August 2017

Behavioral Health Integration Issue Brief Series, No. 1

Advancing the Integration of Behavioral Health into Primary Care for Small Practices

Henry Chung, MD
Montefiore Health System
and Albert Einstein College of Medicine

Ekaterina Smali, MPH, MPA
Montefiore Health System

Lynn Elinson, PhD
Irving Institute for Clinical and Translational Research,
Columbia University Medical Center

Steven Matthews
Montefiore Health System

Harold Pincus, MD, MPH
Department of Psychiatry,
Columbia University and NewYork-Presbyterian Hospital

Support for this work was provided by United Hospital Fund (UHF).

UHF works to build a more effective health care system for every New Yorker. An independent, nonprofit organization, we analyze public policy to inform decision-makers, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care. To learn more, visit www.uhfnyc.org or follow us on Twitter at @UnitedHospFund.

Support for this work was provided by the New York State Health Foundation (NYSHealth).

The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of NYSHealth or its directors, officers, or staff.

Contents

Foreword

Integrating behavioral health services into primary care is widely acknowledged as a pressing goal in an era of patient-centered comprehensive care, but putting in place new systems to screen, diagnose, treat, and manage common behavioral health problems—such as depression, anxiety, and substance use disorders—is a tall order. Given the complexity of evidence-based models, it's particularly challenging for the many resource-constrained smaller practices that provide so much of New York City's and State's primary care.

In their 2016 report *Advancing Integration of Behavioral Health into Primary Care*, a team led by Henry Chung, MD, and Harold Pincus, MD, and supported by a United Hospital Fund grant, introduced an innovative step-by-step approach for bringing integrated care to small and medium-size practices. Their "continuum-based framework," which allows for the phased adoption of key elements of integration across eight essential domains, has been well received by providers across the state.

The current issue brief is the first in a series of three exploring the move from theory to real-world practice, as experienced by 11 small provider groups. With further grant support from United Hospital Fund (for six New York City-based practices), and new support from New York State Health Foundation (for five practices throughout New York State), Drs. Chung and Pincus are working closely with those practices to track and report on the progress of their efforts and learn what works well and what may need to be modified to improve the framework's utility for diverse practices.

We are gratified that this collaboration between funders will be instrumental in advancing this groundbreaking roadmap, and anticipate that this phase of the project will generate much interest and discussion and encourage other practices to begin the behavioral health integration journey.

James R. Tallon, Jr.
President
United Hospital Fund

David Sandman, PhD
President and CEO
New York State Health Foundation

Introduction

For patients with behavioral health conditions such as anxiety or depression, primary care practices can play an important role in providing effective treatment and, when appropriate, effective referrals to specialty care. Current New York State programs—including the Medicaid Delivery System Reform Incentive Program (DSRIP), the Collaborative Care Initiative (CCI), and the Advanced Primary Care (APC) model—provide incentives for integrating behavioral health care into primary care as a way of providing more comprehensive, higher-quality care.

To advance these State programs and behavioral health integration (BHI) more generally, in 2016 Montefiore Health System developed a step-by-step continuum-based framework (Appendix A) that breaks down the complex path toward integration into manageable components, providing a roadmap for primary care practices seeking to begin the process. The framework contains a series of steps—identifying preliminary, intermediate, and advanced stages in eight key domains of practice integration—that allow practices of different sizes to assess, track, and make incremental progress based on their resources and practice structure.

Now, to test and improve the framework, Montefiore is using grant awards from the New York State Health Foundation and United Hospital Fund to help 11 small practices achieve evidence-based BHI through the use of the framework and monthly technical assistance webinars.

This issue brief is the first in a series of three that will describe how these small practices plan and implement integration of behavioral health services over the course of 12 months—how they initiate, build upon, and sustain progress toward a more advanced state of BHI, and how they grapple with real-world challenges and apply ideas and resources to overcome them. We hope that these lessons will be used by practice organizations and policymakers to inform their strategies for helping small practices achieve successful BHI, while helping us refine and enhance the utility of the framework.

In this first issue brief we describe the 11 selected practices using the framework; their motivations for doing so; their current states of integration; their BHI goals for the project's first six months; and perceived barriers to success.

