

Behavioral health integration into ambulatory practice

Expand patient care and improve practice efficiency



CME
CREDITS:
0.5

How will this module help me embed behavioral health in my practice?

- 1 Five steps to implement your new model
- 2 Answers to commonly asked questions
- 3 Examples of practices that have successfully implemented an integrated behavioral health model

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering direct patient care. Embedding behavioral health within primary care or select secondary care practices expands the services a patient can receive. By bringing medical and psychosocial services together with primary care, the team is better able to meet both the mental and general health needs of the patient.

Behavioral health integration into ambulatory practice

Release Date: October 2015

End Date: October 2016

Objectives

At the end of this activity, participants will be able to:

1. Assess current processes and resources to determine the behavioral health model that will work best for the practice and its patients.
2. Describe how to integrate complementary team-based care roles.
3. Determine how to incorporate behavioral health services into team-based primary care.
4. Identify metrics to track and monitor the embedded behavioral health model over time.

Target Audience

This activity is designed to meet the educational needs of practicing physicians.

Statement of Need

The integration of behavioral health professionals into the primary care team provides a more effective and efficient mechanism to address patient behavioral and mental health needs. Embedding behavioral health within primary care expands the services a patient can receive during their regular primary care appointments. By bringing medical and psychosocial services together, the team is better able to conveniently and consistently meet both the general and mental health needs of their patients.

Statement of Competency

This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice and also address interdisciplinary teamwork and quality improvement.

Accreditation Statement

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement

The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Claiming Your CME Credit

To claim *AMA PRA Category 1 Credit*[™], you must 1) view the module content in its entirety, 2) successfully complete the quiz answering 4 out of 5 questions correctly and 3) complete the evaluation.

Planning Committee

Alejandro Aparicio, MD – Director, Medical Education Programs, AMA

Rita LePard – CME Program Committee, AMA

Anita Miriyala – Graduate Intern, Professional Satisfaction and Practice Sustainability, AMA

Ellie Rajceвич, MPA – Practice Development Advisor, Professional Satisfaction and Practice Sustainability, AMA

Sam Reynolds, MBA – Director, Professional Satisfaction and Practice Sustainability, AMA

Christine A. Sinsky, MD – Vice President, Professional Satisfaction, AMA

Krystal White, MBA – Program Administrator, Professional Satisfaction and Practice Sustainability, AMA

Author(s)

Karen S. Rheuban, MD – General Internist, University of Michigan

Marcia Valenstein, MD, MS – (co-author), Professor, Department of Psychiatry, University of Michigan Medical School and Senior Research Scientist, Department of Veterans Affairs

Faculty

Arshiya A. Baig, MD, MPH – Assistant Professor of Medicine, University of Chicago

Sonal Saraswat Gupta, MD, FACP – Internal Medicine, Heritage Medical Associates

John C. Fortney, PhD – Professor and Director, Division of Population Health, Department of Psychiatry and Behavioral Sciences, School of Medicine, University of Washington

Jeffrey M. Pyne, MD – Central Arkansas Veterans Healthcare System

Andrew Schutzbank, MD, MPH – Vice President, Clinical Development, Iora Health

Ellie Rajceвич, MPA – Practice Development Advisor, Professional Satisfaction and Practice Sustainability, AMA

Sam Reynolds, MBA – Director, Professional Satisfaction and Practice Sustainability, AMA

Christine A. Sinsky, MD – Vice President, Professional Satisfaction, AMA

About the Professional Satisfaction, Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement

The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

Media Types

This activity is available to learners through Internet and Print.

References

1. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Collaborative Care Staffing Ratios. <http://aims.uw.edu/resource-library/collaborative-care-staffing-ratios>. Accessed August 10, 2015.
2. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Education & Training. <https://aims.uw.edu/program-area/education-training>. Accessed August 10, 2015.
3. Vanderbilt University School of Nursing. Health Coaching Certificate Program http://www.nursing.vanderbilt.edu/certificate/health_coaching.html. Accessed August 10, 2015.

