Integrating Behavioral Health into Primary Care

Action Guide and Resource Compendium

[Table of Contents]

About this Guide & Table of Contents

This Action Guide and Resource Compendium provides a list of recommendations and resources to help clinicians, provider organizations, and policymakers support the integration of behavioral health into primary care. It is intended to serve as a companion document to the policy brief, *Enhancing Patient Outcomes and Health System Value through Integration of Behavioral Health into Primary Care*, which is based on the ICER report, *Integrating Behavioral Health into Primary Care*. All materials are available on the CEPAC website.

How to use this Action Guide: Each section contains one or more key recommendations from the report, accompanied by resources to provide further background and implementation support to help stakeholders translate and apply the guidance to practice and policy. General and national information are listed in blue tables, and resources specific to the New England region are listed in green tables.

A more detailed explanation of the recommendations contained within this guide is presented in section 10 of the ICER report.

Table of Contents

About Integration

Recommendation: Public and private payers, clinicians, patients, and others should collaborate to reduce fragmentation of care and develop innovative system-wide solutions that include behavioral health integration (BHI), building on efforts already underway and utilizing state and federal programs.

The resources at right provide an overview of the national landscape for integration efforts, the terminology used across the field, and examples of states that are using collaborative models to effectively implement integration.

National Resources	
Where Integration is Happening, Agency for Healthcare Research and Quality (AHRQ)	A map of efforts to integrate care across the US
State Efforts (Except California), Integrated Behavioral Health Project (IBHP)	A list of state efforts to integrate care
Lexicon for Behavioral Health and Primary Care Integration, AHRQ	Main page for the AHRQ Lexicon for Behavioral Health and Primary Care Integration, a critical tool for defining the elements of integrated care
Collaborative Family Health Care Association	A member-based organization that brings together provider groups, patients and families, and communities to promote effective health care delivery models

Vermont Blueprint for Health
The Vermont Blueprint for health is a statewide initiative to implement a service model that incorporates patient-centered medical homes, support services through community health teams, self-management support services, and improved data collection through statewide reporting systems. Stakeholders throughout the state, including provider groups, hospitals, health centers, and payers have worked collaboratively to develop and implement the Blueprint. For more information on the Vermont Blueprint, visit their website.

The Care Transformation Collaborative, Rhode Island
CTC-RI began in 2008 as the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) and is one of the country's longest standing patient-centered medical home (PCMH) initiatives. CTC-RI brings together both private and public payers in the state, as well as physician groups, employers, state agencies, and other key stakeholders to implement the PCMH model in practices throughout Rhode Island. CTC-RI collaborates with over 70 practice sites throughout the state, and a number of these sites have begun to implement integrated behavioral health into their PCMH practice.

State SIM Grants

Many State Innovation Model (SIM) grants have placed emphasis on expanding integrated care services throughout the state. The table at right provides a brief overview of the relevant initiatives.

	New England SIM Grants
CT	Connecticut's model test award will be used to expand PCMHs, offer technical support to federally qualified health centers (FQHCs) integrating behavioral health and developing team-based care, introduce shared-savings contracts in Medicaid, and expand electronic health record (EHR) infrastructure.
MA	Massachusetts's model test award will support primary care practices in transitioning to PCMH models, develop payment methodologies that incorporate shared savings and risk with added quality incentives, aid public and private payers in transitioning to this model, and enhance data infrastructure. It will also provide support for primary care practices transitioning to PCMH models.
ME	Maine's model test award will help expand the number of PCMHs for chronically ill patients, develop workforce models to manage patients with high risk and high utilization, support training for primary care physicians (PCPs) serving patients with behavioral health needs, expand alternative payment models, and implement EHRs to support integration.
NH	New Hampshire's two model design awards will help to improve access for individuals at risk of requiring long-term services and supports (LTSS) through Medicaid; develop Regional Healthcare Cooperative Extensions (RHCEs) where providers can access health systems engineers for consultation, implementation support, and technical assistance; and explore alternative payment methodologies.
RI	Rhode Island's model test award will help to develop a Population Health Plan, including the integration of behavioral health and primary care; strengthen the existing network of PCMHs, Health Homes, and accountable care organizations (ACOs); support the development of community health teams; explore pay-for-performance (P4P) and shared savings payments; and expand EHRs.
VT	Vermont's model test award will support creation of a model that increases coordination between primary care and specialists and development of three alternative payment methodologies: an ACO model, a bundled payment model, and a P4P model.