BHI Project Participating Practices

New York City (6 practices)	New York State (5 practices)
Centro Medico de las Americas, Queens	**Champlain Family Health of Hudson Headwaters Health Network,** Champlain
Delmont Healthcare, Queens	**Hudson River Healthcare at Hudson**, Hudson
Dr. Scafuri + Associates, Staten Island	**Keuka Family Practice of Accountable Health Partners**, Bath
Metro Community Health Center, Bronx	**Koinonia Primary Care**, Albany
Tremont Health Center of Community Healthcare Network, Bronx	**Lourdes Primary Care**, Owego
South Shore Physicians, Staten Island	

The **second issue brief** will present findings on how the practices applied the framework to achieve their six-month BHI goals, and will describe the challenges they faced and their goals for the following six months.

The **final issue brief** will report on the extent to which the practices moved along the continuum of the BHI framework components over the course of the year, and the strategies they applied in these efforts. The findings will also allow us to update and improve the framework and summarize lessons learned.

Small Practices, Special Challenges

Achieving evidence-based models of BHI in primary care is challenging, especially for small practices—defined in this project as five or fewer primary care providers (PCPs) in a single facility. Recent studies indicate that at least 40 percent of primary care providers in New York City and State work in practices of four or fewer physicians.[1]

Small practices face a number of key barriers to implementing BHI. For example, they generally have less physical space for co-locating behavioral health specialists or dedicated behavioral health care management support. In addition, they often have less dedicated time for quality improvement work and find it difficult to support key elements of BHI, such as assertive follow up and outreach between visits. Since these efforts are not billable many small practices encounter challenges in expanding them as they struggle to maintain practice revenue.

1 Population Health Improvement Program (PHIP) New York City. August 2016. *A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City*; New York State Office of Quality and Patient Safety. October 2016. *Small Primary Care Practices in New York State, July 2016* [based on analysis of SK&A and Provider Network Data System data].

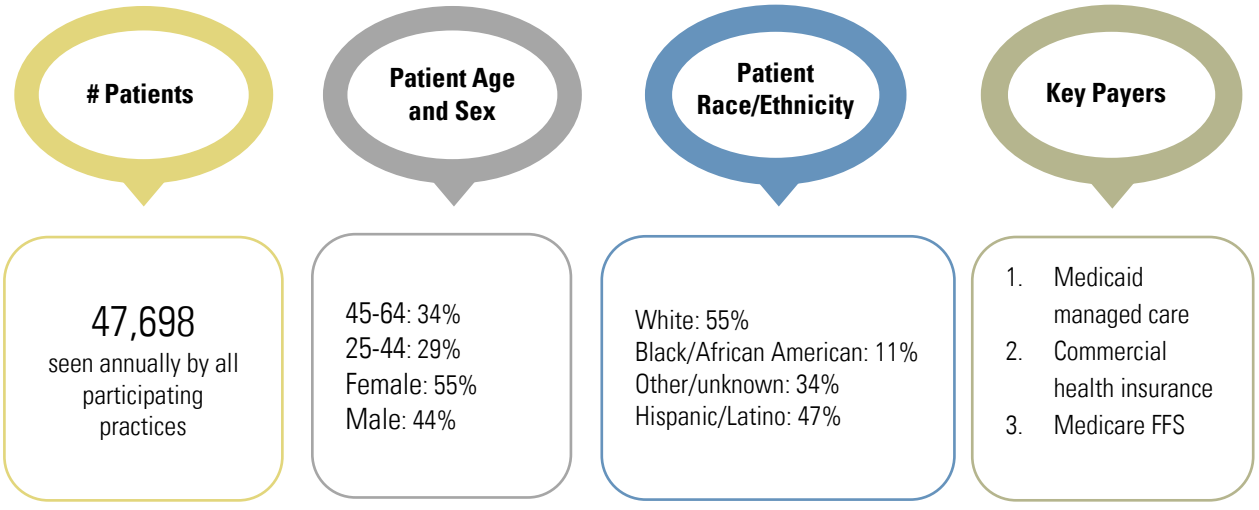
Who Is Involved?

The 11 practices participating in this initiative serve an average of 4,336 patients, in a mix of rural and urban locations. Practices were sought among DSRIP performing provider systems (PPSs) and accountable care organizations (ACOs) and then selected based on their size (5 or fewer PCPs in a single location), a high level of commitment to BHI advancement, geographic diversity, and diversity in practice type (FQHC, hospital-based, and independent). In addition, the majority of practices (n=8) are recognized as a Level III Patient-Centered Medical Home (PCMH) and two others are in the process of achieving their Level III designation. Interviews and a structured baseline survey revealed that these practices are all highly dedicated to holistic care and eager for help with BHI transformation, primarily to:

- Provide better care for their patients with BH needs;
- Achieve excellence in BH service delivery; and
- Become more efficient and effective in delivering primary care.

Other key characteristics are outlined in Appendix B.

