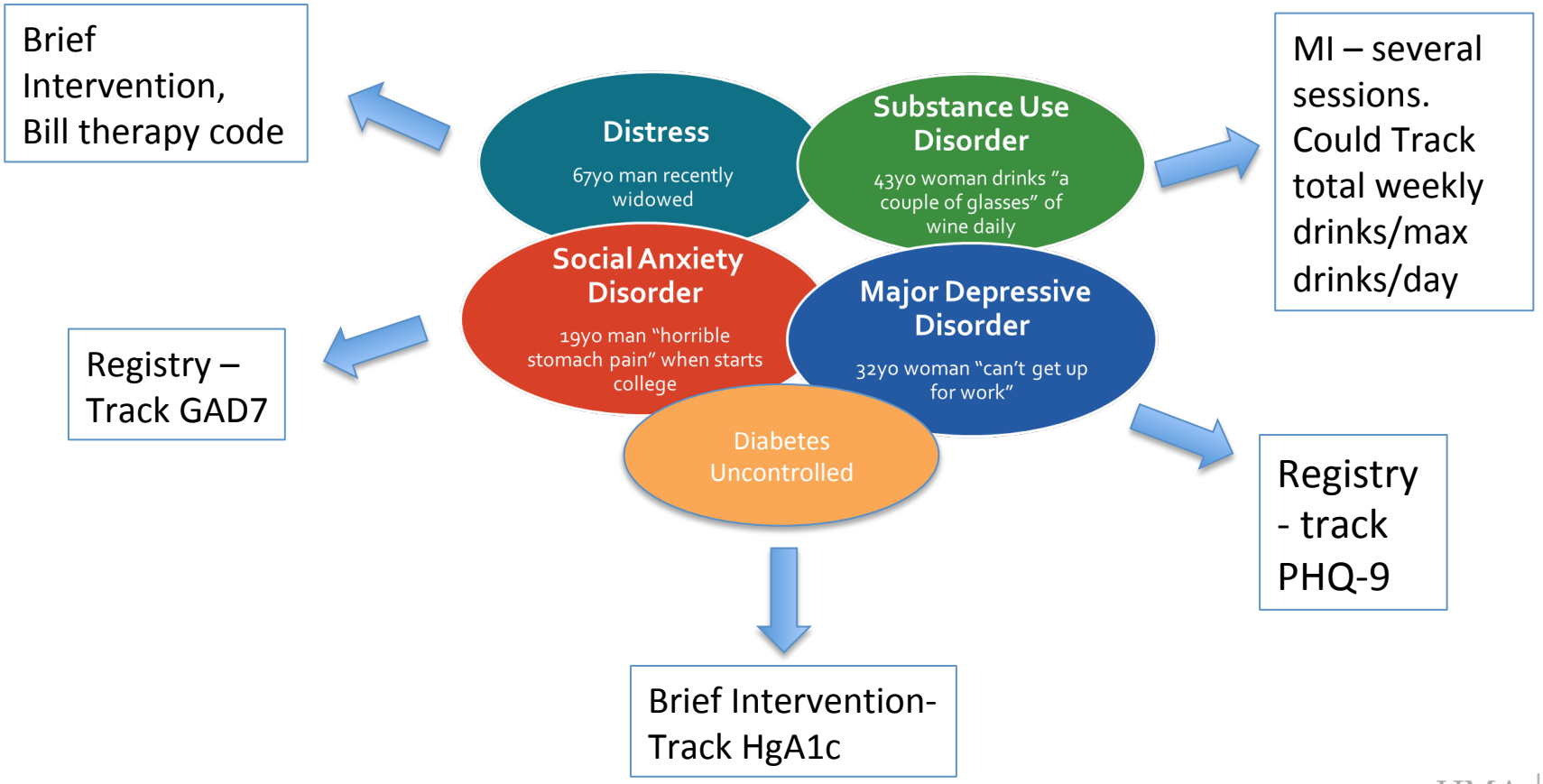
(Van Korff et al 2000)

http://aims.uw.edu

Behavioral Health Presentations in PC



Behavioral Health Presentations in PC



For those of you practicing IC what approach are you using?

Recipe for Success

Ingredients TEMP

Team that consists at a minimum of a PCP, BHP and psychiatric consultant
Evidence-based behavioral and pharmacologic interventions
Measuring care continuously to reach defined targets
Population is tracked in registry, reviewed, used for quality improvement
Accountable for outcomes on individual and population level

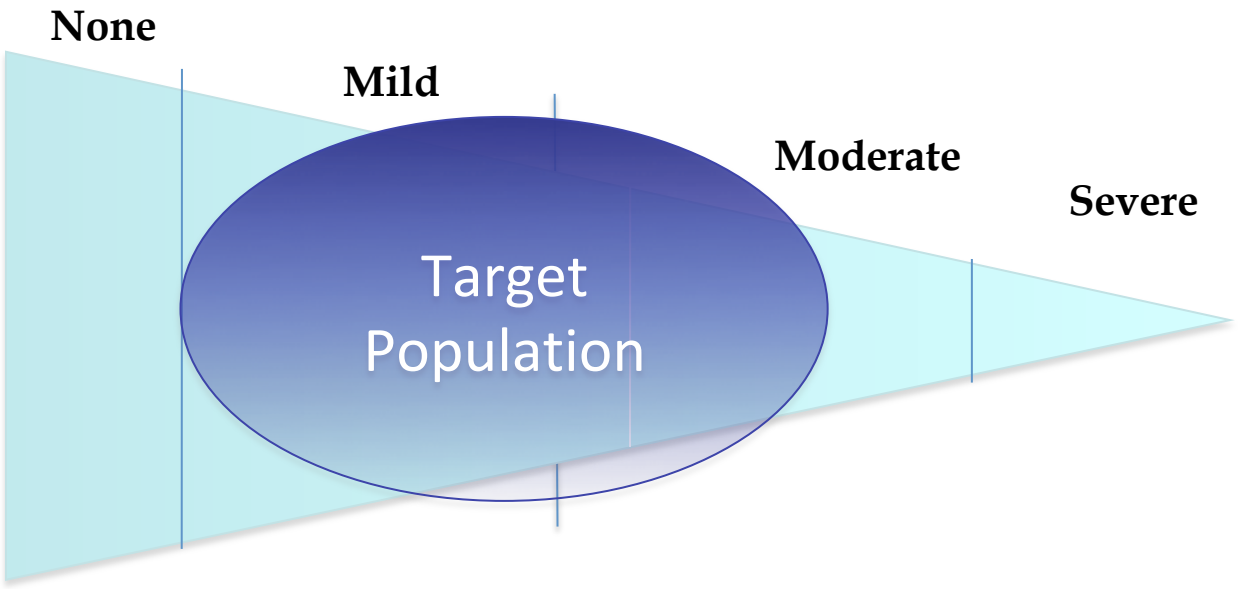
Process of Care Tasks

- ***2*** or more contacts per month by BHP
- Track with registry
- Measure response to treatment and adjust
- Caseload review with psychiatric consultant