Implementation: Learn from Existing Programs

Effective BHI can be accomplished through different care delivery models, and in practice, implementation will be tailored to distinct patient populations and other local considerations.

Recommendation: Since the approach to integration with the strongest evidence base is the Collaborative Care Model (CCM), practices implementing BHI should use available resources and seek guidance from organizations that have experience with the CCM while accounting for differences in patient population, resources, treatment priorities, and options for funding. A second promising approach to integration is the Behavioral Health Consultant model.

The resources at right provide guidance in implementing the CCM, the integration model most backed by evidence, and examples of integration efforts in New England, many of which share core components with the CCM. The next page provides additional resources for successful integration using other approaches.

Resources for Implementing the CCM	
Implementation Guide, AIMS Center	A step-by-step guide to implementing the Collaborative Care Model, one approach to behavioral health integration
Patient-Centered Integrated Behavioral Health Care Principles & Tasks, AIMS Center	A checklist to help organizations evaluate their progress on the principles, core components, and tasks that are central to integration
Implementation Stories, AIMS Center	Experiences of organizations that have implemented integrated care

Examples of Integrated Care in New England	
MaineHealth Behavioral Health Integration, Maine	Fair Haven Community Health Center, Connecticut
Providence Community Health Centers, Rhode Island	Lynn Community Health Center, Massachusetts
University of Vermont Medical Center, Vermont	Dartmouth-Hitchcock Keene, New Hampshire

Implementation Support: General Resources

The resources at right provide general guidance for practices implementing BHI that is not specific to one single approach or model. Rather, the resources may help practices learn from the broad experience of others to identify resources, approaches, and strategies to facilitate BHI given the unique contextual considerations for each practice.

General Implementation Resources	
A Quick-Start Guide to Behavioral Health Integration for Safety-Net Primary Care Clinics, SAMHSA-HRSA CIHS	Decision flowchart to guide practices in their integration efforts
AHRQ Integration Academy, AHRQ	Main page for the AHRQ Integration Academy, which includes information on all aspects of integration
State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment, The Commonwealth Fund	White paper examining various state efforts to integrate behavioral health care in a fragmented Medicaid environment
Behavioral Health in Primary Care, SAMHSA-HRSA CIHS	Resources for integrating behavioral health into primary care, including models, videos, and webinars
Primary Care Behavioral Health Toolkit, Mountainview Consulting Group, Patient-Centered Primary Care Institute	A toolkit of implementation resources, including organizational readiness tools, assessment tools, patient information, and quality management tools
Behavioral Health Integration Capacity Assessment Tool, Resources for Integrated Care	A tool to help behavioral health organizations assess their ability to integrate with primary care services
A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration, AHRQ	Lessons from sites that have integrated behavioral health and primary care

New England Resources	
PCMH Online Courses and Behavioral Health Integration Toolkit, Massachusetts Patient-Centered Medical Home Initiative	A compendium of resources and strategies for practices to use when integrating behavioral health services in primary care.

Integration in Practice

The real-world implementation of behavioral health integration often combines several features of different models and is adapted with the specific resources, population needs, and goals of the practice in mind.

The three programs listed at right have emerged to serve as key examples of integrated care. These programs often contain or adapt elements of the CCM to account for the specific resources, population needs, and goals of the practice.