Practice Demographics



Why Is This Project Important?

As noted earlier, a number of New York State health care reform initiatives focused on primary care—programs developed with the goal of achieving the triple aim of improved patient outcomes, higher care quality, and lower costs—are providing incentives for implementing BHI. Through DSRIP behavioral health transformation initiatives the State aims to integrate physical and behavioral health services to improve the overall quality of care for individuals with multiple health conditions by comprehensively treating the "whole person." Similarly, the New York State APC initiative, the Comprehensive Primary Care program, and the New York State Collaborative Care Initiative are working to support BHI by providing technical assistance and financial resources, and by facilitating robust connections between primary care providers and community-based BH specialists.

Ultimately, these programs encourage the accelerating shift from encounter-based payment structures toward value-driven, population-based care. But whether the majority of New York's primary care practices will be successful in their efforts is an important, and as yet unanswered, question. Since many of these practices are small their challenge in achieving effective and sustainable BHI may be more formidable.

Project Summary

The current project has four objectives:

1. Work with motivated small practices to report BHI readiness, plan for improvement, and track progress toward BHI goals based on the framework.
2. Provide monthly technical assistance webinars to guide BHI using the framework, and assist practices in overcoming barriers to integration.
3. Report lessons learned and discuss policy implications for BHI support in New York State, especially for smaller, less-resourced practices.
4. Understand how the framework supports small practices in their efforts to advance integration, and improve the framework to strengthen that ability.

Initially, the focus has been on learning more about participating practices and their current BHI readiness, and understanding their goals for BHI advancement in the next six months. To gather this information we conducted three separate surveys:

Practice Traits	Readiness Assesssment	Six-Month Planning
• Baseline data including practice type, patient demographics, current care processes/protocols, and payer mix	• Current state of BHI integration, based on the framework's eight evidence-based domains for integration advancement	• Self-assessments of *expected* level of BHI advancement in the framework, including any expected barriers or resources

Highlights of the three surveys' results appear below.

Although participating practices are strongly motivated, they are still largely at the preliminary stage of the continuum in most domains (Appendix C). Each has set as its goal for the rest of the project progress to the intermediate and advanced stages of the framework (Appendix D).

Key Results of Baseline, Practice Readiness, and Six-Month Goals Surveys

Baseline Survey

- Electronic medical/ health record system in place: all sites
- Basic registries for depression management: 3 sites
- Level III PCMH certified: 8 sites; in progress toward certification: 2 sites
- Participating in DSRIP BH projects working toward the adoption of BHI into a primary care site: 10 sites
- Embedded behavioral health staff: 5 sites

Readiness Survey

- Practices are in early stages of BHI with most reporting systematic screening for depression
- Limited process for warm handoffs and proactive follow-up
- Low level of BH provider and PCP communication and information sharing
- Minimal use of quality metrics to inform and improve BH services
- Minimal use of patient self-management support

Six-Month Planning Goals

- Intermediate- and advanced-level framework targets
- Expanded systematic screening with robust follow up
- Enhanced care team with BH providers and care managers
- Increased utilization of registry metrics and evidence-based guidelines
- Regular sharing and updating of treatment and care plans
- More intermediate self-management support on BH conditions

The planning survey also ascertained each site's specific priorities for advancement in the next six months. Practices expressed greatest interest in improving in four domains:

- Domain 1: Case finding, screening, and referral to care
- Domain 2: Multidisciplinary team used to provide care
- Domain 3: Ongoing care management
- Domain 7: Information tracking and exchange among providers

Appendix E provides more detail on practices' six-month planning goals, resources available to achieve them, and concerns noted for each domain.