4. Duke Integrative Medicine. Integrative Health Coach Training. <https://www.dukeintegrativemedicine.org/integrative-health-coach-training/>. Accessed August 10, 2015.
5. National Society of Health Coaches. <http://www.nshcoa.com/>. Accessed August 10, 2015.
6. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10:CD006525.
7. Cochrane. Collaborative care for people with depression and anxiety. http://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety. Accessed August 10, 2015.
8. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Collaborative Care Case Study: Behavioral Health Integration Program. <http://aims.uw.edu/collaborative-care-case-study-behavioral-health-integration-program>. Accessed August 10, 2015.
9. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Impact Training. <http://aims.uw.edu/resource-library/impact-training>. Accessed August 10, 2015.
10. Unützer J, Chan YF, Hafer E, et al. Quality improvement with pay-for-performance incentives in integrated behavioral health care. *Am J Public Health*. 2012;102(6):e41-e45.
11. Smith TE, Erlich MD, Sederer LI. Integrated care: integrating general medical and behavioral health care: the New York State perspective. *Psychiatr Serv*. 2013;64(9):828-831.
12. Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions. Behavioral Health in Primary Care. Integrating behavioral health into primary care. <http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care>. Accessed August 10, 2015.
13. SAMHSA-HRSA Center for Integrated Health Solutions. Patient Health Questionnaire (PHQ-9). <http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>. Accessed August 10, 2015.
14. SAMHSA-HRSA Center for Integrated Health Solutions. Generalized Anxiety Disorder 7-item (GAD-7) Scale. <http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>. Accessed August 10, 2015.
15. SAMHSA-HRSA Center for Integrated Health Solutions. Stable Resource Toolkit: AUDIT-C. http://www.integration.samhsa.gov/images/res/tool_auditc.pdf. Accessed August 10, 2015.
16. Morisky Medication Adherence Scales: MMAS-4 and MMAS-8. http://c.ymcdn.com/sites/www.aparx.org/resource/resmgr/Handouts/Morisky_Medication_Adherence.pdf. Accessed August 10, 2015.
17. U.S. Department of Health and Human Services. National Institutes of Health. PROMIS. <http://www.nihpromis.org/default#2>. Accessed August 26, 2015.



Introduction

What does it mean to integrate behavioral health into ambulatory practice?

Many medical conditions are greatly affected by patients' behavioral choices and mental health issues. Physician-led primary care teams often must address many common mental health disorders, such as depression, anxiety and substance abuse. In addition, behavioral and lifestyle issues, such as smoking, lack of exercise and poor sleep, impact many aspects of health. By bringing medical and behavioral health services together within primary care, the team is better able to meet both the mental and general health needs of the patient.



Five steps for integrating a behavioral health model into ambulatory care

1. Assess current needs and resources

2. Design a team-based care model

3. Train members of the primary care team

4. Implement the team-based behavioral health model

5. Monitor and improve processes



1 Assess current needs and resources

Physician-led primary care teams are in a position to effectively screen patients for a range of behavioral health issues and to systematically follow up on treatment response. These issues could include mild to moderate depression or anxiety. The practice team should review the ways in which behavioral health issues are currently being identified and followed. Defining existing behavioral treatment resources will allow a practice to accurately identify any additional resources that might be needed, such as an embedded behavioral health specialist. Determine the practice needs for behavioral health resources based on your patient population. Caring for a large population of patients with mild or moderate depression or anxiety may warrant the development of a model with a set of resources that is different than that used for patients with chronic disease who need behavior and lifestyle support. Through this exercise, your practice will determine whether, for example, training a nurse to become a behavioral health care manager or hiring a social worker to become the practice's behavioral health specialist will work best based on your patient population's needs.

Q&A

Which patients would benefit most from an integrated behavioral health model?