Cherokee Health Systems

Cherokee Health Systems is a network of federally qualified health centers (FQHCs) and community mental health organizations in Tennessee that operates over 50 clinic sites throughout the state. All patients are screened for behavioral health conditions and then are assigned to the appropriate level of support. Care teams include embedded behavioral health consultants who develop treatment plans and manage patient care in collaboration with primary care physicians (PCPs) . Team members are connected through electronic health records (EHRs)and use standard measures to track patient outcomes. For more information, click here.

Department of Veterans Affairs (VA)

The VA program is built on existing infrastructure and focuses exclusively on serious mental illness (SMI) and depression. PCPs screen all patients for depression and post-traumatic stress disorder, and care managers assess the behavioral health needs of patients who screen positive using structured protocols. Depression care managers are included on the primary care team, where they make treatment recommendations to the PCP, follow-up with patients, and communicate with psychiatric consultants as necessary. EHRs facilitate provider communication, support data analysis and reporting, and provide point-of-care decision support. For more information, click here.

Intermountain Healthcare

Intermountain Healthcare is an integrated health system of over 20 hospitals and 200 outpatient clinics serving the metropolitan area of Salt Lake City, Utah. All patients receive a comprehensive mental health assessment, and they are screened for depression, anxiety and other behavioral health concerns using validated tools. PCPs and behavioral health providers collaborate to develop treatment plans and facilitate seamless patient transition across providers. Team members track and upload patient data though a secure, central health information exchange. For more information, click here.

Measuring Outcomes

Recommendation: Payers, practices, and policymakers should work collaboratively to build consensus around a set of validated outcomes measures for BHI.

Standardized measures would help payers and practices understand the degree of integration being achieved, the benefit, and the true cost of implementing and maintaining BHI.

The resources at right aid clinicians and policymakers in implementing standardized outcomes measures, and in measuring the quality of care provided by an integrated practice.

Screening Tools	
Tools, AHRQ	Compendium of screening tools
Clinical Tools, MaineHealth	Screening and assessment tools for adults and children

Resources for Measuring Quality of Care	
Atlas of Integrated Behavioral Health Care Quality Measures, AHRQ	Provides resources for developing quality measures to monitor integration efforts
Primary and Behavioral Health Care Integration Sustainability Checklist, SAMHSA-HRSA CIHS	Organizational worksheet to identify and prioritize the changes that are necessary for integration
Health Indicators, SAMHSA-HRSA CIHS	Information about health indicators and tools for setting up a clinical registry to track outcomes

Workforce

Recommendation: The specific staffing model that a practice adopts should reflect the disease burden and broader psychosocial characteristics of the population seen and should include designated leadership positions to facilitate team collaboration and oversee the transition to integrated care.

The resources at right provide information about what types of professionals may be included on a care team, and how practices can effectively recruit and employ these professionals.

Building Your Care Team	
The Mental Health Workforce: A Primer, Congressional Research Service	Report on the roles, credentials, and scope of practice of mental health professionals
Workforce, SAMHSA-HRSA CIHS	Resources to support development of an effective workforce in an integrated setting
Team Structure, AIMS Center	Description of the team structure used in the CCM, including sample job descriptions and flowchart of roles
Collaborative Care Staffing Ratios, AIMS Center	Recommendations for appropriate staffing ratios based on the CCM
Recruitment & Retention, SAMHSA-HRSA CIHS	Resources to aid in hiring and retention efforts; includes sample job descriptions

Staffing Ratios:

The table at right outlines the ratios suggested by the **AIMS Center** using the Collaborative Care Model, based on the needs of the patient population.

Other models suggest fewer case managers or behavioral health professionals may be necessary to fulfill patient needs. A Truven Analytics report suggests that behavioral health staff should be available 2-4 hours weekly for every 1,000 primary care patients in FQHCs. Alternatively, other practices have used one behavioral health clinician per every 3-4 PCPs.