Secret Sauce *Whitebird Brand*

- Strong leadership support
- A strong PCP champion and PCP buy-in
- Well-defined and implemented BHP/Care manager role
- An engaged psychiatric provider
- Operating costs are not a barrier

Go Upstream: "Sweet" Spot in Primary Care

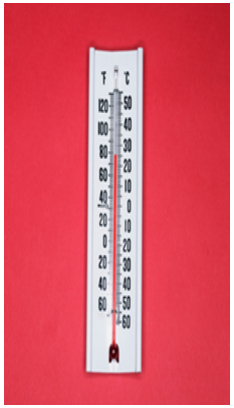


- Issues with depression and substance abuse can be pre-empted, rather than progressing to diagnosis
- Goal is to detect early and apply early interventions to prevent from getting more severe

Core Principles of Effective Integrated Care

- Effective integrated care operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.
- Care is:
  - **T**eam-based effective collaboration and Patient-centered
  - **E**vidence-based and practice-tested care
  - **M**easurement-based care, treat to target
  - **P**opulation-based care – registry, systematic screen

  - **A**ccountable care



Collaborative Care

Informed, Activated Patient

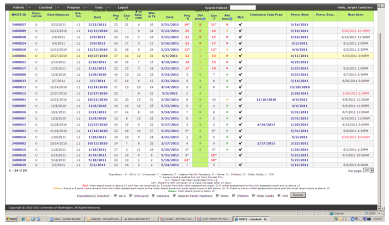
Effective Collaboration

PRACTICE SUPPORT

PCP supported by Behavioral Health Care Manager

Measurement-based Treat to Target

Psychiatric Consultation



Caseload-focused Registry review

Training

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A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

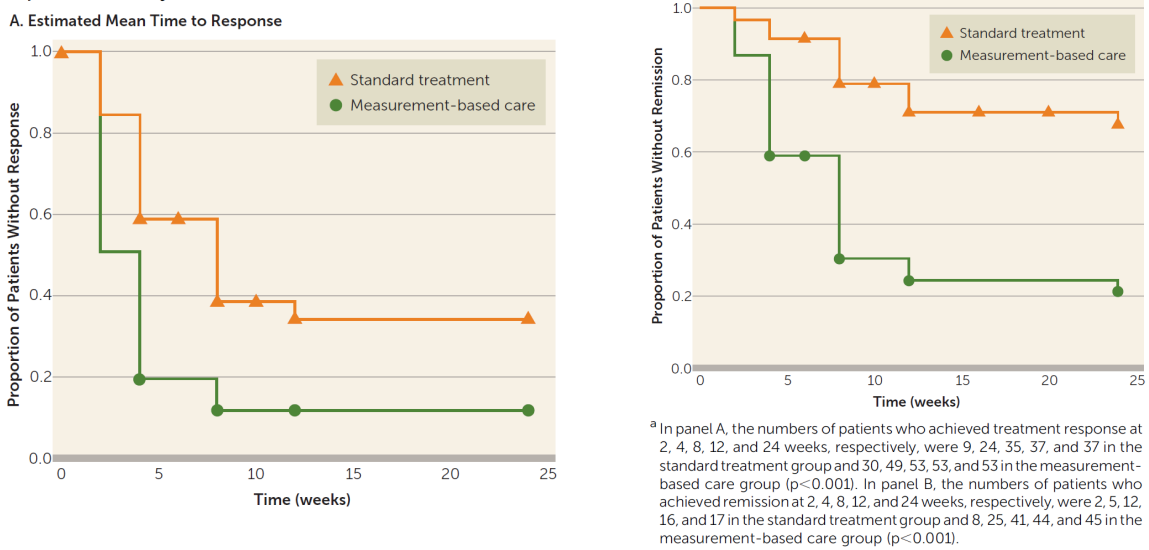
Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439

Care That Is Measured Gets Better

FIGURE 1. Estimated Mean Time to Response and Remission, by Kaplan-Meier Analysis[a]



[a] In panel A, the numbers of patients who achieved treatment response at 2, 4, 8, 12, and 24 weeks, respectively, were 9, 24, 35, 37, and 37 in the standard treatment group and 30, 49, 53, 53, and 53 in the measurement-based care group ($p<0.001$). In panel B, the numbers of patients who achieved remission at 2, 4, 8, 12, and 24 weeks, respectively, were 2, 5, 12, 16, and 17 in the standard treatment group and 8, 25, 41, 44, and 45 in the measurement-based care group ($p<0.001$).