This model is most appropriate for patients with mild to moderate depression and anxiety. The resources allocated to support the model within the primary care practice can also be impactful for patients who have behavioral or educational needs based on a lifestyle-altering condition, such as obesity, diabetes or hypertension. The model is not meant to meet the needs of patients who have acute suicidal ideation or unstable psychosis. These patients should be under the direct care of a psychiatrist.

How many patients with behavioral health needs do I need to have to warrant embedding a behavioral health specialist?

The ideal staffing ratio depends on the model of care that is used and the patient population. The University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center has created a [matrix](#) of staffing ratios for diverse clinic settings with recommendations about the use of full-time equivalent (FTE) care managers and psychiatric consultants based on the size and needs of the patient population. It also includes the suggested case load for each care manager within the model. Tools like this matrix can help your practice determine the resources required to support your patients.

2

Design a team-based care model

In an embedded behavioral health model, team members will often have complementary roles in providing care to patients with mental health conditions. Frequently, the integrated behavioral health care team will include the patient, the primary care physician (PCP), a behavioralist and a consulting psychiatrist. The behavioralist may be a behavioral health case manager (often a social worker or nurse), a medical assistant (MA) or lay person trained to do lifestyle counseling or a clinical psychologist. In most models, the clinical psychologist is involved on a consultative basis. The physician-led team works together with shared goals, treatment plans, workflows and, ideally, in at least a partially co-located space to increase team member communication and collaboration. The PCP and/or psychiatrist supervise the hands-on work of the behavioralist and collaborate in frequent patient panel reviews with the team to identify patient needs and opportunities for intervention. In more remote areas or smaller practices, the behavioralist or psychiatrist may consult via telemedicine; this may be a more cost-effective and feasible approach to offering behavioral health services.

Q&A

What should our model look like?

Models vary depending on patient needs and practice capabilities. While this module describes the optimal model for providing basic mental health care, some practices may expand their model to offer a broader panel of behavioral health services. Some models include a lay person behavioralist who has been trained in lifestyle counseling for weight loss, exercise and smoking cessation. This person would function as an advanced health coach, and the position could be filled by a high-performer who already works in the practice and has an interest in additional training. Another practice model may involve a nurse or social worker who provides lifestyle counseling and addresses anxiety, depression, sleep disturbances and social-service needs. Additionally, most models involve a psychiatrist who is available to consult in-person or virtually with the behavioralist and/or PCP on the management of patients with more complex psychiatric problems. Of these options, you may find that one model or a hybrid will work best for your practice.

What is a warm hand-off and how does it improve care?

A warm hand-off gives the PCP, MA or nurse the opportunity to directly hand off the patient to their behavioralist. During a conversation with the patient during rooming, for example, the MA may find that the patient needs a more in-depth assessment by a behavioralist. Paging the behavioralist directly to the room and involving the patient in the transition of care to that person increases their credibility and the patient’s trust in them. It also eliminates the need for the patient to schedule a follow-up appointment with a behavioralist, which is an additional step that may not be taken by patients.

Could the behavioralist be shared among multiple physician-led teams in a practice?

Yes. A behavioralist could support multiple clinicians within a practice. It is possible that s/he could support multiple clinics, though a warm hand-off of care is ideal and is more often possible if the behavioralist is available on site. The practice can try to anticipate which patients will require assistance from a behavioralist and request their presence while the patient is still in the clinic. This will ensure that the warm hand-off occurs seamlessly, thereby decreasing wait time for the patient, PCP and behavioralist.

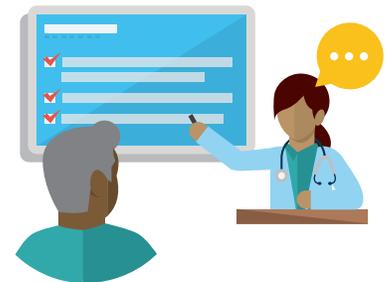
3

Train members of the primary care team

In training the physician-led team to appropriately integrate behavioral health into patient care, there are several critical elements that should be covered.