Clinic Population	Prevalence of Depression	Typical Active Caseload for 1 FTE Care Manager	Primary Care Panel Size for 1 FTE Care Manager	Typical Personnel Requirements for 1,000 Primary Care Patients (FTEs)	
				Care Manager	Psychiatric Consultant
Low need (e.g., insured, employed)	2%	100-125	5,000	0.2	0.05 (2 hours/week)
Medium need (e.g., FQHC, chronic pain, substance use)	5%	65-85	1,500	0.7	0.07 (3 hours/week)
High need (e.g., homeless, addiction issues)	15%	50	333	3.0	0.3 (12 hours/week)

Training

The capacity for practices to implement BHI is strained by an overall shortage of primary care and behavioral health providers by a and lack of providers with expertise in integrated care.

Recommendation: Additional specialized training or re-training of staff is necessary to build the integrated care workforce and help each team member understand their scope of work and the goals of integrated care.

The resources at right can help practice leadership and clinicians identify training opportunities related to the provision of care in integrated settings.

Training Programs	
Training Programs, Agency for Healthcare Research and Quality (AHRQ)	A list of programs for training and development
Primary Care Psychiatric Consultation Training Series, AIMS Center	Training for psychiatrists in the CCM
IMPACT Training, AIMS Center	IMPACT training on depression care for a variety of health care providers
Brief Interventions in Primary Care, SAMHSA-HRSA CIHS	Slide deck on using brief interventions in primary care

Training in New England	
Certificate Program in Primary Care Behavioral Health, UMASS Medical School	Certificate program at the University of Massachusetts Medical School Center for Integrated Primary Care
CTC-RI Practice Training and Support Activities, Care Transformation Collaborative of Rhode Island	Learn how CTC-RI is training its PCMH practice sites to deliver integrated behavioral health care

Workflow and Clinical Tools

Recommendation: If a population-based approach to BHI is not feasible, practices should consider rolling out BHI interventions to a subset of the patient population with the greatest clinical need and potential benefit.

Recommendation: Flexible workflows facilitate BHI. To the extent possible, clinic operations should allow for "warm hand-offs" and real-time (in-person or virtual) collaboration and consultation across providers.

The resources at right can support the development of a successful clinical workflow and operations strategy.

Screening and Clinical Operations Tools	
Example Pocket Provider Tool, AIMS Center	Physician tool to help identify appropriate patients for collaborative care
Care Manager Resources: Common Questions & Answers About Treatments for Depression, AIMS Center	Guidance for care managers talking to patients about depression
Patient-Centered Integrated Behavioral Health Care, AIMS Center	Checklist to track performance of key components and tasks involved in integrated care
Primary Care/Behavioral Health Provider Communication Form, Beacon Health Strategies	Sample form for exchanging information between providers

Resources to Support Effective Workflow	
Workflow, SAMHSA-HRSA CIHS	Practice examples and tools for creating an effective workflow
Clinical Workflow Plan, AIMS Center	Worksheet to help practices identify who will complete tasks that are part of the CCM
Workflow Assessment for Health IT Toolkit, HealthIT.gov	An interactive flow chart of the impact of health IT on workflow

Workflow Strategies

The information at right is based on the experiences of practices that have integrated behavioral health and primary care services. It provides guidance and examples for how to structure workflow and clinical operations to accommodate the flexibility needed in an integrated care setting.

Practice Innovation:
Cherokee Health Systems has adopted an innovative approach in which behavioral health consultants carry a laptop, allowing them to move throughout exam and consultation rooms to address patient issues as they arise. RNs are used to carefully manage workflow and allocate space to ensure that appointments run on schedule. If PCPs fall behind in their schedule, behavioral health clinicians may initiate appointments with patients and provide some primary care services to keep them from waiting.

Space for Warm Hand-Offs
Consider establishing designated locations where brief behavioral health consultations can take place to help accommodate warm hand-offs.

No Closed Door Policies
In co-located practices, consider implementing "no closed door" policies, in which physicians are able to interrupt appointments for a brief consultation, to help foster collaboration.