- HAM-D 50% or <8
- Paroxetine and mirtazapine
- Greater response
- Shorter time to response
- More treatment adjustments (44 vs 23)
- Higher doses antidepressants
- Similar drop out, side effects

Quo T, Correll, et al. American Journal of Psychiatry, 172 (10), Oct, 2015

MBC Concepts

Process:

- Systematic administration of symptom rating scales – use huddle or registry
- NOT a substitute for clinical judgement
- Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
- Patient rated scales are equivalent to clinician rated scales
- Aggregate data for
  - Professional development at the provider level – MACRA
  - Quality improvement at the clinic level
  - Inform reimbursement at the payer level

Ineffective Approaches:

- One-time screening
- Assessing symptoms infrequently
- Feeding back outcomes outside the context of the clinical encounter

Fortney et al Psych Serv Sept 2016

Validated Tools

Mood Disorders

- PHQ-2, PHQ-9: Depression
- CIDI 3.0: Bipolar disorder
- MDQ: Bipolar disorder

Anxiety and Trauma Disorders

- GAD- 7: Anxiety, GAD
- PCL-C: PTSD (with Criterion A)

Substance Use Disorders

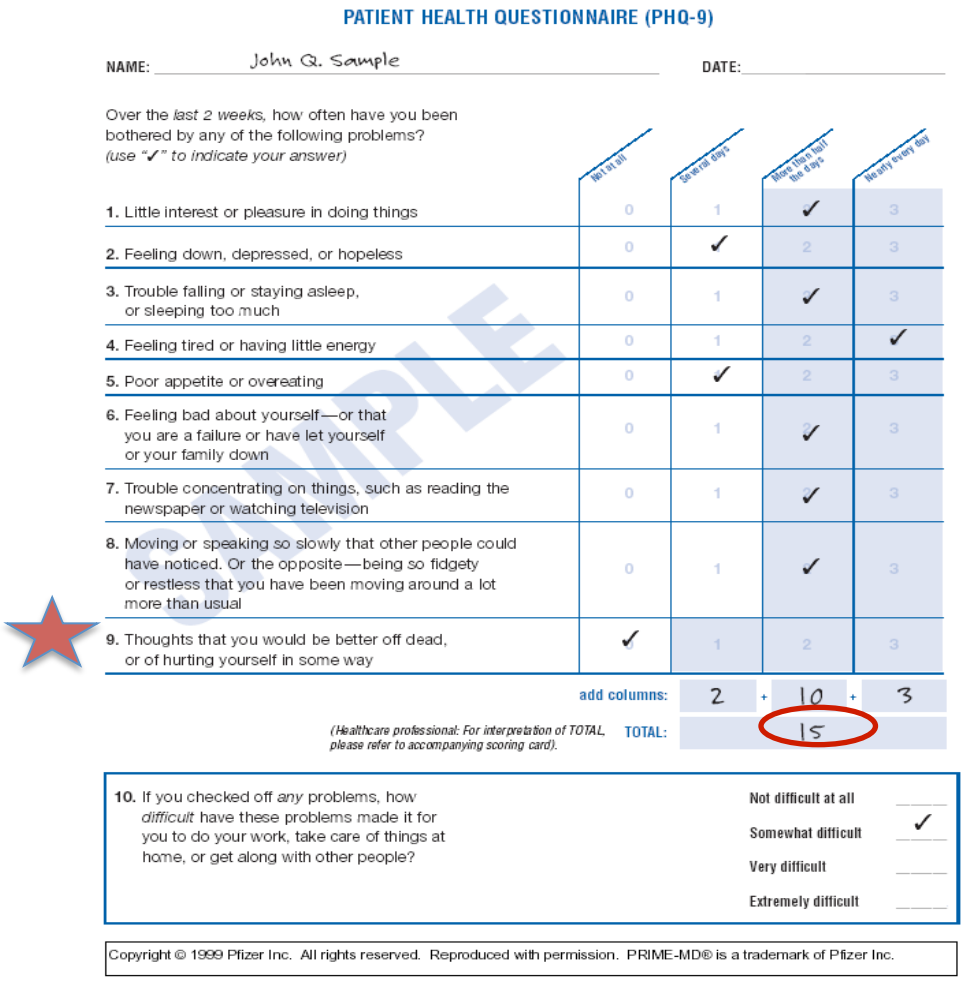
- AUDIT-C
  Full AUDIT
- DAST

PHQ - 2

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

- Ultra brief screening
- Commonly used in primary care
- Scoring:
  - 0-2: Negative
  - 3 or Higher: Positive and patient needs further assessment

Validated Screening and Measurement Tools



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE:

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:			15	

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

PHQ 9 > 9

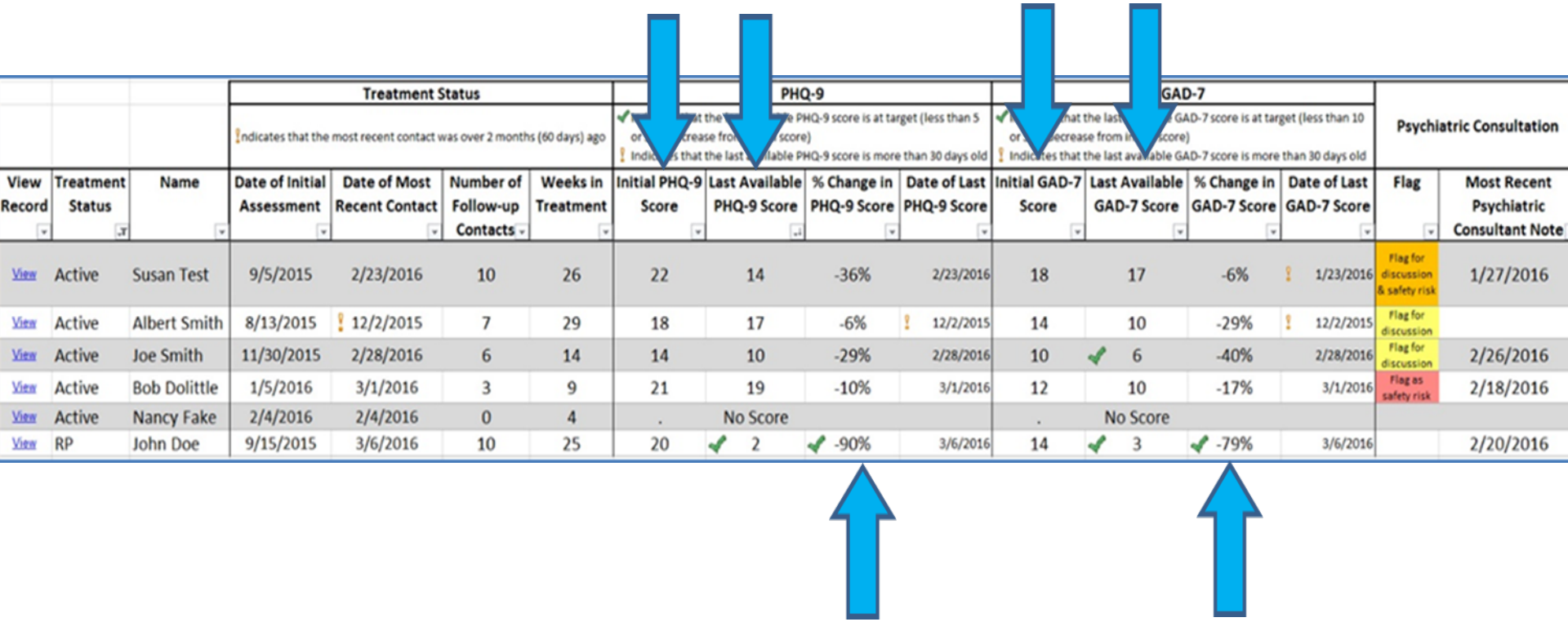
- < 5 – remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =	Score ≥ 10 indicates possible diagnosis			

Readiness Quiz:
What screening and measurement tools are you currently using?

