



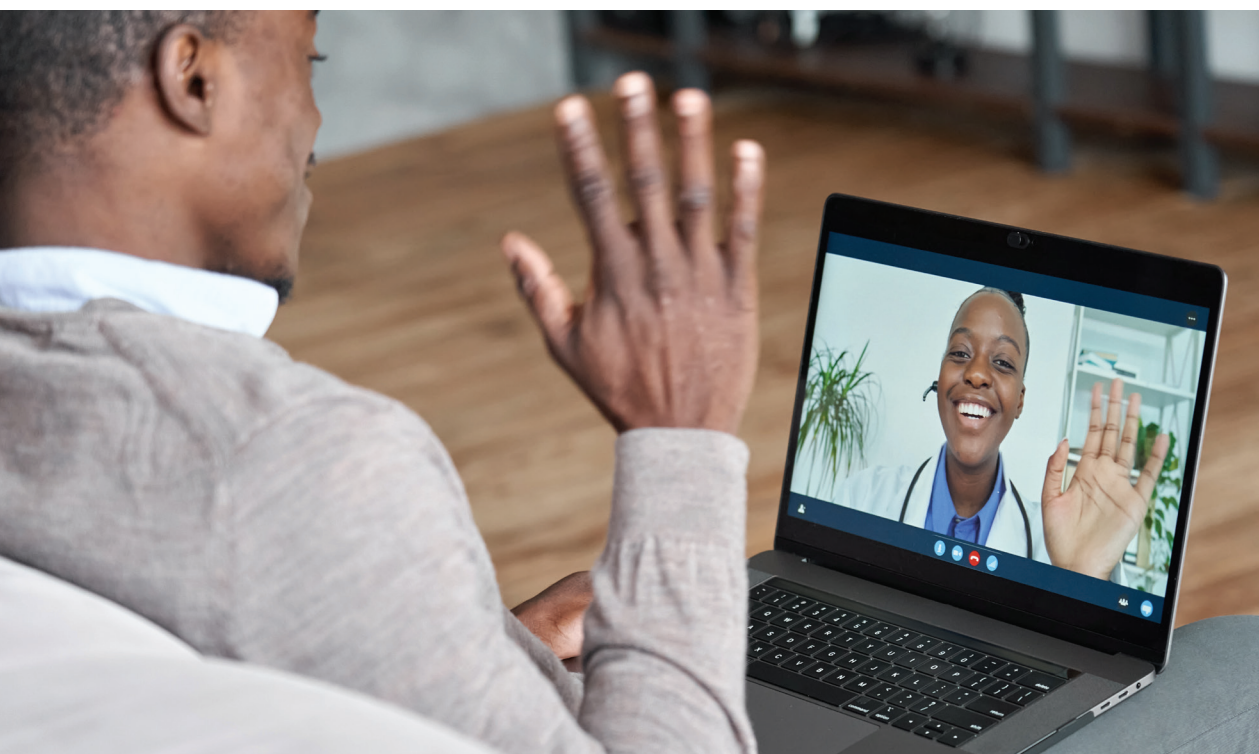
## Behavioral Health Integration Improvement Collaborative Curriculum

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## Why Behavioral Health Integration?

Integrating behavioral health into primary care is essential for health care providers looking to deliver patient-centered, high-quality whole person care — Advanced Primary Care. Evidence shows integration improves patient outcomes and quality of life while increasing access to mental health and substance use disorder treatment services. Integration also may reduce health care costs, particularly for those living with co-occurring chronic conditions. Today, behavioral health integration (BHI) is incentivized by purchasers and plans that are reimbursing for behavioral health screening and including mental health and substance use measures in pay-for-performance quality programs. Health care providers need to invest in their integration journey now to be ready for the next era of primary care transformation and to better provide care that meets patients' physical and behavioral needs.



## About the Behavioral Health Integration Improvement Collaborative (BHIIC) Curriculum

The [Purchaser Business Group on Health's California Quality Collaborative \(CQC\)](#) designed this Behavioral Health Integration Improvement Collaborative (BHIIC) Curriculum for health care provider organizations looking to integrate behavioral health (BH) services and primary care (PC). Curriculum content, curated resources and learning activities will help organizations launch or expand BH screening, treatment and referrals for patients with mild- to moderate-severity depression, substance use disorders and other conditions.

To support organizations with integration efforts, the BHIIC Curriculum walks learners through a step-wise approach to implementation rooted in quality improvement methodologies, such as the Model for Improvement. All activities are learner-centered, using adult learning approaches that enable participants to apply and adapt expertise to their own care settings. In tandem, these two approaches support organizations tackling complex projects by promoting team accountability, leveraging team and organizational strengths, testing and evaluating successful practices and spreading what works. The curriculum features content from over 60 leading organizations across the country, including perspectives from a diverse set of [provider organizations](#) across commercial and safety-net sectors. This resource reflects CQC's experience guiding practice change over 10 years in more than 2,000 practices through large-scale, multi-year improvement collaboratives and its expertise developing quality improvement learning and resources to support care teams to effectively implement evidence-based best practices.