Open Access Appointments
Some practices follow open-access appointment models, meaning that very few, if any, appointments are scheduled in advance. Patients are seen on a first-come, first-served basis in 30 minute increments. This approach removes the issue of no-show appointments, which can be very prevalent in high-needs populations and can prevent other patients from accessing services.

Same Day Appointments
Whether or not it is important to offer your patients same day behavioral health appointments will depend on your patient population. While same-day appointments can be convenient for some patients, other patients may be unable to afford two co-pays in one day, or may not have the time to wait for a second appointment after finishing their first.

Making Time for Consultation
Reserving time throughout the day to allow different providers to discuss patient cases and collaborate on care plans is important to integration. Some practices reserve every other appointment slot for provider-to-provider consultation.

Licensing and Certification

Recommendation: States should take steps to alter licensing and certification requirements that serve as a direct barrier to BHI and pursue policies that streamline licensing processes for integrated or multi-site care settings.

The information at right outlines examples of current barriers that licensing requirements pose for integration, as well as efforts some states are taking to support the inclusion of behavioral health services in primary care and other settings.

Existing Barriers	
Policies that Limit Practices' Abilities to Integrate Care	Massachusetts has laws that require new or renovated facilities to provide separate waiting rooms for behavioral health and primary care patients. Originally thought to reduce stigma, this requirement places physical limitations on practices' abilities to provide behavioral health care in a primary care setting. The state has begun to issue waivers to allow practices to override this regulation, but it can take over a year to obtain the waiver.

Possible Solutions	
Multi-Care Facilities Licensing	The Connecticut Department of Public Health recently approved legislation that reversed a longstanding rule that prevented behavioral health facilities from providing any service "off-site" in satellite physician offices or other health care settings. A multi-care facility license now allows behavioral health facilities to provide care in a variety of settings, removing a significant barrier to integration.
Licensing Requirements that Support Provision of Behavioral Health	Massachusetts recently proposed legislation that would require hospitals and FQHCs to provide access to behavioral health services, either directly or through outside contracts, in order to be licensed.

Billing and Payment

Recommendation: To align incentives among providers and encourage integration, payment for behavioral health services should be shifted away from fee-for-service (FFS) to value-based reimbursement contracts, including risk-adjusted capitation and opportunities for shared savings and/or shared risk. When developing reimbursement arrangements, decision-makers should consider the following:

- Where possible**,** **supplemental capitated payments or performance bonuses** should be based on implementing and sustaining BHI.
- To support the transition towards value-based reimbursement, payers and state agencies should **activate currently available billing code sets for care and case management** so the incremental services being provided in integrated settings can be documented.
- Behavioral health carve-outs, though potentially suboptimal for achieving the goals of BHI, are likely to remain an important aspect of health care financing. To the extent possible, **carve-out arrangements should be improved through enhanced communication, information sharing, and care planning across entities** to encourage collaborative care planning and follow-up.

Recommendation: Even with a shift toward capitation, FFS will continue to be a reality of the reimbursement landscape, at least in the short-term. Therefore, several changes to billing requirements are needed to facilitate BHI. Although they will differ by state, these include allowing more types of clinicians to bill for behavioral health services; expanding billing codes for care management and case management; and paying for behavioral health services provided when a patient is not present, rather than requiring a physical face-to-face interaction.

Recommendation: Health plans should design benefits and provider networks to support a role for behavioral health providers as members of primary care teams and not require that patients pay specialist-level copayments for these providers.

Resources to support implementation of these recommendations are available on the following page.

New England Payment Reform Efforts	
Vermont Blueprint for Health, Vermont Department of Health Access	The Blueprint is a multi-payer initiative involving fee-for-service payments in addition to a per-member per-month payment based on National Committee for Quality Assurance (NCQA) scores.
Massachusetts Primary Care Payment Reform Initiative (PCPRI), MassHealth	The PCPRI involves a risk-adjusted, capitated payment, an annual quality incentive, and shared savings. Practices receive payments based on their level of BHI.
Alternative Quality Contract (AQC), Blue Cross Blue Shield of Massachusetts	The AQC features risk-adjusted, capitated payments, shared savings and risk, and performance bonuses based on validated outcomes measures.