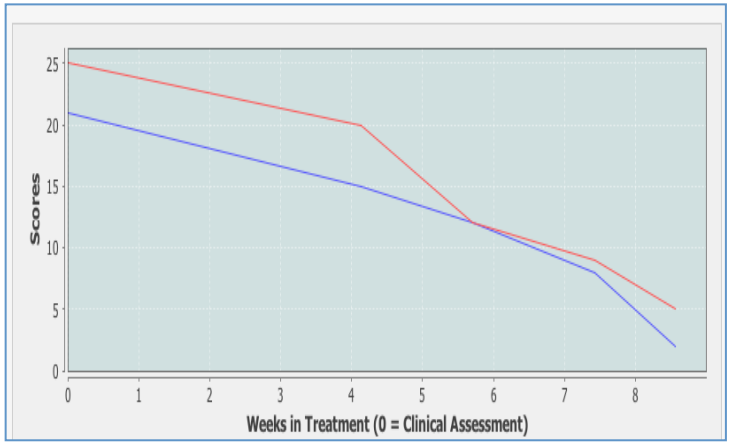
Using Data to Drive Response

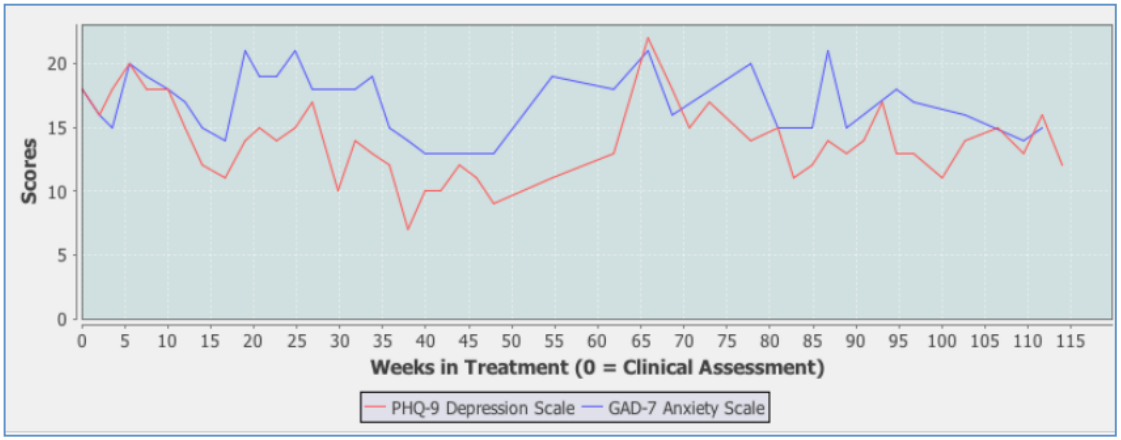


			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the PHQ-9 score is at target (less than 5 or ... decrease from ... score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last GAD-7 score is at target (less than 10 or ... decrease from ... score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Measurement Based Treatment To Target





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Applying the Core Principles in Your Clinic: Initial Analysis

Gap Analysis Effective Integrated Care Team Exercise

Key Component	Score 0 = not at all in place 5 = fully in place	If you scored low in this category- what are the barriers to having this element in place?	Strengths/Opportunities-
1.Team-based approach to care			
Clinic has a defined team(s) with clear roles.			
Behavioral health staff member is a regular member of the clinical care team.			
The team has created and trained on processes and workflows for hand-offs and communications from one team member to another.			
PCPs and BHP meet with regularly with consulting psychiatrist/psych NP			
2. Evidence-based care			
The care team understands the evidence for screening for BH conditions in the primary care setting.			
Providers have reviewed and applied the evidence-based guidelines on depression diagnosis and treatment.			
The model of "stepped care" is the approach. The team understands this approach and it is used for systematic			

BHPs/Care Managers

Who are the BHPs/CMs?

- Typically MSW, LCSW, MA, RN, PhD, PsyD, paraprofessionals
- Brief intervention skills, generalists preferrable

What makes a good BHP/CM?