A Know how and when to give mental health assessments.

The team members who will be **rooming patients** and conducting **pre-visit planning** should be trained in how to give mental health screens using a **PHQ-2** or **PHQ-9**. On a pre-visit questionnaire, there may be a question that is a “trigger” for a more in-depth mental health assessment, such as “Have you felt down, depressed or hopeless or lost interest in doing things lately?”



B Recognize triggers for involving behavioral health.

Events such as a death in the family, job loss, a recent cancer diagnosis (for the patient, a partner or friend), domestic abuse or a history of depression or some other psychiatric condition should trigger a behavioral health assessment and, potentially, a behavioral health referral. For a patient who possesses one or more of these triggers, the practice may decide that they want the behavioralist to be proactively involved in the patient’s care.

C Understand the behavioral health referral process.

When a patient does require a behavioral health intervention, make sure the team knows what pathway to follow. Should the patient be assessed that day? Do they need a full consult with a psychiatrist? Create processes and protocols for staff to recognize when the behavioralist should become involved. Also ensure that the staff knows which aspects of patient follow-up are their responsibility and which belong to the behavioralist. This should be determined based on shared practice protocols.

Q&A

Who should provide the training?

Online and in-person training is available through many different organizations, and the practice can find the program that is right for developing the skillset and role of the behavioralist. One example of an organization that offers online education is the University of Washington [AIMS Center](#). To meet the training needs of the practice, it is common for practices or organizations to develop training based on the skillset that the designated behavioralist will need. If possible, schedule a site visit to observe an embedded behavioral health model that already exists. The PCP and psychiatrist should help determine the important skills that should be gained by the end of the training process. The AMA does not endorse any particular training program referenced in this module.

We would like to train one of our nurses to do behavioral counseling for weight loss, smoking cessation, sleep counseling, stress reduction and exercise. Can you recommend some training resources?

Professional health coach training could give your staff the skillset they need to more effectively educate your patients about lifestyle and behavioral issues. The curricula often include tips for patient engagement, motivational interviewing and creating an action plan with patients. Many training programs exist and offer online educational options. Some examples of training programs include those administered by the [Vanderbilt University School of Nursing](#), the [Duke University Integrative Medicine program](#), [Clinical Health Coach](#) and the [National Society of Health Coaches](#). The AMA does not endorse any particular training program referenced in this module.

4

Implement the team-based behavioral health model

In a physician-led team-based behavioral health model, the entire team—the PCP, behavioralist, nurses, MAs and the consulting psychiatrist—will work together to provide collaborative care to patients.

- The MA or nurse assesses the patient for mental health needs by listening for triggers and reviewing any screening questions on the pre-visit questionnaire.
- The PCP implements screening and monitoring tools for mental health disorders, makes the diagnosis, initiates treatment and manages medications.
- The behavioralist (e.g., nurse, care manager or social worker) monitors depression symptom severity, treatment adherence and side effects and reports these results to the PCP. Depending on training and skill level, the behavioralist can also provide motivational interviewing, problem solving therapy, behavioral activation and grief support.
- A consulting psychiatrist can assist with review of the panel of patients with behavioral health issues and/or answer the PCP's questions about diagnosis and medication management in more complex situations or as needed.

5

Monitor and improve processes

After the new model has been implemented, the team has the opportunity to continually refine and improve the process. Identifying metrics to track prior to implementation will help the team stay focused and monitor improvement over time. Include these metrics on the practice dashboard or scorecard, and consider them as part of the practice's most important quality metrics. Examples could include the following:

- Increased referrals to behavioralist
- Increased percentage of patients on antidepressants seen by behavioralist

- Increased use of the following forms:
 - **PHQ-2** and **PHQ-9** to screen for depression
 - **GAD-7** to screen for anxiety
 - **AUDIT-C** to screen for alcohol abuse
 - **Morisky medication adherence Scales** to monitor medication adherence
- Improved medication adherence
- Decreased depression scores
- Fewer emergency department visits
- Fewer readmissions

Continuous training, reminders and development opportunities for the team members, including the behavioralist, nurses and MAs, will help them continue to develop their skillsets and more fully integrate their behavioral health knowledge into their daily interactions with patients.