Anticipated Opportunities and Challenges

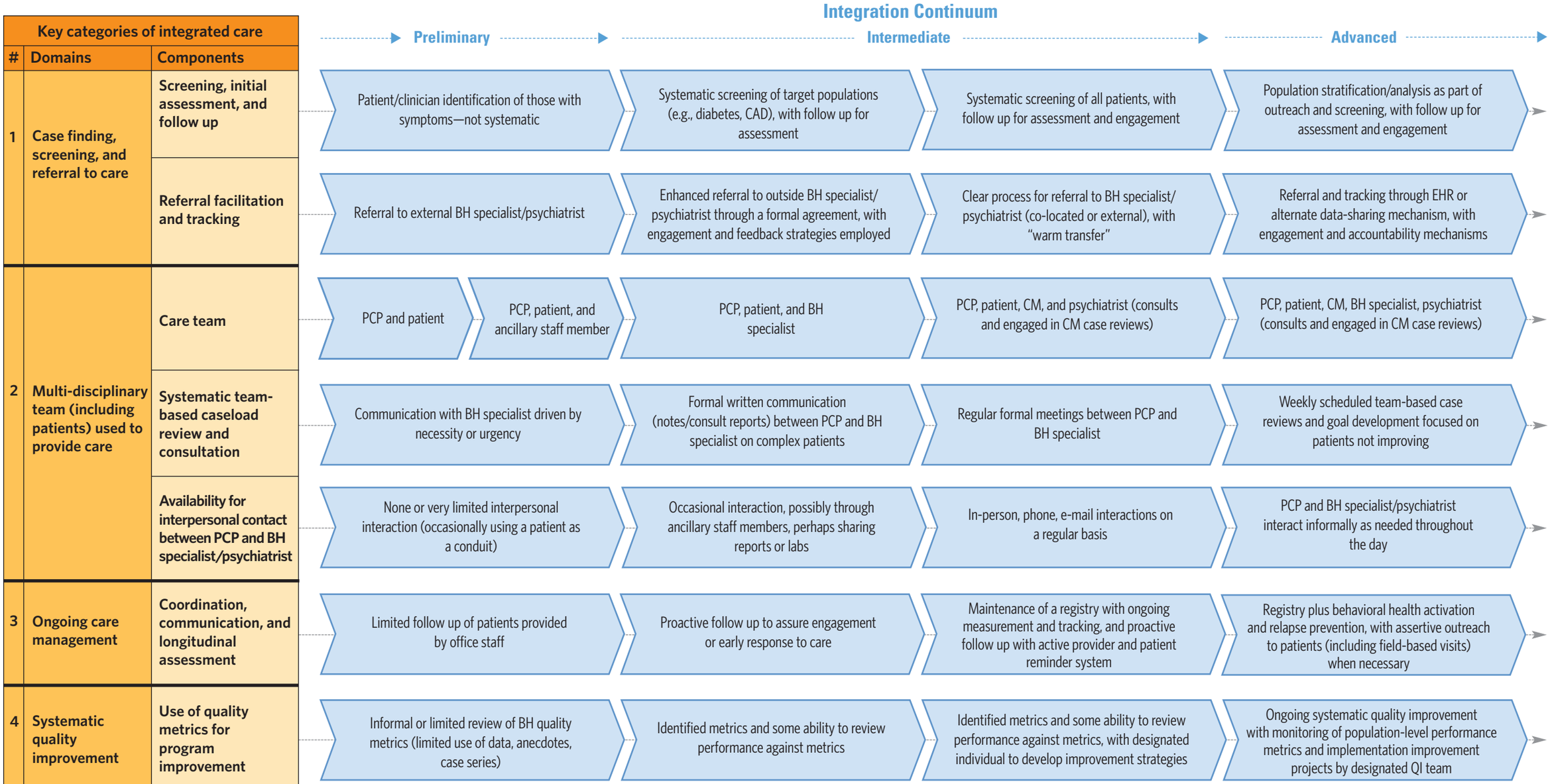
Although it is still too early to draw any firm conclusions about the barriers faced by participating practices, our surveys and discussions with them thus far have identified some key considerations that practices and policymakers should be aware of:

- **Billing and revenue support.** More clarification is needed on the degree to which billing for behavioral health screening and treatment is reimbursable, both generally and specifically when BH services and primary care services are provided during a single visit. Practices are also requesting support from vendors of electronic health records to help make BH coding and billing a priority in their systems, as well as behavioral health registry development support from these vendors.
- **Enhanced behavioral health provider collaboration.** Small practices need clarification on how to improve the sharing of relevant diagnostic and treatment information between the practice and behavioral health providers. There is some interest in the use of memorandums of understanding (MOUs) to solidify partnerships between BH specialists and PCPs, to improve patient access and communication.
- **Quality metrics management.** Practices appear to be overwhelmed by the many metrics they are required to report to payers and programs such as DSRIP. There is a need for prioritizing metrics and considering specific payment incentives to ensure commitment to BHI.

- **Promoting uptake of new technology.** Further adoption of mobile technology, such as texting with patients, collection of self-reported patient symptoms, and real-time video conferencing, can provide greater access and better services, especially for rural patients. Practices are also interested in clarifying compliance and billing issues to better understand how to implement and adopt these technologies.