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## Who should use this curriculum

Use the BHIIC Curriculum if you are:

- A primary care practice, health system or Federally Qualified Health Center (FQHC)
- An Independent Physician Association (IPA), Management Services Organization (MSO) or commercial Accountable Care Organization (ACO)
- Serving any mix of commercial, Medicare and Medi-Cal/Medicaid populations
- A coach or improvement collaborative convener
- Supporting a practice or site at the beginning or middle of their BHI journey
- Ready to resource a team to lead and successfully implement BHI over approximately 20 months

Note: This BHIIC Curriculum can be used by organizations regardless of location; however, a few resources that are unique to California are called out specifically. Differences between FQHCs and private providers regarding current financing of integrated care are also noted. A facilitator's guide for coaches or learning collaborative conveners can be found [here](#).

## Join us

We are very interested in hearing from learners who have used or are implementing the curriculum. Share questions or feedback via [this survey](#). Please also indicate if you are interested in learning more about a future CQC improvement collaborative focused on BHI.





## 1 Launch the journey

### Month 1

Begin self-assessment, identify team and establish learning community



## 2 Get started

### Months 2–4

Understand current BH data and patient needs, determine the business case and identify Aim statement



## 3 Prepare for the pilot

### Months 5–9

Build your implementation team, assess training needs, begin care model development and clinic focus, design a measurement strategy and address HIT needs



## 4 Implement care model

### Months 10–15

Design training plan, roll out new care pathways and redesigned workflows and measure progress



## 5 Evaluate and spread

### Months 16–17

Analyze pilot site success and plan for future care model spread across clinics/network



## 6 Refresh your sustainability plan

### Months 18–19

Ensure ongoing sustainability by addressing ongoing staffing, training/education, retention and financing



## 7 Reflect on your journey

### Month 20

Assess and catalog improvements and challenges and develop performance story

# How to use this curriculum

## Curriculum Structure: Phases, Activities and Topic Areas

The BHIIC Curriculum is organized into seven phases covering 20 months of project work: 1) launch, 2) get started, 3) prepare for the pilot, 4) implement the care model, 5) evaluate and spread, 6) refresh the sustainability plan and 7) reflect. These phases are designed to be sequential, so implementation and sustainability work in later phases builds on planning work in the early phases. Activities numbered in each phase may be sequential within a phase, but some tasks can and should be carried out simultaneously. For example, in Phase 4, teams may develop a strategy to engage a patient or family member in planning while they also engage in the initial design of care pathways for relevant clinical conditions. Specific topic areas, which may overlap within an activity, are based on the curriculum driver diagram and include: project planning, patient family engagement, workforce, health IT, clinical/care model, data/report, financing, sustainability and health equity (all are defined further in the Legend on each page).

## Sequencing Curriculum Activities

While learning activities of the BHIIC Curriculum were sequenced for a “stepwise” implementation, the reality of implementation for a new and complex project means some steps may need to occur at the same time or in a slightly different order than outlined. While each step included is essential to creating an effective, sustainable BH program, implementing sites may need to prioritize key actions based on their organization’s bandwidth and focus area. (Those participating in the learning collaborative will have support from a coach as they set their aim statements and implement the pilot project.)

Additionally, an organization’s level of readiness when embarking on the curriculum may impact what is achieved in the 20 months of planned activities: Some self-directed learning teams may be able to progress faster and some may need more time. For example, an organization just starting on this work may only reach Phase 5 in the allotted time. Also, some sections with content on how to expand and spread projects (for example, Phase 6: Sustain) may not be relevant for certain types of organizations (e.g., single clinic practices).

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## Self-Directed Learners

While select aspects of the BHIIC Curriculum are designed to be used as part of a virtual improvement collaborative, the work is largely self-directed: Participants will define a project team and engage in many tasks asynchronously. Self-directed learners can achieve the same learning objectives by completing tasks and activities described in the first column and by reviewing curated resources and completing materials outlined in the second column. Activities that are not relevant to self-directed learners have been identified with [blue text](#). Resources that may be more relevant to teams looking for additional support on a topic are included after the “Dive Deeper” note.

## Improvement Collaborative Participants

This curriculum is designed for use in a virtual improvement collaborative that would feature at least monthly touch points with other cohort participants to share progress and problem solve challenges. In addition to monthly cohort webinars for peer exchange of promising practices, each team would be assigned an improvement advisor to support implementation through tailored technical assistance. Asynchronous activities listed under the Learning Objectives column in blue would prepare participants for virtual event objectives, which are described alongside coaching support in the fourth column.

## Where to Start if You Have Not Started

If your organization is interested in undertaking the work and does not know where to start, experienced organizations have identified these common considerations and quick steps to get you started on the journey of BHI. Review with a possible project sponsor and team.

## Online Curriculum

To view the online version of this curriculum go to:  
<https://www.pbgh.org/bhiicc>

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## Common questions about getting started


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### How can we find existing financing opportunities for behavioral health integration to maximize our current revenue?