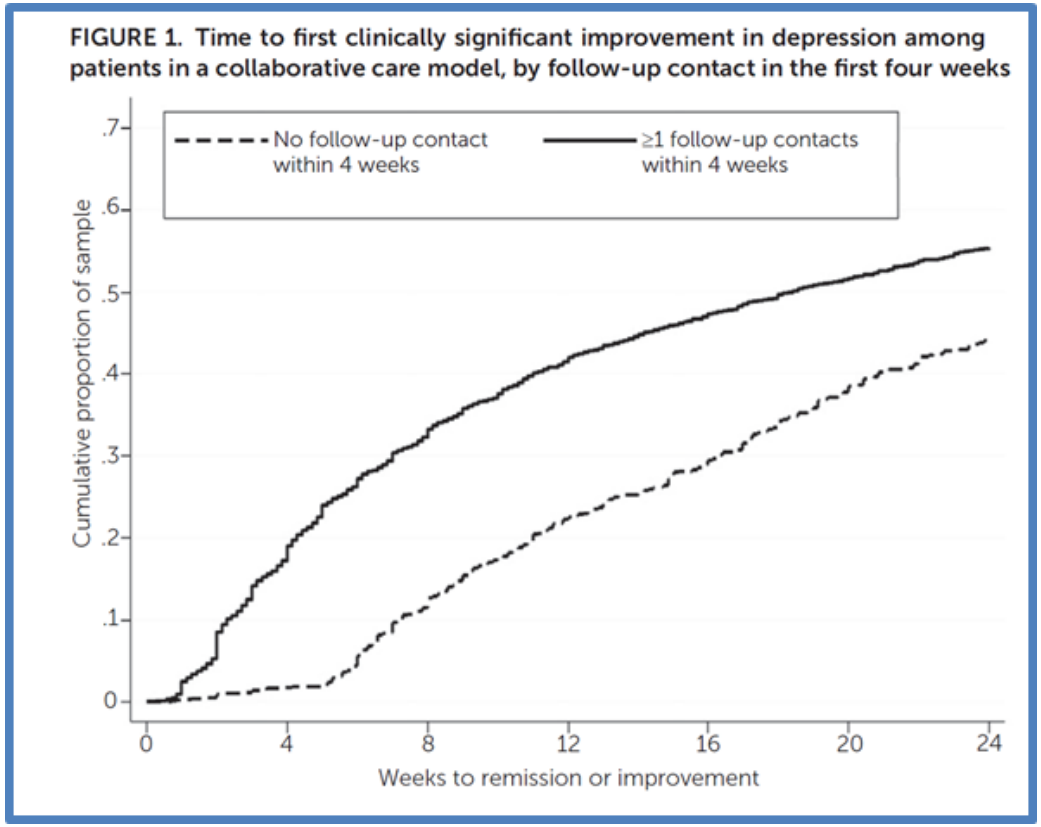
- Believes brief treatment works
- Organizational skills
- Persistence- tenacity
- Adaptable to change
- Comfortable with efficient and quick assessments
- Good triage skills
- Willingness to be interrupted
- Ability to work in a team

CAUTION:
Traditional Approach to therapy
Not willing to be interrupted
Timid, insecure about skills

Evidence-based Brief Interventions

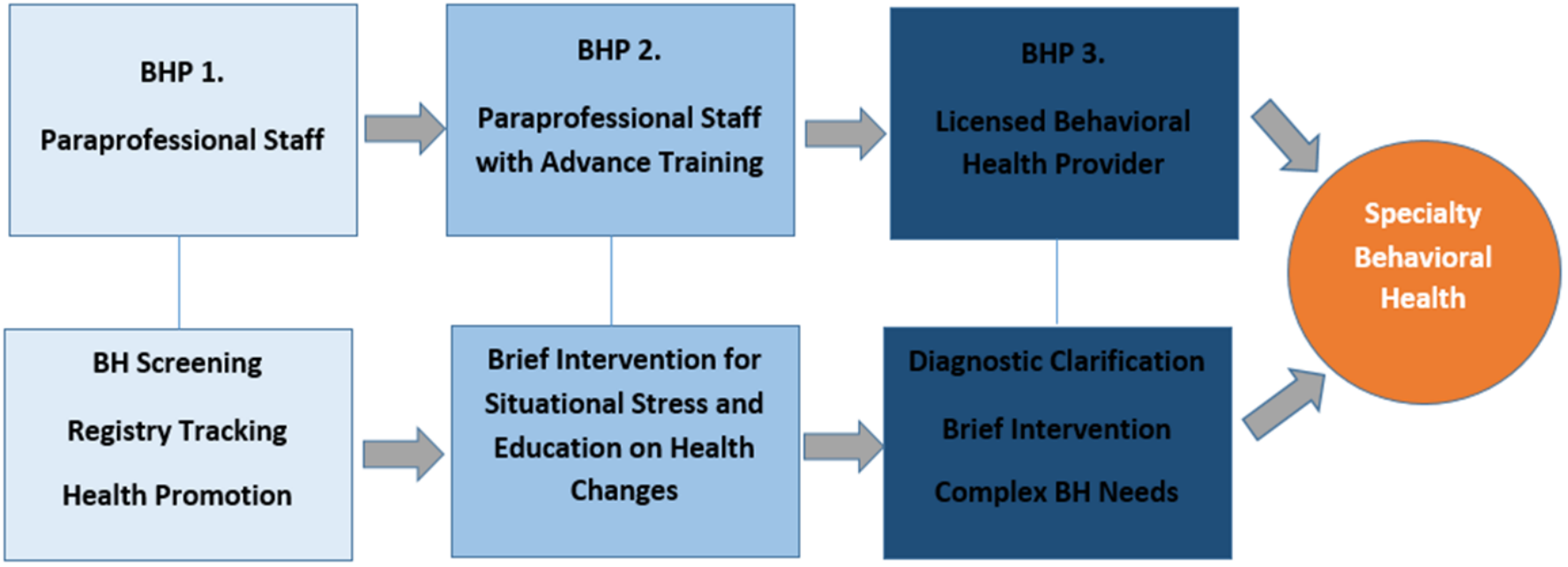
- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy