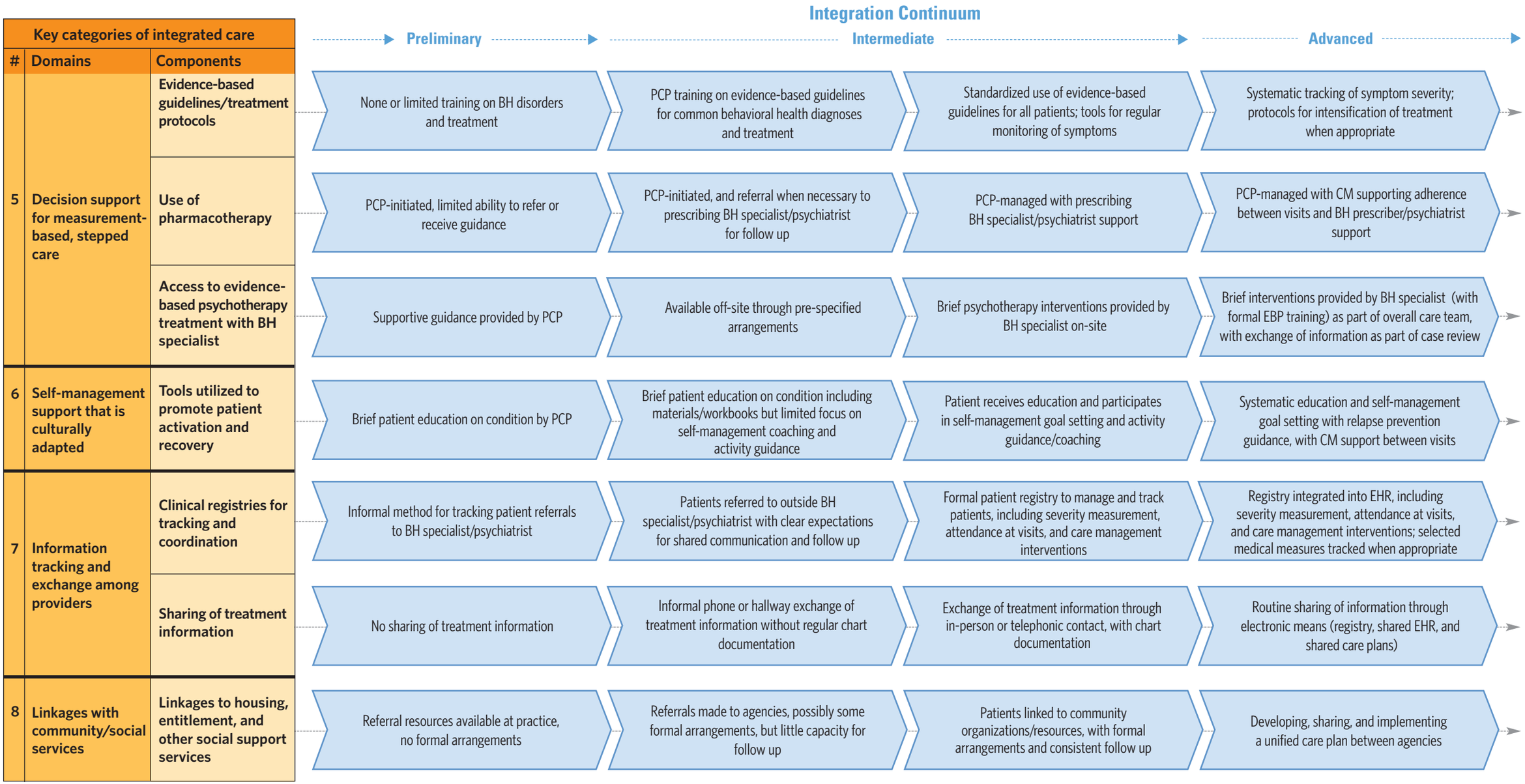
Throughout the remainder of this project we will seek to improve our understanding of the assistance needed to overcome barriers to BHI, whether these small practices' BHI goals can be achieved, and how advances can be supported and sustained. As participants move from planning to implementation, we will report on their achievements and challenges, and the implications for broader adoption of BHI in New York State.