- Identify incentive payments with current payers (commercial, Medi-Cal/Medicaid and Medicare), as depression screening is now included in many pay-for-performance programs
- Review list of billable behavioral health screenings, checking for possible updates since publication (See: Getting Paid for Screening and Assessment Services; Family Practice Management; 5 pages; [link](#))
- Assess billing options for Collaborative Care Model, accepted by Medicare, some Medicaid programs and some commercial payers (See [Activity 4.7](#) for resources)
- Work with health plan partners to secure pilot project financial support and in-kind implementation resources, such as project management and data analytics
- Apply for grant funding, even for care organizations outside the traditional safety net; state funding and local philanthropy funders seek to fund support for mental health (See: California’s Prop 56 funding)


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### We don’t have any current behavioral health staff — How do we start hiring?

- Identify and onboard a BHI clinical role (e.g., licensed clinical social worker) from existing staff or begin recruitment
-  Hiring and Onboarding Integrated Behavioral Health Providers in Primary Care (Rocky Mountain Health Plans; 26 pages; [link](#))


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### What are the key steps to BHI implementation?

- Review the Quick Start guide below with a possible pilot team to understand project scope
-  Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers (SAMHSA-HRSA; 10 pages; [link](#))

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### What will we need to tackle the Behavioral Health Integration Improvement Collaborative Curriculum?

- Review the below checklist with a possible pilot team
-  Implementing the BHI Improvement Collaborative Curriculum: Pre-Implementation Checklist [CQC; [link](#)]



## Phase 1

## Launch the journey Month 1

Quick links: [Table of Contents](#) | [Phase 1](#) | [Phase 2](#) | [Phase 3](#) | [Phase 4](#) | [Phase 5](#) | [Phase 6](#) | [Phase 7](#)

Learning Objectives	Virtual Improvement Collaborative & Self-Paced Learners (On-Demand)	Virtual Improvement Collaborative (Live Sessions & Peer Network)
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### 1.1 Identify project team and orient learners to the program (P)

<ul style="list-style-type: none"> <li>Assemble an appropriately staffed project team, including an executive sponsor, project lead, clinical leader, administrative champions, IT specialists, quality improvement and front-line staff</li> <li>Convene teams to review collaborative materials and to identify each team members' role, project capacity and goals</li> <li>Understand expectations and timing for collaborative activities</li> </ul>	<ul style="list-style-type: none"> <li>CQC Resource: Curriculum Overview (CQC; <a href="#">link</a>)</li> <li>CQC: Team Description Worksheet (1 page; <a href="#">link</a>)</li> <li>Science of Improvement: Forming the Team (Institute for Healthcare Improvement (IHI); 3 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Improvement Collaborative Materials               <ul style="list-style-type: none"> <li>Welcome orientation video</li> <li>Collaborative calendar with learning activity objectives and facilitator guide</li> </ul> </li> <li>Webinar</li> </ul>
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### 1.2 Assess the current state of your organization's integration efforts and identify priority areas for action and change (P) (S)

<ul style="list-style-type: none"> <li>As a team, evaluate the current state of your organization's integration via the Self-Assessment Tool</li> <li>As a team, document:           <ul style="list-style-type: none"> <li>Results of the self-assessment for internal stakeholders, including leadership</li> <li>Areas for action or further exploration</li> </ul> </li> <li>Perform an environmental scan to identify known current and future external factors that impact integration efforts</li> <li>Review the entire learning curriculum (See <a href="#">Activity 1.1</a>.) to identify areas and resources that will most support your organization's needs and goals</li> </ul>	<ul style="list-style-type: none"> <li>Self-Assessment Tool (Adapted from Maine Health Access Foundation, with permission; 21 pages; <a href="#">link</a>)</li> <li>A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers (The National Council; 10 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Complete and discuss Self-Assessment Tool results with coach to identify priority focus areas</li> <li>Review aggregated cohort assessment results to identify common focus areas and peers with more experience in key areas that can provide guidance</li> </ul>
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#### Legend

##### Topic

- P Project planning: project management and quality improvement activities
- E Patient family engagement: feedback from patient and families
- W Workforce: recruitment, hiring, retention and training
- I Health IT: electronic health records, registries, privacy and security
- C Clinical/care model: operational workflows and clinical decisions
- D Data/reporting: performance measurement and quality reporting
- \$ Financing: funding and financial planning
- S Sustainability: creating standard work; spreading pilot
- Q Health equity: addressing disparities in care and outcomes

##### Curriculum Areas

- I **Materials**  
Project activities for teams driving implementation
- F **Resources**  
Curated documents, including core concepts, examples and tools
- C **Events**  
Live virtual improvement collaborative sessions
- S **Improvement Advisor**  
Assigned coach support
- V **Video**  
Recorded informational session

##### Colored text

Activities for virtual improvement collaborative

To be created during collaborative

Learning Objectives	Virtual Improvement Collaborative & Self-Paced Learners (On-Demand)	Virtual Improvement Collaborative (Live Sessions & Peer Network)
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1.3 Establish a strong foundation for the project team and learning community P