Frequent, Persistent Follow-up

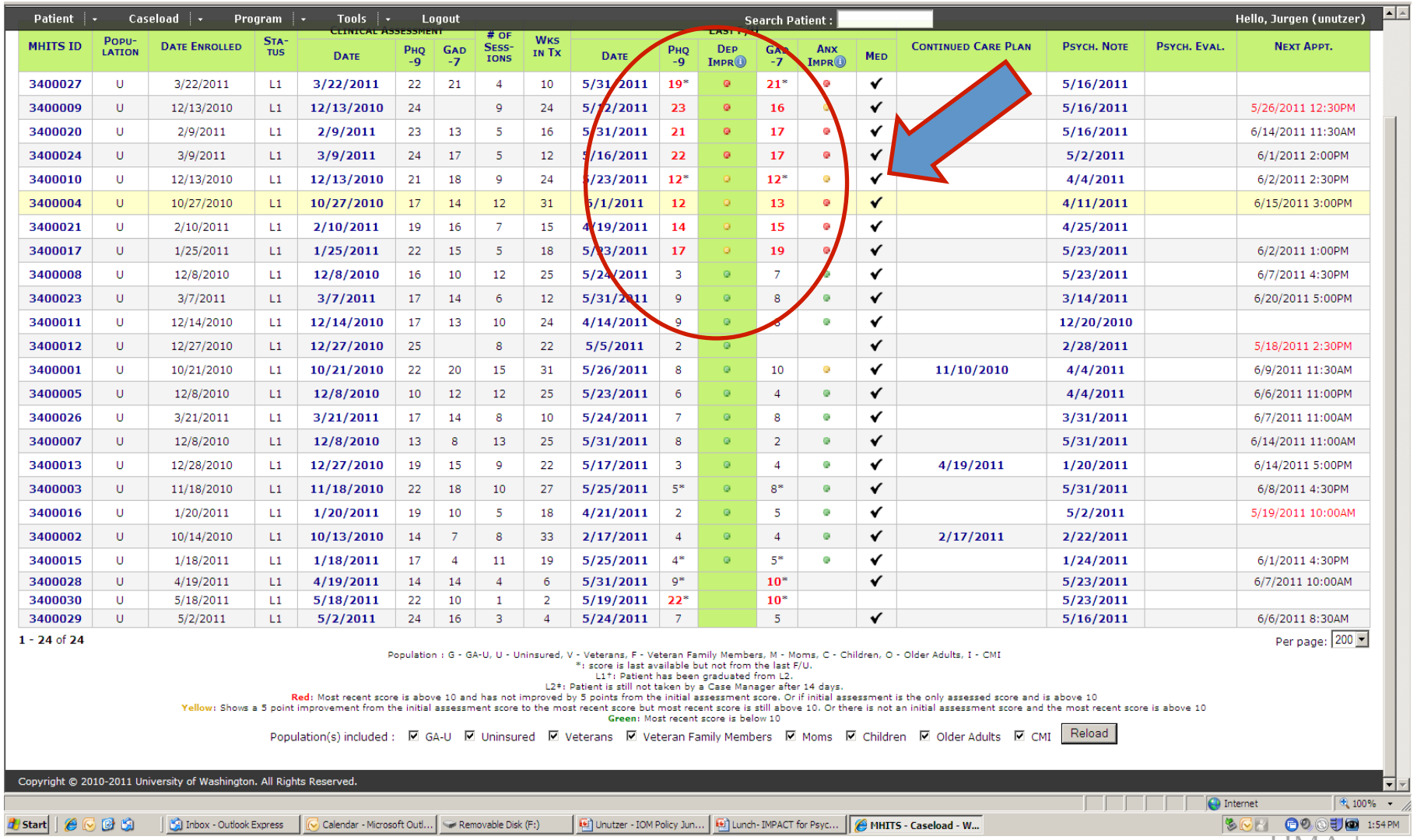


Bao et al: Psych Serv 2015

Task Sharing - Behavioral Health Provider



Registries to Track Progress, Change Treatment



Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last PHQ-9								
				Date	PHQ-9	GAD-7			Date	PHQ-9	Dep Impr	GAD-7	Anx Impr	Med	Continued Care Plan	Psych. Note	Psych. Eval.	Next Appt.
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/[illegible]2/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
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3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/16/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
3400004	U	10/27/2010	L1	10/27/2010	17	14	12	31	5/1/2011	12		13		✓		4/11/2011		6/15/2011 3:00PM
3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓		4/25/2011		
3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
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3400023	U	3/7/2011	L1	3/7/2011	17	14	6	12	5/31/2011	9		8		✓		3/14/2011		6/20/2011 5:00PM
3400011	U	12/14/2010	L1	12/14/2010	17	13	10	24	4/14/2011	9		[illegible]		✓		12/20/2010		
3400012	U	12/27/2010	L1	12/27/2010	25		8	22	5/5/2011	2				✓		2/28/2011		5/18/2011 2:30PM
3400001	U	10/21/2010	L1	10/21/2010	22	20	15	31	5/26/2011	8		10		✓	11/10/2010	4/4/2011		6/9/2011 11:30AM
3400005	U	12/8/2010	L1	12/8/2010	10	12	12	25	5/23/2011	6		4		✓		4/4/2011		6/6/2011 11:00PM
3400026	U	3/21/2011	L1	3/21/2011	17	14	8	10	5/24/2011	7		8		✓		3/31/2011		6/7/2011 11:00AM
3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
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1 - 24 of 24 — Per page: 200

Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1†: Patient has been graduated from L2.
L2*: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

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Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... | 1:54 PM

HMA

AIMS Center: http://aims.uw.edu

Psychiatric Consultant

Availability to Consult Promptly

- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated
- ***Pattern recognition*****
- ***Education*****
- ***Build confidence and competence*****

Caseload Reviews

- Scheduled (ideally weekly)
- Prioritize patients that are not improving – extends psychiatric expertise to more people in need
- Make recommendations – PCP may or may not implement
- **NO RX**

Psychiatric Providers Supporting Teams

Care Manager/BHP 4

Care Manager/BHP 1

Care Manager/BHP 3

Care Manager/BHP 2

50-80 patients/caseload
2-4 hrs psych/week/ care coordinator
= a lot of patients getting care

Roles of Primary Care Provider

- *IDENTIFY* individuals who need BH support and
- *ENGAGE* them in the treatment model
- Utilize screening tools to track progress (e.g., PHQ-9)
- Sufficient knowledge of psychopharmacology – prescribe meds

PCP "Buy-In"

Before Implementation	After Implementation
• This is going to slow me down • I don't have time to address one more problem • I have liability concerns • I already do a good job of treating mental illness	• This takes a load off my plate • This speeds me up • I always want to practice like this • I am giving better care to my patients • This gives me time to finish my note

"If you aren't uncomfortable with your practice you aren't practicing integrated care."