Appendix A. An Evidence-Based Framework for Primary Care–Behavioral Health Integration



Notes: BH Specialist refers to any provider with specialized behavioral health training; **CM** can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice; **Ancillary staff member** refers to non-clinical personnel, such as office staff or receptionist; **EBP** refers to evidence-based psychotherapy

Appendix A cont'd. An Evidence-Based Framework for Primary Care–Behavioral Health Integration



Notes: BH Specialist refers to any provider with specialized behavioral health training; **CM** can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice; **Ancillary staff member** refers to non-clinical personnel, such as office staff or receptionist; **EBP** refers to evidence-based psychotherapy

Appendix B.
Characteristics of Participating Practice Sites

(as reported in the baseline survey)

Legend

Staffing
PA—Physician Assistant
MA—Medical Assistant
NP—Nurse Practitioner
RN—Nurse
LPN—Licensed Practical Nurse

Ethnicity
W—White
B/AA—Black or African American
NA—Native American

Participating Practices	Description	Full-time Equivalents (FTEs)/Staffing Structure	No. of Patients (annual)	PCMH Certified	Ethnic Composition (percentage)	Top-Ranking Payer Types
Centro Medico de las Americas*	A physician-owned multispecialty medical clinic serving for more than 20 years.	Family PCP: 0.8 Internal PCP: 1.2 PA: 2.4 MA: 4	Total = 9,263 F: 5,470 M: 3,793	Yes	W: 3 Asian: 2 B/AA: 1 Total Hispanic/ Latino: 94	1. Medicare Advantage 2. Medicaid managed care 3. Commercial health insurance
Champlain Family Health of Hudson Headwaters Health Network	A Federally Qualified Health Center (FQHC)** providing services to Champlain and neighboring rural communities. In 2017, the site is expanding into a new, 25,916 ft^2 state-of-the-art primary care facility.	Family PCP: 4 Internal PCP: 0.75 NP: 1.75 RN: 6 LPN: 12.5 Social Worker: 2 Care Manager: 2	Total = 4,507 F: 2,254 M: 2,253	Yes	W: 95 B/AA: 2 NA: 0.5 Asian: 0.5 Other: 2 Total Hispanic/ Latino: 0	1. Commercial health insurance 2. Medicaid managed care 3. Medicare FFS

*The ethnic data for Centro Medico de las Americas is based on number of patients, not visits; Hispanic/Latino calculated as ethnic group, not race group.

** FQHCs are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. They provide primary care services regardless of a patient's ability to pay and utilize a sliding-scale fee based on ability to pay.

Participating Practices	Description	Full-time Equivalents (FTEs)/Staffing Structure	No. of Patients (annual)	PCMH Certified	Ethnic Composition (percentage)	Top-Ranking Payer Types
Delmont Healthcare	Physician group primary care practice providing whole-person, continuous medical care.	Internal PCP: 1.5 PA: 1 Social Worker: 1 Care Manager: 1	Total = 3,500 F: 2,450 M: 1,050	Yes	W: 10 B/AA: 20 NA: 1 Asian: 1 Other: 68 Total Hispanic/ Latino: 100	1. Commercial health insurance 2. Medicaid managed care 3. Medicare FFS
Dr. Scafuri + Associates	A physician group offering a full spectrum of primary care medical services, with an emphasis on preventive medicine and wellness.	Internal PCP: 3 Pediatric PCP: 1 PA: 1 NP: 2 RN: 1	Total = 5,000 F: 2,500 M: 2,500	No	W: 75 B/AA: 10 Asian: 15 Total Hispanic/ Latino: 20	1. Commercial health insurance 2. Medicaid managed care 3. Medicare FFS
Hudson River Healthcare at Hudson	FQHC providing a holistic approach to health care directly to residents of Columbia and Green Counties.	Family PCP: 0.75 NP: 0.25 RN: 1	Total = 900 F: 405 M: 495	Yes	W: 70 B/AA: 20 NA: 5 Asian: 5 Total Hispanic/ Latino: 5	1. Self-paying or uninsured 2. Commercial health insurance 3. Medicaid managed care

NOTE: FQHCs are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. They provide primary care services regardless of a patient's ability to pay and utilize a sliding-scale fee based on ability to pay.

Participating Practices	Description	Full-time Equivalents (FTEs)/Staffing Structure	No. of Patients (annual)	PCMH Certified	Ethnic Composition (percentage)	Top-Ranking Payer Types
Keuka Family Practice of Accountable Health Partners	A physician group serving the Keuka Lake region and its surrounding community for more than 30 years.	Family PCP: 3 PA: 1 NP: 2 LPN: 5 Care Manager: 1 MA: 1	Total = 6,000 F: 3,000 M: 2,850 Trans-gender: 150	Yes	W:90 B/AA: 5 Asian: 5 Total Hispanic/ Latino: 5	1. Medicaid managed care 2. Commercial health insurance
Koinonia Primary Care	A nonprofit Article 28 diagnostic and treatment center offering community-driven care to the West Hill neighborhood of Albany.	Family PCP: 1 PA: 1 NP (volunteer): 0.25 RN: 1 LPN: 1 Psychologist: 1 Licensed Mental Health Counselor: 0.1 Social Worker (LCSW-R/ volunteer): 0.4	Total = 1,800 F: 990 M: 810	In progress	W: 50 B/AA: 46 Asian: 3 Other: 1 Total Hispanic/ Latino: 2	1. Medicare Advantage 2. Medicaid managed care