<ul style="list-style-type: none"> <li>Conduct effective project kickoff meeting</li> <li>Generate project team trust, create accountability and identify shared vision</li> <li>Create an organizational overview to identify and share key characteristics and priorities of your organization</li> <li>Prior to the peer-sharing webinar, review each organization's overview and list at least two questions you would ask of another organization in the collaborative</li> <li>Discuss and refine learning community ground rules and participation requirements</li> </ul>	<ul style="list-style-type: none"> <li>Conducting a Kickoff Meeting (Agency for Healthcare Research and Quality (AHRQ); 2 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Build Team Trust with This Self-Reflection Activity (IDEO; 3 pages; <a href="#">link</a>)</li> <li>Creating a Shared Vision (University of Washington AIMS Center (AIMS Center); <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>CQC: Organizational Background template (<a href="#">link</a>), including:                             <ul style="list-style-type: none"> <li>Improvement of team members</li> <li>Populations served</li> <li>Payer mix</li> <li>Priority domains for change and learning, informed by the Self-Assessment Tool</li> <li>Current state of and needs for behavioral health integration</li> <li>External factors that may impact integration activities</li> <li>Ideal future state around BHI</li> </ul> </li> </ul> <p><b>Cohort participants</b></p> <ul style="list-style-type: none"> <li>Participant list with key organizational descriptors</li> <li>Overview of learning community (Organizations based on peer sharing (e.g., number of patients, business lines, FTE providers, etc.))</li> </ul> <p><b>Ground rules for learning community</b></p> <ul style="list-style-type: none"> <li>Ground rules for cohort feedback (<a href="#">link</a>)</li> <li>Webinar</li> </ul>
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## Phase 2

## Get started Months 2 – 4

Quick links: [Table of Contents](#) | [Phase 1](#) | [Phase 2](#) | [Phase 3](#) | [Phase 4](#) | [Phase 5](#) | [Phase 6](#) | [Phase 7](#)

Learning Objectives	Virtual Improvement Collaborative & Self-Paced Learners (On-Demand)	Virtual Improvement Collaborative (Live Sessions & Peer Network)
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### 2.1 Assess the behavioral health needs of patients in your community (especially as proxy if organization is not collecting clinical BH data) D

<ul style="list-style-type: none"> <li>Review existing and available data sets around BHI in the state, county or region</li> <li>Identify the most significant BH needs of patients in your community (e.g., rates of depression, serious mental illness, SUDs, related ED utilization)</li> </ul>	<ul style="list-style-type: none"> <li>California Health Interview Survey — AskCHIS resource with health statistics in your county, region and state (free, registration required; <a href="#">link</a>)</li> <li>California Health and Human Services Open Data Portal <a href="#">link</a></li> </ul>	<ul style="list-style-type: none"> <li>CQC: BH Community Prevalence slide template <a href="#">link</a></li> </ul>
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### 2.2 Review and understand current quality measures collected by your organization around behavioral health integration D

<ul style="list-style-type: none"> <li>Review existing behavioral health-related measures</li> <li>Understand how to prioritize key measures</li> <li>Identify which measures are tracked by your organization, current performance and related performance incentives (both currently used and should be used based on payer support)</li> <li>Identify which measures are not currently tracked by your organization might connect to your integration efforts</li> </ul>	<ul style="list-style-type: none"> <li>Behavioral Health Integration Measure Crosswalk (CQC; 3 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Atlas of Integrated Behavioral Health Care Quality Measures (AHRQ; <a href="#">link</a>)</li> <li>Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care (National Committee for Quality Assurance; 38 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Review quality measures currently collected with coach to identify priority metrics and identify data collection improvement areas</li> <li>Reflect on <b>aggregate measure crosswalks</b> to understand common measures that the improvement collaborative cohort is measuring collectively and individually</li> <li>Hear opportunities to expand measurement locally from peers</li> </ul> <p><b>Webinar</b></p>
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**2.3 Analyze impact of health equity on BHI outcomes to identify priority action** D Q

<ul style="list-style-type: none"> <li>Investigate opportunities for understanding and addressing current health disparities and promote health equity in the context of BHI vision (<a href="#">Activity 1.3</a>) and current performance (<a href="#">Activities 2.1</a> and <a href="#">2.2</a>)</li> <li>Identify one priority action area based on internal data, considering patient, organization and community needs</li> </ul>	<ul style="list-style-type: none"> <li>Using Data to Reduce Disparities and Improve Quality (Advancing Health Equity; 25 pages; <a href="#">link</a>)</li> <li>Behavioral Health Equity Resources (SAMHSA; 6 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Eliminating Inequities in Behavioral Health Webinar Series (California Institute for Behavioral Health Solutions; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>With coach, stratify key performance measures for health disparities, including analyzing data available, data clean-up progress and analyst resources required</li> <li>Identify one to two priority areas impacting BHI strategy and brainstorm possible solutions</li> <li>Reflect in breakout sessions on one priority area to address disparities in BH care</li> </ul> <p> Webinar</p>
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**2.4 Review patient experience directly from patients and staff perception of BH needs** D E






<ul style="list-style-type: none"> <li>Review existing patient feedback and surveys relevant to BH; if BH feedback is not collected, consider launching focus groups or conducting patient interviews</li> <li>Perform survey or interview select provider/staff on perspectives of BH needs: top priorities, concerns and barriers</li> <li>Compile patient and staff perspective regarding opportunities for BH at organization</li> </ul>	<ul style="list-style-type: none"> <li>Assessing Patient Experience (Integrated Behavioral Health Partners; 7 pages; <a href="#">link</a>)</li> <li>Satisfaction Measures for Providers (Integrated Behavioral Health Partners; 1 page; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Get Patient Feedback (AHRQ; 5 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>With coach, identify surprises and summarize trends from patient and staff feedback regarding patients' experience and needs around BHI</li> <li>Review <b>patient experience data sources from improvement collaborative cohort members</b></li> </ul>
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**2.5 Determine clinical areas for pilot project and improvement work** C