Billing and Payment (cont.)

Billing Resources	
Billing Tools, SAMHSA-HRSA CIHS	State-by-state guide to billing, including the types of practitioners that can bill for specific services, and a list of CPT codes reimbursable by Medicare/Medicaid (Current as of June 2014. Some states may have updated rules.)
Coding Behavioral Health Services: CPT, DSM, AND ICD, National Council for Behavioral Health	Information on billing for behavioral health services
Tips and Strategies for Billing for Mental Health Services in a Primary Care Setting, Suicide Prevention Resource Center	Guidance on billing for mental health services in a primary care setting

National Payment Models and Recommended Reading	
AHRQ Policy Innovation Profile: Missouri Health Homes, AHRQ	How Missouri's health homes support integrated care using a capitated payment model
AHRQ Policy Innovation Profile: Minnesota DIAMOND Program, AHRQ	How Minnesota's DIAMOND initiative uses fixed monthly payments from plans to provide bundled services to all patients who meet specific criteria
Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry	Link to a report prepared by Milliman, Inc. evaluating the economic impact of integrating behavioral health and primary care

About the Health and Behavior Assessment and Intervention Codes	
Tip Sheet: Health Behavior and Assessment Intervention (HBAI) Services, National Council on Aging	Tips for billing using HBAI codes, where applicable
Health & Behavior Assessment & Intervention, National Association of Social Workers (NASW)	Position statement from the NASW calling for social workers and community health workers to be allowed to bill for HBAI codes
Health and Behavior Codes Guidelines for Use, MaineHealth	Guidelines for how to use the Health and Behavior Codes

Billing and Payment (cont.)

The table at right highlights what types of practitioners are able to bill for various services in each state.

Information is current as of July 2014. Source: SAMHSA-HRSA CIHS State Billing and Financial Worksheets. July 2014.

PA=physician assistant; NP=nurse practitioner; LCSW=licensed clinical social worker; LMHC=licensed mental health counselor; LMFT=licensed marriage and family therapist; LCPC=licensed clinical professional counselor; CNS[MH]=certified nurse specialist [mental health]; APRN=advanced practice registered nurse; ANP=adult nurse practitioner; CMHC=community mental health center

	Service	VT	NH	ME	MA	CT	RI
HBAI Codes	Assessment	MD, PA, NP, clinical psychologist	Not activated	MD, PA, APRN, clinical psychologist, LCSW, LCPC	Not activated	Activated but credentialing information not available	Not activated
	Reassessment						
	Individual treatment						
	Group treatment						
	Family treatment with patient						
	Family treatment, no patient	Not activated		Not activated			
Mental Health	Psychiatric evaluation without medical services	Psychiatrist, physician, PA, psychiatric NP	Credentialing Information not available		Physician, ANP, CNSMH	Psychiatrist, MD, APRN	Credentialing information not available
	Psychiatric evaluation with medical services				PA employed by a CMHC		
	Therapy	LCSW, LMHC, LMFT, psychiatric NP, psychiatric physician, doctorate and master's level psychologists	MD, PA, NP, clinical psychologist, LCSW	Licensed clinical psychologist, LCSW, LCPC, CNS	Credentialing information not available	LCSW, PhD, PsyD Psychologist	MD, PA, NP, clinical psychologist, clinical social worker
	Mental health assessment		Not covered	Not covered	Not covered	Not covered	Not covered
	Group therapy					LCSW, PhD, PsyD Psychologist	
	Crisis intervention	Information not available					
	Case management					Not covered	

[Return to Table of Contents]

Billing for Telehealth

Recommendation: Providers should be reimbursed for behavioral health services delivered via telehealth.

Recommendation: To address network capacity concerns, provider organizations should develop systems that link providers electronically and help triage patients to the level of care most appropriate for their individual needs.