Participating Practices	Description	Full-time Equivalents (FTEs)/Staffing Structure	No. of Patients (annual)	PCMH Certified	Ethnic Composition (percentage)	Top-Ranking Payer Types
Lourdes Primary Care	Part of Lourdes Hospital, offering primary care services in the Owego region to enhance the well-being of the total person: mind, body, and spirit.	Family PCP: 3.25 NP: 1.5 RN: 5.5 Care Manager: 1 MA: 1	Total = 1,836 F: 734 M: 1,102	Yes	W: 92 B/AA: 2 NA: 0.08 Asian: 0.2 Other: 5 Total Hispanic/ Latino: 0	1. Commercial health insurance 2. Medicaid managed care 3. Medicare FFS or self-pay/ uninsured
Metro Community Health Center	FQHC focused on patients who are underserved, with a special commitment to the needs of people with disabilities. Center has four New York City locations.	Family PCP: 0.25 Internal PCP: 0.4 Pediatric: 0.5 Ob-Gyn: 0.25 NP (psychiatry and PCP): 1.5 RN: 2 Psychiatrist: 1.25 Psychologist: 1.75	Total = 8,226 F: 4,524 M: 3,702	Yes	W: 15 B/AA: 30 NA: 5 Other: 50 Total Hispanic/ Latino: 50	1. Medicare FFS 2. Medicaid FFS 3. Medicaid managed care

NOTE: FQHCs are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. They provide primary care services regardless of a patient's ability to pay and utilize a sliding-scale fee based on ability to pay.

Participating Practices	Description	Full-time Equivalents (FTEs)/Staffing Structure	No. of Patients (annual)	PCMH Certified	Ethnic Composition (percentage)	Top-Ranking Payer Types
South Shore Physicians	A physician group serving the Staten Island community for more than 25 years.	Internal PCP: 2 Care Manager: 1 MA: 6	Total = 3,000 F: 1,350 M: 1,650	Yes	W: 75 B/AA: 15 NA: 5 Asian: 5 Total Hispanic/ Latino: 30	1. Medicare Advantage 2. Medicaid managed care 3. Commercial health insurance
Tremont Health Center of Community Healthcare Network	FQHC serving the Bronx community since 2011.	Family PCP: 0.4 Internal PCP: 0.8 NP (PCP and Psychiatry): 2.4 RN: 5 Psychiatrist: 0.4 Mental Health Therapist/Social Worker: 1.2 Social Worker: 1 MA: 2	Total = 3,666 F: 2,933 M:733	Yes	W: 11 B/AA: 40 Asian: 2 Other: 47 Total Hispanic/ Latino: 60	1. Medicaid FFS 2. Self-Pay/Uninsured 3. Commercial health insurance

NOTE: FQHCs are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. They provide primary care services regardless of a patient's ability to pay and utilize a sliding-scale fee based on ability to pay.

Appendix C. Behavioral Health Integration Readiness (Number of practice sites, of 11 total, at each stage of behavioral health integration)*

KEY CATEGORIES OF INTEGRATED CARE		INTEGRATION CONTINUUM		
DOMAINS	**COMPONENTS**	**PRELIMINARY Current State**	**INTERMEDIATE Current State**	**ADVANCED Current State**
1. Case finding, screening, and referral to care	Screening, initial assessment, and follow up	2	8	-
	Referral facilitation and tracking	6	-	5
2. Multi-disciplinary team (including patients) used to provide care	Care team	7	4	-
	Systematic team-based caseload review and consultation	5	4	1
	Availability for interpersonal contact between PCP and BH specialist/psychiatrist	4	3	4
3. Ongoing care management	Coordination, communication, and longitudinal assessment	9	2	-
4. Systematic quality improvement	Use of quality metrics for program improvement	6	4	-
5. Decision support for measurement-based, stepped care	Evidence-based guidelines/treatment protocols	9	2	-
	Use of pharmacotherapy	1	10	-
	Access to evidence-based psychotherapy treatment with BH specialist	5	5	1
6. Self-management support that is culturally adapted	Tools utilized to promote patient activation and recovery	8	3	-
7. Information tracking and exchange among providers	Clinical registries for tracking and coordination	7	4	-
	Sharing of treatment information	5	5	1
8. Linkages with community/social services	Linkages to housing, entitlement, and other social support services	6	4	1