<ul style="list-style-type: none"> <li>Complete the Clinical Focus Areas Worksheet with:             <ul style="list-style-type: none"> <li>Prevalence of diagnoses/ conditions among your patient population</li> <li>Where you have data gaps around prevalence</li> <li>Inclusion for targeted improvement</li> <li>Identified disparities based on demographics (<a href="#">Activity 2.3</a>)</li> </ul> </li> <li>As a team, review each clinical area and determine whether you will include it as a target for improvement work</li> </ul>	<ul style="list-style-type: none"> <li> CQC: Clinical Focus Areas Worksheet (3 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Review a <b>visual representation</b> of the learning community's prevalence, priority areas, guidelines, tools and performance measures</li> <li>Discuss how to leverage commonalities across the cohort</li> <li> <b>Webinar</b></li> </ul>
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**2.6 Review evidence-based BH screening tools to identify current use of and measures to monitor screening rates** C D






<ul style="list-style-type: none"> <li>Match validated screening tools for your organization's clinical condition(s) of focus established in <a href="#">Activity 2.5</a> and collect current state of implementation at your organization</li> <li>Brainstorm how screening tool use will be incorporated in outcome and process measures and used for performance monitoring</li> </ul>	<ul style="list-style-type: none"> <li>Review screening tools:             <ul style="list-style-type: none"> <li> Depression – <a href="#">PHQ-9</a> (English and Spanish, AIMS Center), <a href="#">PHQ-2</a> (English)</li> <li> Anxiety – <a href="#">GAD-7</a> (English, AIMS Center)</li> <li> Substance use – Screening, Brief Intervention and Referral for Treatment process (<a href="#">SBIRT</a>) includes AUDIT, DAST, CRAFFT 2.0 (English,)</li> <li> Opioid use – <a href="#">ORT</a> (English, Drug Abuse)</li> <li> Maternal – <a href="#">Edinburgh Postnatal</a> (English, <a href="#">Perinatology.com</a>), 5Ps Prenatal Substance Abuse (English, <a href="#">ILPQC</a>)</li> <li> Trauma – <a href="#">ACEs</a> (Adult, multiple languages, ACEs Aware); <a href="#">PEARLS</a> (Children, multiple languages, ACEs Aware)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li> Analyze how screening data are captured with coach and solidify plans for performance monitoring</li> <li>Access a <b>list of validated screening tools being used by improvement collaborative cohort members</b></li> </ul>
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2.7 *Review available research demonstrating financial and operational ROI for BHI to create or update your own BHI business case, including how integration can impact clinical care costs and patient clinical quality outcomes* Ⓢ Ⓢ

<ul style="list-style-type: none"> <li>Summarize the clinical quality case and the business case for integration to help you make the case to internal stakeholders</li> <li>In addition to clinical quality outcomes (e.g., chronic disease and hospital utilization), identify one to two other organizational areas impacted by BHI current state (e.g., impact on staff and patient satisfaction, staff recruitment and retention; the attraction of patients to your practice, hospital costs)</li> <li>Reflect on lessons from leading California organizations regarding startup funding</li> </ul>	<ul style="list-style-type: none"> <li>How Do Individuals with Behavioral Health Conditions Contribute to Physical and Total Healthcare Spending?" (Milliman; 22 pages; <a href="#">link</a>)</li> <li>The Value of Integrated Behavioral Health (The National Council; 42 pages; <a href="#">link</a>)</li> <li>Get the Balance Right, Part 2: BHI Interviews (CQC; 13 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li><i>For commercial organizations:</i> Weaving Together Mental and Physical Health Care Outside the Safety Net (California Health Care Foundation (CHCF); 16 pages; <a href="#">link</a>)</li> <li>Business Case Template (IHI; registration required; <a href="#">link</a>)</li> <li>"Potential Economic Impact of Integrated Medical-Behavioral Healthcare: Updated Projections for 2017" (Milliman; 40 pages; <a href="#">link</a>)</li> </ul>	<p>Analyze and document current state around financial case for integration with coach, reviewing current reimbursement structures (including carve-outs for commercial organizations, Prospective Payment System for FQHCs, incentives such as P4P, savings and risks, grants)</p> <ul style="list-style-type: none"> <li>Describe incentive models and BHI business plan in place at your organization</li> <li>Discuss with similar-type organizations how those models could be leveraged or adapted for BHI</li> </ul> <p><span style="color: red;">📅</span> Webinar</p>
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Learning Objectives	Virtual Improvement Collaborative & Self-Paced Learners (On-Demand)	Virtual Improvement Collaborative (Live Sessions & Peer Network)
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**2.8 Review the continuum of behavioral health integration and identify your pilot project site progress along the continuum** (P) (C)