PCP "Champion"

- Someone that has *natural leadership skills*, respect from their peer physicians
- They may be in a formal leadership role or not – but they are seen as having a *respected opinion by their colleagues* and peers (formal or informal leader)
- Understand the integration and team approach to all care – respecting various roles and that while typically physicians are leading the team, the *other roles are vitally important and need to be respected*. They can lead other physicians to that approach and ability to "let go" of some of the work that they think they are the only ones that can do.
- *Committed to the work* and most ideal would be that they are given some time to truly lead the work and be the "champion" – *attending meetings, helping to aid in implementation , education to physicians and other team members, helping to recruit the consulting psychiatrist, etc.*

Whitebird, et al. Am J Manag Care. 2014;20(9):699-707

**PCP Buy-In Handout

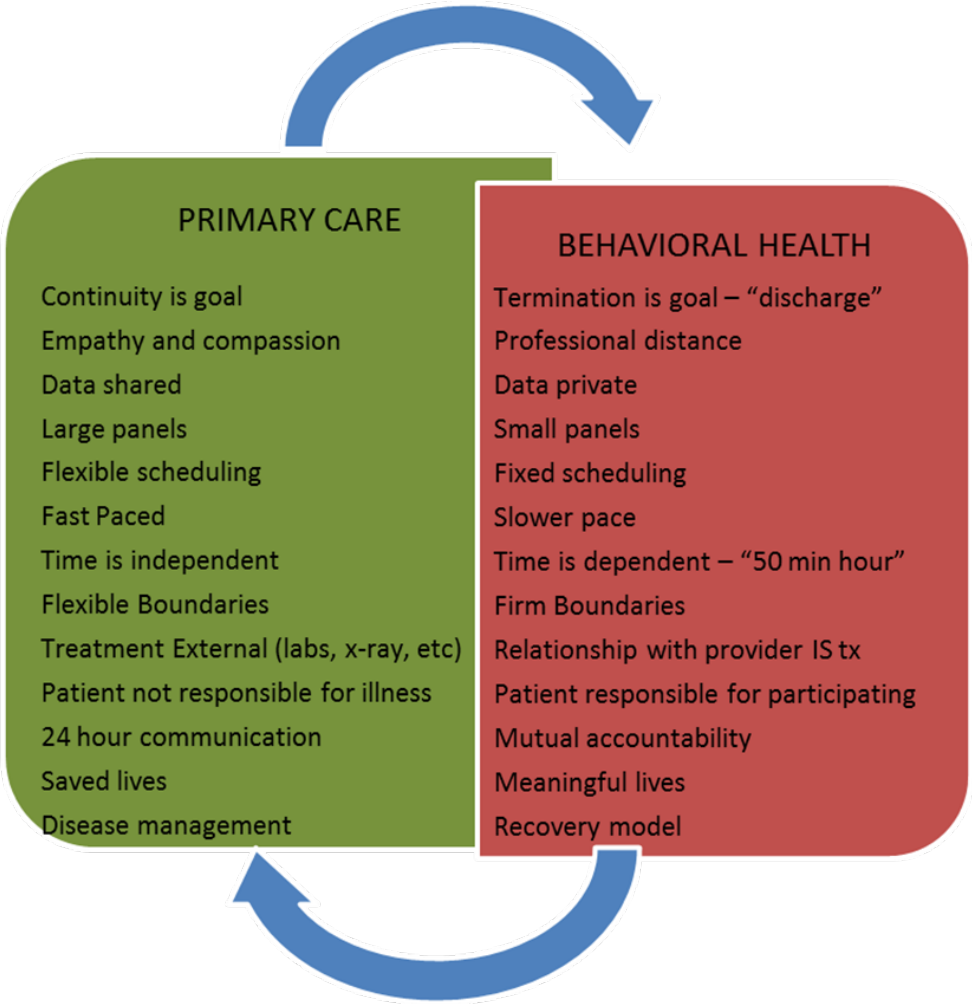
Pitch

- We have *a new way we are providing health care at the clinic* for patients experiencing stressors like yours.
- In this program, *you will still have appointments with me to continue working with your medications*, **and**
- *You will be working with a behavioral care manager,* whose job it is *to help you improve your day to day function*, while we work on your medications if you choose to take them.
- *S/he and I will be in communication about your care* and function. *S/he will really be my "eyes and ears" between our appointments* to let me know how you're doing and if what we are doing is working to improve your function; so ***it*** *is really important that you work closely with her/him* so s/he can give me the clearest picture of what's going on with you. S/he can also provide therapy.
- *I want to set up an appointment/go get them now for you to meet her/him*, so that s/he can meet you and assess your situation.

Audience Participation: Role Play

- PCP
- BHP

Two Cultures : One Patient



Effective Implementation: 9 Factors

Table 1. Factors Considered Important for Implementation of DIAMOND

Ranking	Implementation Factor	Definition
1	Operating costs of DIAMOND not seen as a barrier	The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.
2	Engaged psychiatrist	The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.
3	Primary care provider (PCP) "buy-in"	Most clinicians in the clinic support the program and refer patients to it.
4	Strong care manager	The care manager is seen as the right person for this job and works well in the clinic setting.
5	Warm handoff	Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.
6	Strong top leadership support	Clinic and medical group leaders are committed and support the care model.
7	Strong PCP champion	There is a PCP in the clinic who actively promotes and supports the project.
8	Care manager role well defined and implemented	The care manager job description is well defined, with appropriate time, support, and a dedicated space.
9	Care manager on-site and accessible	The care manager is present and visible in the clinic and is available for referrals and patient care problems.

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

Whitebird, Jaeckels Kamp et al. Am J Manag Care. 2014;20(9):699-707

Psychological Safety

"A shared belief that the team is safe for interpersonal risk taking. It can be defined as "being able to show and employ one's self without fear of negative consequences of self-image, status or career". In *psychologically safe* teams, team members feel accepted and respected. It is also the most studied enabling condition in group dynamics and team learning research."

Source: Amy Edmondson, Novartis Professor of Leadership and Management at Harvard Business School.
Ted X on Psychological Safety in Teams 2014

WHAT HAPPENS ON TEAMS WITHOUT PSYCHOLOGICAL SAFETY?

Natural human tendency to use "impression management."