Finally, to keep the focus on improvement, keep the behavioral health team on the agenda at **team meetings**. This will give the team the opportunity to continuously explore ways to collectively make the process better, increase communication and keep everyone focused on providing the best care to patients.

Q&A

What patient outcomes should we expect to see?

From a patient perspective, success will correlate with decreased symptoms as reflected in improved scores on symptom-based scales or improved functioning. Population health data will reflect decreased symptoms, improved functional status and enhanced well-being and quality of life for patients. The success of the program will also be reflected in the satisfaction of the health care team members as they provide their patients with quality care in a timely, integrated fashion. **PROMIS** provides tools to help your practice identify how to measure the important indicators that you choose to evaluate.

Can you give an example of a patient who received care from an integrated behavioral health team?

Patient 1: Anna is a 52-year-old female who has a history of depression and who has been stable on fluoxetine daily for many years. At the patient’s yearly physical, the MA administers a PHQ-9 screen that identifies increasing mood symptoms, and the MA alerts the physician. The patient confides in her physician that she and her husband have recently separated in the setting of infidelity. Over several months, her PCP titrates her fluoxetine upwards to 40 mg daily and ultimately adds Wellbutrin XL for augmentation, but no improvement is seen and the patient reports experiencing unwanted side effects. She is referred to the behavioral health care manager for brief psychotherapy over six weeks. Through a routine panel management meeting, her case is reviewed with the embedded psychiatrist who recommends a transition to Effexor. Her PCP implements this plan with the support of the behavioralist. The patient is reevaluated in six weeks and is found to have significant improvement in her symptoms.

Patient 2: Rhoda is a 39-year-old female who has had stable depression for five years on bupropion. She is enrolled in a depression population registry through her PCP’s office. The behavioralist calls her every three months and administers a PHQ-9 over the phone. The patient consistently scores less than 4 (favorable) until the most recent call, when she scores 17 (indicative of residual depressive symptoms). The behavioralist learns of the recent unexpected death of the patient’s child. He schedules an urgent appointment with her PCP who diagnoses the patient with recurrent depression and prescribes trazadone and sertraline. The case manager provides grief counseling and also refers her to a grief support group. Over time, the patient reaches her treatment goals.

Conclusion

Embedding behavioral health within primary care or select secondary care practices expands the services a patient can receive in their primary care clinic. It is convenient for the patient (one-stop shopping). In addition, many medical conditions are greatly impacted by patients' behavioral choices and mental health issues. By bringing medical and psychosocial services together within primary care, the team is better able to meet both the mental and general health needs of the patient.



STEPS in practice

1

How's it working in Ann Arbor, MI?

At the University of Michigan, the Tailored Mental Health Management Support for Primary Care (**TaMMS**) program was designed to help manage the treatment of depression and anxiety among the patient population. The model is dependent on the skills and abilities of the TaMMS care manager, who often has a social work background and plays a critical role in the care of mild to moderately depressed patients. Not only does the TaMMS care manager follow up to insure that the treatment is working, but he or she also involves a psychiatry consultant in routine review of patient progress and in providing recommendations to the PCP for medication adjustment or other interventions. The TaMMS care managers also have a variety of additional and important functions on the team:

- Help triage patients to appropriate services
- Provide short-term psychotherapy interventions, such as behavioral activation or problem solving therapy
- Contribute to team efforts to improve systems of care delivery to make them Lean and efficient
- Assist in identifying additional resources and referring difficult behavioral health cases that require specialty mental health care.