The resources at right link to each state's policies regarding telehealth, along with information to support its implementation. The table on the following page summarizes the regulations surrounding telehealth in each New England state.

National Telehealth Resources	
Telebehavioral Health Training and Technical Assistance, SAMHSA-HRSA CIHS	6 session implementation training and resources
State Telemedicine Gaps Analysis: Coverage and Reimbursement, American Telemedicine Association	State assessments of the status of telehealth coverage

Telehealth in New England	
Learn about the status of telehealth in your state with resources from the Center for Connected Health Policy:	Connecticut
	Maine
	Massachusetts
	New Hampshire
	Rhode Island
	Vermont
Learn how the Massachusetts Child Psychiatry Access Project uses telehealth to increase access to behavioral health services	Massachusetts Child Psychiatry Access Project

Telehealth Regulations in New England

The table at right outlines key regulations and coverage policies for telehealth in the New England states.

	CT	ME	MA	NH	RI	VT
Allows out-of-state physicians providing telemedicine to practice without license in state where patient resides?	No	No	No	No	No	No
Allows for provider-to-provider consultation from out-of-state physicians?	Yes—time limits apply	Yes—time limits apply	No	Yes	Yes—time limits apply	Yes
Private insurance coverage for telemedicine required?	No	Yes	Yes	Yes	No	Yes
Medicaid reimbursement for telemedicine?	Yes	Yes	No	No (Legislation Pending)	No	Yes

Information Sharing: EHRs and Privacy

Recommendation: BHI depends on the ability of clinicians to collaborate and share patient information. Systems that better support communication between primary care providers and specialty behavioral health providers are therefore needed, particularly where EHR systems are not used or lack interoperability. Clearer guidance is also needed from federal and state officials to help clinicians understand laws that affect the sharing of patient information related to mental health and substance use disorders. Enhanced information sharing would allow for more coordinated treatment, particularly around vulnerable times of transition, and would help to avoid duplication of services.

The resources at right provide information to support practices seeking to implement an EHR system, use existing EHR systems more efficiently, or better understand privacy laws surrounding the exchange of patient information.

Electronic Health Records	
Technology and Electronic Health Records, American Psychological Association	Information about choosing and implementing an EHR system
EHR Incentive Programs, Centers for Medicare & Medicaid Services (CMS)	Information about Medicare's federal EHR incentive program
EHR Meaningful Use Criteria, CMS	CMS eligibility criteria regarding financial incentives for "meaningful use" of EHRs
"Ten Minutes at a Time" Health Information Technology Portal, SAMHSA-HRSA CIHS	Videos and tutorials on a variety of topics related to implementation and effective use of electronic health records
Improved Care Coordination, HealthIT.gov	How EHRs can help to integrate care
Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange, Manatt, Phelps & Phillips	A report from the Robert Wood Johnson Foundation on integrating care and the Health Information Exchange

Privacy	
HIPAA Privacy Rule and Sharing Information Related to Mental Health, US Department of Health and Human Services	Common questions about Health Insurance Portability and Accountability Act (HIPAA) regulations and mental health information
Confidentiality of Client Records and Information, IBHP	Information on confidentiality of patient records, including examples of when it is appropriate to share health information
What Takes Precedence: HIPAA or state law?, American Psychological Association	A summary of how state laws and HIPAA interact

Information Sharing: EHRs and Privacy

Many New England states have laws about privacy and information sharing that take precedence over HIPAA. A brief summary of these laws is shown at right.