<ul style="list-style-type: none"> <li>Identify current state on the BHI continuum for prospective project pilot site(s)</li> <li>Use results to determine project pilot site</li> <li>Discuss and agree on elements of the various care models to be integrated into your organization's BH given current conditions and project resources</li> <li>Review opportunities for improved integration through telehealth/virtual care</li> </ul>	<ul style="list-style-type: none"> <li> SAMHSA's Six Levels of Collaboration/Integration (The National Council; 4 pages; <a href="#">link</a>)</li> <li> CQC: Collaboration/Integration Discussion Guide (2 pages; <a href="#">link</a>)</li> <li> Telebehavioral Health: An Effective Alternative to In-Person Care; Section: Evidence on Telebehavioral Health (Milbank Memorial Fund; 11 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li> Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework (United Hospital Fund + Montefiore; 39 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li> Discuss applicability and pros/cons of various integration models within your organization as team with coach, solidifying where to go on the continuum</li> <li>Identify learning community peers aligned with your current place and target location on the integration continuum</li> <li>Share insights on how telehealth/virtual care could support your BH collaboration/integration</li> </ul> <p> Webinar</p>
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**2.9 Dive deeper into your project site strengths, needs, available resources and potential barriers** (P)

<ul style="list-style-type: none"> <li>Review and complete the Patient-Centered Integrated Behavioral Health Care Principles and Tasks Checklist for possible project pilot site(s)</li> <li>Contemplate common barriers to integration (See Commonwealth Fund Exhibit 2, page 3.)</li> <li>Rank internal barriers from largest to smallest and submit</li> <li>Reflect on and document ideas for next steps, areas of deeper exploration and questions for experts or peers</li> </ul>	<ul style="list-style-type: none"> <li> Patient-Centered Integrated Behavioral Health Care Principles and Tasks Checklist (AIMS Center; 2 pages; <a href="#">link</a>)</li> <li> How Practices Can Advance the Implementation of Integrated Care in the COVID-19 Era (The Commonwealth Fund; 12 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li> Lexicon for Behavioral Health and Primary Care Integration (AHRQ; 57 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li> Share checklist reflections and discuss barriers in coaching session</li> <li>Aggregated rankings of learning cohort</li> <li>Share insights on how telehealth/virtual care could support your BH collaboration/integration</li> </ul> <p> Webinar</p>
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2.10 Define your organization's project goals through an aim statement and confirm pilot project site (P) (Q)

<ul style="list-style-type: none"> <li>Compose your organizational aim statement</li> <li>Select performance measures and goals to include in the aim statement, ensuring alignment with measures currently being reported</li> <li>Identify pilot project site</li> <li>Obtain baseline performance data on measures</li> <li>Include equity component (e.g., balancing measure to make sure care access does not decline for key populations)</li> <li>Customize a driver diagram that includes your aim statement, related drivers and relevant change concepts</li> </ul>	<ul style="list-style-type: none"> <li>Model for Improvement Overview (Center for Care Innovations' Academy website; <a href="#">registration required</a>; 3:52 <a href="#">video</a>; <a href="#">slide deck</a>)</li> <li>Developing an Aim Statement (Center for Care Innovations' Academy website; <a href="#">registration required</a>; 8:32 <a href="#">video</a>; <a href="#">slide deck</a>)</li> <li>CQC: Aim Statement Template (2 pages; <a href="#">link</a>)</li> <li>CQC: Program Driver Diagram Template (<a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Receive suggestions and improvements from coach on aim statement</li> <li>Present your team's aim statement</li> <li>Provide peer feedback on another team's organizational aim statements and driver diagrams</li> <li>Share with peers how organizations selected their pilot site, including criteria and how they are kicking off the project</li> </ul> <p> Webinar</p>
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2.11 Understand opportunities for meeting patients' social needs in context of BHI (C) (Q)






<ul style="list-style-type: none"> <li>Reflect on how social risk factors (e.g., housing instability, food insecurity) will influence your organization's ability to engage patients with BH needs and improve outcomes for your population</li> <li>Identify opportunities for how current teams (e.g., care management, care collaboration) can support patients' social needs in context of BHI project</li> <li>Note opportunities to strengthen external referral pathways for social needs (See <a href="#">Activity 4.4</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Identifying and Addressing Social Needs in Primary Care Settings (AHRQ; 6 pages; <a href="#">link</a>)</li> <li>Addressing Social Determinants of Health in Primary Care (American Association for Family Physicians; 12 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Social Determinants of Health Toolkit (Iowa State Innovation Model; 16 pages; <a href="#">link</a>)</li> <li>CIN Case Study: Coordinated Behavioral Care IPA (CHCF; 12 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Optional webinar to discuss social risk needs and link to improving health equity, per cohort feedback</li> </ul> <p> Webinar</p>
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## Phase 3

## Prepare for the pilot Months 5 – 9



Quick links: [Table of Contents](#) | [Phase 1](#) | [Phase 2](#) | [Phase 3](#) | [Phase 4](#) | [Phase 5](#) | [Phase 6](#) | [Phase 7](#)

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### 3.1 Review planning scope and timeline, incorporating pilot site team members P

<ul style="list-style-type: none"> <li>Review all activities and tasks within this phase and determine timing (e.g., identify what tasks happen in parallel versus sequentially)</li> <li>Identify pilot site leads and roles and expectations for project</li> </ul>	<p> See <a href="#">Activity 1.1</a></p>	<ul style="list-style-type: none"> <li> Share updated planning documents with coach and assess for feasibility</li> <li> Optional opportunity coach to attend project meeting with pilot site team members</li> </ul>
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### 3.2 Operationalize your project plan P