While TaMMS was designed for the care of patients with mild to moderate depression, the TaMMS care managers are often asked to help with patients who have serious mental illness (SMI) because of their network, connections and system knowledge. The care manager can answer a few quick questions or involve the appropriate people to make the right next steps happen for these complex patients. The TaMMS program is now implemented in four clinics (two community and two university clinics) and will be implemented in four additional clinics (two community and two more university clinics) in 2016. The TaMMS program has been supported by funds provided by the UM health system, Blue Cross Blue Shield Foundation, Medicaid Match and, most recently, the UM Department of Family Medicine. Efforts are being made to develop a sustainable plan for funding this integrated behavioral health effort longer-term implementation.

2

How's it working in Ithaca, NY?

A pilot program at Cornell University, a highly diverse international community of 22,000 students, demonstrated the value of an embedded behavioral health consultant (BHC) as a cost-effective, accessible, culturally sensitive approach to providing mental health care.

Each year nearly 80 percent of students use Cornell's campus medical services, and about 18 percent access mental health services, both for a nominal \$10 per visit charge. Though staff share an electronic record, students access counseling and medical services through separate intake processes. Demand for mental health services continues to grow, and surveys suggest that as many as 40 percent of students could benefit from mental health care. Some of this need is experienced by medical providers as growing complexity in medical presentations. Though university leadership recognizes the importance of health to its academic mission, it would be prohibitively expensive to meet the estimated need of the student population with traditional mental health services. Additional barriers included the time required for treatment and the perceived stigma that many students have towards mental health care.

As a one-year pilot effort aiming to cost-effectively increase the quality of medical care and the reach of mental health services, a behavioral health consultant was embedded in a medical unit and assigned to work with four clinicians. The experiment proved highly successful. Students, including many who said they would not have sought traditional mental health services, found BHC interventions to be very helpful. The clinicians reported that the partnership increased the effectiveness and cultural sensitivity of their care. Mental health staff developed new appreciation for the volume and significance of mental health concerns presenting in the primary care setting. The program reached under-represented minorities, international and graduate students well beyond their proportion in the general student population, which was particularly gratifying.

Based on the success of this pilot, Cornell University Health Services Executive Director and Associate Vice President Janet Corson-Rikert, MD decided to expand the program as a key component of their integrated health program. The program includes one behavioral health consultant on each medical team.

When asked about lessons her team would share with others implementing similar programs, Dr. Corson-Rikert suggested:

1. Set up an interdisciplinary team to support the BHC and enable nimble problem-solving around operational challenges
2. Leverage the BHC's expertise for both behavioral and cultural concerns
3. Use regular case reviews to facilitate education and team discussion based on BHC experience

3

How's it working in Boston, MA?

Brigham and Women's Advanced Primary Care Associates, located in South Huntington, MA, has been increasingly successful in implementing its integrated behavioral health model. With four years of experience in integrating behavioral health into its daily practice functions, Stuart Pollack, MD, the clinic director, credits the practice's strong culture and multidisciplinary model for its continued success. Each step within its workflow has been deliberately designed by the clinical team.

The practice consists of three physician-led teams, each of which includes a physician, a physician assistant, two MAs, a licensed practical nurse and a social worker who specializes in behavioral health. In addition to the core clinical members, the three teams share a pharmacist, nutritionist, nurse care manager and a consulting psychiatrist.

Medical assistants function as integral components in streamlining and strengthening the workflow. They are responsible for determining whether a patient requires behavioral health services by utilizing [PHQ-2](#) and [PHQ-9](#)

screening tools. These questionnaires are administered at the beginning of each patient visit. After the MA completes the patient intake activities, she meets with the physician in a mini-huddle. During this hand-off, they determine whether the behavioral health social worker should become involved in the patient's care. If so, the social worker will see patient after the physician portion of the visit.