	New England Privacy Laws
Connecticut	CT ST § 52-146c: Consent is required for disclosure of information shared between a patient and psychologist. 52-146f: Information may be disclosed without authorization between providers involved in diagnosis and treatment of the patient.
Maine	ME R REV 503: A patient may refuse to allow disclosure of confidential information. LD534 An Act To Improve Care Coordination for Persons with Mental Illness: Authorization for disclosure is not required for information shared within an office, practice, or affiliate facility.
Massachusetts	MA Title XVI Chapter 112 Section 129A: Keeps communication between a licensed psychologist and a patient confidential.
New Hampshire	189:2 Use and Disclosure of Protected Health Information; Health Information Exchange: Health care providers can share patient health information through the state's health information organization. Information can only be used by a health care provider for treatment, care coordination, and quality assurance, or by a legal representative. Patients must have the opportunity to opt out of having personal information shared with their protected health information. NH ST § 332-I:2: Patients must provide consent for any provider to share confidential information, except as required by law or to protect the patient or public interest. Rule 503. Patient's Privilege: Keeps interactions between patients and psychologists confidential. Chapter 330-A Mental Health Practice Section 330-A:32: Keeps interactions between patients and licensed state mental health providers confidential.
Rhode Island	RI Gen L § 23-17-19.1 (2012): State-licensed health care facilities must ensure patient privacy and confidentiality and keep all patient records private. Confidentiality does not prevent sharing of information between providers for the purposes of patient care. § 40.1-5-26 Disclosure of confidential information and records: Consent is required for sharing of mental health information and records. Consent is not required for information sharing between medical and mental health providers involved in the patient's care, but it is required for sharing information outside of the facility where the patient receives treatment.
Vermont	12 V.S.A. § 1612: Providers, including mental health professionals, cannot share a patient's confidential information without consent.

Patient Resources

The resources at right are available to help clinicians communicate with patients the benefits and goals of BHI. Resources are also included that can be provided to patients having trouble accessing a behavioral health clinician, or who have questions on how BHI relates to patient confidentiality and privacy.

About Integration	
Patient Stories, AIMS Center	Hear about patients' experiences receiving mental health care at their primary care office
Patient Information on Integration, MaineHealth	Read one patient's story of how integrated care made a difference
Hear Their Stories, Advancing Care Together	Hear from patients and providers in integrated care settings

Finding Care	
Recognition Directory, National Committee for Quality Assurance (NCQA)	Tool to find clinicians who are recognized by the NCQA's PCMH recognition program
Finding the Right Mental Health Care for You, Mental Health America	Read about different types of mental health care, and learn where to find care
Finding a Mental Health Professional, Depression and Bipolar Support Alliance	Information about types of mental health care, questions to ask, and how to prepare for an appointment
Consumers as Partners in Improving Health, the National Council for Behavioral Health and Mental Health America	Learn what patients can do to make sure they get the best mental health care

Information Privacy	
Understanding HIPAA Privacy Rules, US Department of Health and Human Services	Understand how HIPAA protects personal health information

Future Research Needs

Recommendation: Researchers, research funders, and clinicians should work together to generate more evidence on the effectiveness of BHI approaches in addition to the CCM and on the effectiveness of BHI in treating health conditions other than depression and anxiety.

Although the research literature has focused on the CCM and effects on depression and anxiety, many organizations across the country have developed and are implementing alternative approaches to integrate care for these and other behavioral health conditions. While the evidence base does not yet demonstrate the effectiveness of these programs, inadequate evidence does not mean proof of ineffectiveness. More evidence is needed to help decision makers determine the effectiveness of alternative approaches to BHI and identify the specific components of integrated care that are essential for improved patient outcomes.

Resources and Recommended Reading for Developing a Research Agenda	
Future Research Needs for the Integration of Mental Health/Substance Abuse and Primary Care, AHRQ	A 2010 report from the AHRQ Effective Health Care program that identifies research needs, priorities, and study design considerations for advancing the knowledge base on integration
A National Agenda for Research in Collaborative Care, AHRQ	A collection of three papers from 2011 detailing a research agenda for collaborative care, the metrics that are necessary to execute the research agenda, and the development history of the AHRQ lexicon for integration
Collaborative Care Research Network, American Academy of Family Physicians (AAFP)	Main page for the AAFP effort to support, conduct, and disseminate research on integrated care