***** Readiness Assessment survey conducted March 2017; based on each item of each domain in the framework.

Appendix D. Expected Progress in Six Months (Number of practice sites, of 11 total, expected to achieve each stage of behavioral health integration)*

KEY CATEGORIES OF INTEGRATED CARE		INTEGRATION CONTINUUM		
DOMAINS	**COMPONENTS**	**PRELIMINARY 6-Month Progress State**	**INTERMEDIATE 6-Month Progress State**	**ADVANCED 6-Month Progress State**
1. Case finding, screening, and referral to care	Screening, initial assessment, and follow up	-	7	2
	Referral facilitation and tracking	1	6	2
2. Multi-disciplinary team (including patients) used to provide care	Care team	-	4	3
	Systematic team-based caseload review and consultation	-	7	-
	Availability for interpersonal contact between PCP and BH specialist/psychiatrist	1	1	5
3. Ongoing care management	Coordination, communication, and longitudinal assessment	-	7	-
4. Systematic quality improvement	Use of quality metrics for program improvement	-	5	-
5. Decision support for measurement-based, stepped care	Evidence-based guidelines/treatment protocols	1	1	-
	Use of pharmacotherapy	-	1	1
	Access to evidence-based psychotherapy treatment with BH specialist	-	1	1
6. Self-management support that is culturally adapted	Tools utilized to promote patient activation and recovery	-	5	-
7. Information tracking and exchange among providers	Clinical registries for tracking and coordination	1	7	2
	Sharing of treatment information	-	7	3
8. Linkages with community/social services	Linkages to housing, entitlement, and other social support services	-	3	-

* Assessed using the 6-Month Planning Survey, which asked respondents to provide feedback only on the domains targeted for advancement for this project.

Appendix E. Survey Results for the Top Four Priority Domains Selected

Top Chosen Domains	6-Month Planning Goals	Top Resources Available	Common Concerns
Domain 1: Identification of Patients and Referral to Care	• Practices want to ensure that systematic screening of all patients is completed using a combination of PHQ 2 and PHQ 9 for depression and GAD for anxiety. • "Warm transfers" to a BH specialist or psychiatrist, either co-located or external to the practice site, is the leading goal. Practices are reminded that warm transfers do not need to occur every time with every patient; rather, the goal is setting up the capacity and protocols to have this process in place if needed.	• Screening tools available and staff trained in their use • Behavioral health specialists onsite or available for referral • Access support and BH specialists available through networks and affiliates	• Staff time/schedule management and warm transfer timing • Patient cooperation and follow through • Electronic health record and registry utilization and training
Domain 2: Multi-Professional Team Approach to Care (Includes Patients)	• Every practice staffing composition varies, but the majority of sites want to create teams that consist of patient, PCP, and BH specialist. • To ensure that complex patients do not have gaps in their treatment plan, practices want to implement the use of formal written communication (notes/consult reports) between PCP and BH specialist. • For consistent communication, practices want PCP and BH specialist to maintain informal interaction as needed, throughout the day.	• Behavioral health specialists onsite or available for referral • Electronic health record systems available to link PCP and BH for those with co-located staff	• Managing coordination and communication of the team • Determining appropriate metrics to measure success

All results have been summarized for reporting purposes and are not verbatim submitted responses.

Appendix E. Survey Results for the Top Four Priority Domains Selected (continued)

Top Chosen Domains	6-Month Planning Goals	Top Resources Available	Common Concerns
Domain 3: Continuous Care Management	• The majority of PCPs set as their goal maintaining proactive follow up to assure engagement and early response to care. Follow up would be delivered between visits to ensure that patients understand their treatment plans and to check on medication adherence.	• Available care managers • Effective communication process and follow-up procedures	• Non-adherent patients or patients unreachable for follow up • Utilizing appropriate tracking tools
Domain 7: Information Tracking and Exchange Among Providers	• PCPs without co-located BH resources will work toward supporting patient referrals to outside BH specialists/psychiatrists with clear expectations for communication and follow up with PCP practice. • PCPs plan to work toward ensuring that treatment information is exchanged through in-person or telephone contact, with documentation.	• Telephone follow ups • Available electronic health record management tools and progress notes for co-located BH resources	• Limited staff time for implementation projects • Time to create and run reports • Perceived regulatory barriers from external BH staff

All results have been summarized for reporting purposes and are not verbatim submitted responses.