The team's social worker maintains continuity of care by checking in with patients after their initial visit and between visits. The social worker reports back to the consulting psychiatrist and PCP regarding each patient's care. The three teams in the practice utilize approximately six hours per week of the consulting psychiatrist's time. The psychiatrist attends practice meetings and is considered to be an integral member of the team. Through a multidisciplinary approach and an engaged staff, Brigham and Women's Advanced Primary Care Associates has mobilized its collective intelligence to develop a successful embedded behavioral health model that is able to provide integrated health services to patients.

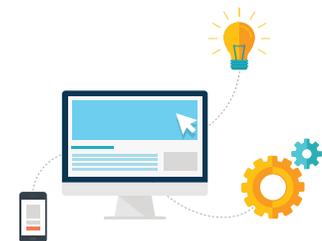


To demonstrate completion of this module and claim *AMA PRA Category 1 Credits™*, please visit:

www.stepsforward.org/BehavioralHealth

Get implementation support

The AMA is committed to helping you implement the solutions presented in this module. If you would like to learn about available resources for implementing the strategies presented in this module, please call us at (800) 987-1106 or [click here](mailto:StepsForward@ama-assn.org) to send a message to StepsForward@ama-assn.org



References

1. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Collaborative Care Staffing Ratios. <http://aims.uw.edu/resource-library/collaborative-care-staffing-ratios>. Accessed August 10, 2015.
2. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Education & Training. <https://aims.uw.edu/program-area/education-training>. Accessed August 10, 2015.
3. Vanderbilt University School of Nursing. Health Coaching Certificate Program http://www.nursing.vanderbilt.edu/certificate/health_coaching.html. Accessed August 10, 2015.
4. Duke Integrative Medicine. Integrative Health Coach Training. <https://www.dukeintegrativemedicine.org/integrative-health-coach-training/>. Accessed August 10, 2015.
5. National Society of Health Coaches. <http://www.nshcoa.com/>. Accessed August 10, 2015.
6. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10:CD006525.
7. Cochrane. Collaborative care for people with depression and anxiety. http://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety. Accessed August 10, 2015.
8. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Collaborative Care Case Study: Behavioral Health Integration Program. <http://aims.uw.edu/collaborative-care-case-study-behavioral-health-integration-program>. Accessed August 10, 2015.

9. University of Washington, Psychiatry & Behavioral Sciences, Division of Integrated Care & Public Health. Advancing Integrated Mental Health Solutions (AIMS) Center. Impact Training. <http://aims.uw.edu/resource-library/impact-training>. Accessed August 10, 2015.
10. Unützer J, Chan YF, Hafer E, et al. Quality improvement with pay-for-performance incentives in integrated behavioral health care. *Am J Public Health*. 2012;102(6):e41-e45.
11. Smith TE, Erlich MD, Sederer LI. Integrated care: integrating general medical and behavioral health care: the New York State perspective. *Psychiatr Serv*. 2013;64(9):828-831.
12. Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions. Behavioral Health in Primary Care. Integrating behavioral health into primary care. <http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care>. Accessed August 10, 2015.
13. SAMHSA-HRSA Center for Integrated Health Solutions. Patient Health Questionnaire (PHQ-9). <http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>. Accessed August 10, 2015.
14. SAMHSA-HRSA Center for Integrated Health Solutions. Generalized Anxiety Disorder 7-item (GAD-7) Scale. <http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>. Accessed August 10, 2015.
15. SAMHSA-HRSA Center for Integrated Health Solutions. Stable Resource Toolkit: AUDIT-C. http://www.integration.samhsa.gov/images/res/tool_auditc.pdf. Accessed August 10, 2015.
16. Morisky Medication Adherence Scales: MMAS-4 and MMAS-8. http://c.ymcdn.com/sites/www.aparx.org/resource/resmgr/Handouts/Morisky_Medications_Adherence.pdf. Accessed August 10, 2015.
17. U.S. Department of Health and Human Services. National Institutes of Health. PROMIS. <http://www.nihpromis.org/default#2>. Accessed August 26, 2015.