No one wants to look:

Source: Amy Edmondson Ted X on Psychological Safety in Teams

Uninformed

Don't ask questions

Lack of cross training occurs & and reduces collaboration

Incompetent

Don't admit weakness or mistake

Lack of trust developed between PCP & BHP

Intrusive

Don't offer ideas

Don't benefit from diversity of disciplines & reduced warm handoffs

Negative

Don't critique the status quo

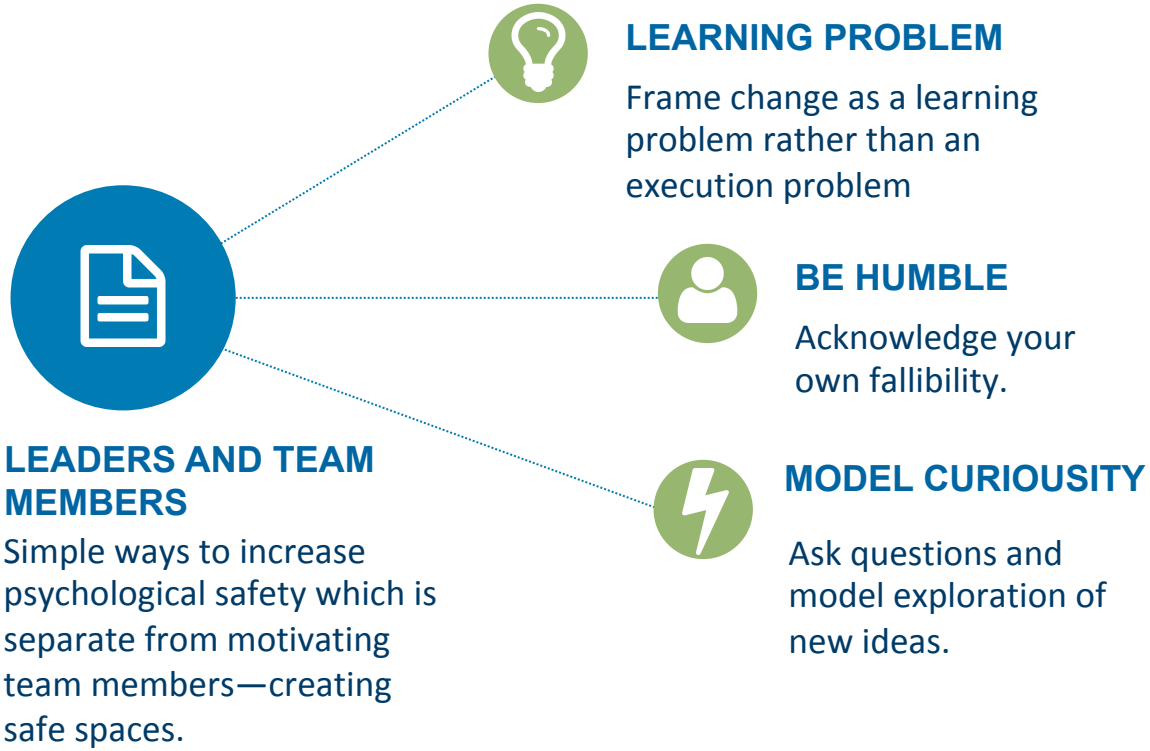
Missed opportunity to integrate

TEAMS WITH PSYCHOLOGICAL SAFETY

A SHARED BELIEF THAT THE TEAM IS SAFE FOR INTERPERSONAL RISK TAKING

- Okay and even expected that team members will speak up with concerns, ideas, questions, mistakes, etc.
- Team members take risk
- Embrace and celebrate diversity of team members
- Team members value and respect one another
- Teams continuously improve processes
- High communication and shared information

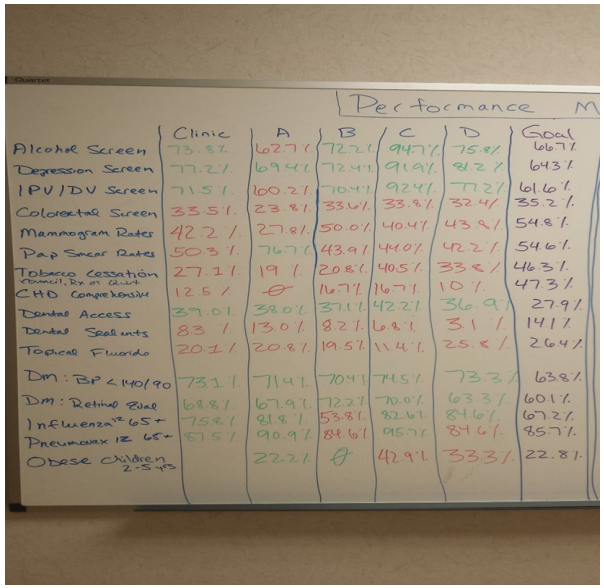
3 SIMPLE WAYS TO INCREASE PSYCHOLOGICAL SAFETY



Source: Amy Edmondson Ted X on Psychological Safety in Teams

Performance Measures: Accountability

- Process Metrics:
  - Percent of patients screened for depression
  - Percent with follow-up with behavioral care manager within 2 weeks
  - Percent not improving that received case review and psychiatric recommendations
  - Percent treatment plan changed based on advice
  - Percent not improving referred to specialty BH
- Outcome Metrics
  - Percent with 50% reduction PHQ-9 – Clinical Response
  - Percent reaching remission (PHQ-9 < 5) NQF 710 and 711
- Satisfaction – patient and provider
- Functional –work, school, homelessness
- Utilization/Cost
  - ED visits, 30 day readmits, med/surg/ICU, overall cost



CPT Codes for CoCM

99492 - $160
99493 - $130
99494 - $66
99484 - $48
G0512 -$134 (FQHCs only)

Billed once a month by the PCP

- Outreach and engagement by BHP
- Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

*Plus can bill for traditional CPT codes

Applying the Core Principles in Your Clinic

Gap Analysis Effective Integrated Care Team Exercise

Key Component	Score 0 = not at all in place 5 = fully in place	If you scored low in this category- what are the barriers to having this element in place?	Strengths/Opportunities-
1.Team-based approach to care			
Clinic has a defined team(s) with clear roles.			
Behavioral health staff member is a regular member of the clinical care team.			
The team has created and trained on processes and workflows for hand-offs and communications from one team member to another.			
PCPs and BHP meet with regularly with consulting psychiatrist/psych NP			
2. Evidence-based care			
The care team understands the evidence for screening for BH conditions in the primary care setting.			
Providers have reviewed and applied the evidence-based guidelines on depression diagnosis and treatment.			
The model of "stepped care" is the approach. The team understands this approach and it is used for systematic			

What will you take back to your home team from this Learning Lab ?

Who in this room could you connect with to help in your current stage of integrating primary care and behavioral health?

Swap business cards ☺

?

Email: lraney@healthmanagement.org

Webinars

Resources

Office hours