<ul style="list-style-type: none"> <li>Set specific, measurable and achievable 3- to 12-month goals in priority change domains/drivers, using current measure performance and aim statement targets (See <a href="#">Activity 2.10.</a>)</li> <li>Prepare a high-level work plan, including roles and responsibilities</li> <li>Create communication plan for project</li> </ul>	<p> CQC: Work + Communication Plan Template (2 pages; <a href="#">link</a>)</p>	<ul style="list-style-type: none"> <li>Each team shares their 3-month goals, highlighting their stretch goals</li> <li>Teams discuss factors that may help in achieving stretch goals</li> </ul> <p> <b>Webinar</b></p>
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**3.3 Agree on expectations for staff and care teams participating in BHI pilot** (W) (P)

<ul style="list-style-type: none"> <li>Review essential elements and, as a team, agree which will be key to success of pilot implementation; include clinician and staff champions, current care team capabilities, community assets and clinic/site culture</li> </ul>	<ul style="list-style-type: none"> <li>Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams (The National Council; 24 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>With coach, share expectations for pilot project care teams and make a plan for how team will create accountability and address gaps</li> </ul>
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**3.4 Outline behavioral health competencies and experience required at pilot site** (W)






<ul style="list-style-type: none"> <li>Collate BHI competencies, training and experience that are required and desired for your BHI pilot project</li> <li>Share with site pilot team to gather opportunities and resources</li> </ul>	<ul style="list-style-type: none"> <li>Provider- and Practice-Level Competencies for Integrating Behavioral Health in Primary Care (AHRQ; 26 pages; <a href="#">link</a>)</li> <li><b>Sample job descriptions</b></li> <li><a href="#">Psychiatric Consultant</a> (AIMS Center)</li> <li><a href="#">Behavioral Health Center Manager</a> (AIMS Center)</li> <li><a href="#">Behavioral Health Integration Specialist</a> (Clinica Romero)</li> <li><a href="#">Behavioral Health Counselor</a> (Integrated Behavioral Health Partners)</li> </ul>	<ul style="list-style-type: none"> <li>As a large group, discuss the areas of expertise that are most useful in developing a strong care team for BHI and identify ways organizations can support these competencies</li> <li>Review examples from peer organizations</li> <li>Webinar</li> </ul>
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3.5 Understand key elements and resources for the clinical condition(s) of focus C

<ul style="list-style-type: none"> <li>Review and share resources and materials for the diagnoses and condition(s) your quality project addresses:                             <ul style="list-style-type: none"> <li>Depression and anxiety</li> <li>Maternal mental health</li> <li>Adverse childhood experiences (ACEs)</li> <li>Substance use disorders (SUDs)</li> <li>Medications for addiction treatment (MAT)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>General clinical resources (SAMHSA <a href="#">Treatment Improvement Protocols TIPS</a>)</li> </ul> <p><b>Depression and Anxiety</b></p> <ul style="list-style-type: none"> <li>Evidence-based clinical guidelines (<a href="#">American Psychiatric Association</a>)</li> <li>Screening tools (<a href="#">Western Journal of Medicine, November 2001</a>)</li> <li>Screening workflows (<a href="#">University of Massachusetts</a>)</li> <li>Treatment modalities (<a href="#">Health Services Insights, May 2020</a>)</li> <li>Clinical resources (PBGH <a href="#">PHQ9 Measurement Toolkit</a>)</li> </ul> <p><b>Maternal mental health</b></p> <ul style="list-style-type: none"> <li>Evidence-based clinical guidelines</li> <li>Screening tools (<a href="#">American College of Obstetricians and Gynecologists</a>)</li> <li>Screening workflows (<a href="#">Community Partners</a>)</li> <li>Treatment modalities (<a href="#">Can J Psychiatry, August 2007</a>)</li> <li>Clinical resources (<a href="#">2020 Mom</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Optional webinar(s) with guest speakers supporting select clinical areas (per improvement collaborative feedback)</li> </ul> <p> Webinar</p>
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	<p><b>Substance use disorders (SUDs)</b></p> <ul style="list-style-type: none"> <li>Evidence based clinical guidelines (<a href="#">Psychiatric Clinic North America, December 2003</a>)</li> <li>Screening tools (<a href="#">National Institute on Drug Abuse</a>)</li> <li>Screening workflows (<a href="#">Reproductive Health National Training Center</a>)</li> <li>Treatment modalities (<a href="#">American Addiction Centers</a>)</li> <li>Clinical resources (<a href="#">ASAM</a>, <a href="#">APA</a>, <a href="#">CQC Toolkit</a>)</li> </ul> <p><b>Medication for addiction treatment (MAT)</b></p> <ul style="list-style-type: none"> <li>Evidence-based clinical guidelines (<a href="#">USDHHS</a>)</li> <li>Screening workflows (<a href="#">Camden Coalition</a>)</li> <li>Clinical resources (<a href="#">AHRQ</a>, <a href="#">CQC Toolkit</a>)</li> <li>Opioid Crisis Resources (National Overdose Prevention Network)</li> <li><a href="#">Reducing Stigma Education Tools (ReSET)</a> (Dell Medical School and Providers Clinical Support System)</li> <li><a href="#">Utilization Management for MAT Toolkit</a> (Providers Clinical Support System)</li> </ul> <p><b>Adverse childhood experiences (ACEs)</b></p> <p>Note: While ACEs are not a condition or diagnosis, they signal potential issues related to adverse events — and signal additional supports patients may need in their care.</p> <ul style="list-style-type: none"> <li>Evidence-based clinical guidelines</li> <li>Screening tools (<a href="#">ACEs Aware</a>)</li> <li>Screening workflows (<a href="#">ACEs Aware</a>)</li> <li>Treatment modalities (<a href="#">ACEs Aware</a>)</li> <li>Clinical resources (CQC <a href="#">ACEs Toolkit</a>)</li> </ul>	

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3.6 *Define care model elements, including screening, triage, levels of care, patient engagement, treatment, care coordination and care management* C

<ul style="list-style-type: none"> <li>For integration model selected in <a href="#">Activity 2.8</a> and condition(s) selected in <a href="#">Activity 3.5</a>, describe care model components in language used by the care team, reflecting patient's journey through the system</li> <li>Document BHI care model process flow from patient arrival at office, including referrals</li> <li>Confirm each team member's role in the process</li> <li>Identify gaps or unknowns and document a process to address those gaps, especially for partner organizations</li> </ul>	<p> CQC: Care Model Planning Worksheet (1 page; <a href="#">link</a>)</p> <p><b>Dive Deeper:</b></p> <p> Measurement-Based Care in the Treatment of Mental Health and Substance Use Disorders (Meadows Mental Health Policy Institute; 66 pages; <a href="#">link</a>)</p>	<p> Review Care Model Planning Worksheet as team with coach</p> <ul style="list-style-type: none"> <li>Review <b>care model examples</b> shared from peer organizations</li> <li>Each organization describes care model approach and includes time for feedback through virtual gallery walk</li> <li>Consider which organizations have functionalities that others can learn from and which functionalities commonly need strengthening (and focus in the learning community)</li> </ul> <p> Webinar</p>
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3.7 *Evaluate existing HIT functionality to support BHI for gaps and opportunities* I






<ul style="list-style-type: none"> <li>Complete Health IT Functionality Checklist to indicate the status of BHI-related functionalities and IT requirements from new care models</li> <li>Identify next steps for health IT tools necessary for BHI, including workflow modifications, data collection, analyst/SME support and reporting</li> </ul>	<p> CQC: Health IT Functionality Checklist (2 pages; <a href="#">link</a>)</p> <p><b>Dive Deeper:</b></p> <p> Measurement-Based Care in the Treatment of Mental Health and Substance Use Disorders (Meadows Mental Health Policy Institute; 66 pages; <a href="#">link</a>)</p>	<p> <b>HIT functionality checklist with real examples</b> from technologies (e.g., EHRs, registries) used by the learning community</p> <p>In breakouts, teams describe their current status and 3- and 6-month priorities and get feedback (if possible, teams with the same EHR vendor are grouped together)</p> <p> Webinar</p>
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**3.8 Analyze regulations for privacy and data sharing and begin developing a compliance strategy** ①

<ul style="list-style-type: none"> <li>Gather and review existing privacy and data-sharing policies and procedures</li> <li>Determine how to adapt for regulatory compliance and your organization's interpretations</li> </ul>	<ul style="list-style-type: none"> <li>Privacy and Security: Know the Rules for Communication of Behavioral Health Information (American Medical Association; 54 slides; <a href="#">link</a>)</li> <li>Behavioral Health Data Sharing Toolkit, including <a href="#">CA context</a> and <a href="#">templates</a> (privacy/data-sharing policies and consent forms) (Integrated Behavioral Health Partners; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>With HIT and privacy expert at coaching session, discuss key challenges</li> <li>Facilitated by a health IT and privacy expert, in a large group, discuss the biggest challenges with implementing consent rules and document ideas to address those challenges</li> <li>Improvement collaborative's library of policies, procedures and consent forms</li> </ul> <p> Webinar</p>
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**3.9 Design a systematic QI measurement strategy with regular performance feedback and monitoring** ④ ⑤

<ul style="list-style-type: none"> <li>Review BHI measures currently collected (<a href="#">Activity 2.2</a>)</li> <li>Prepare a measurement plan supporting your aim statement (<a href="#">Activity 2.10</a>) using the template</li> <li>Identify how data will be reviewed by team and shared with organization</li> </ul>	<ul style="list-style-type: none"> <li>CQC: Measurement Plan Template (2 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Peruse <b>measurement plan examples developed by improvement collaborative</b></li> <li>In partners, exchange:             <ul style="list-style-type: none"> <li>one theme you observed</li> <li>one thing that intrigued you</li> <li>one thing you will incorporate into your organization's measurement plan</li> </ul> </li> </ul> <p> Webinar</p>
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**3.10 Develop patient-facing materials on new BHI resources** ⑥ ⑦






<ul style="list-style-type: none"> <li>Create or update patient-facing marketing materials (e.g., patient flyer or rack card, provider information card, bio card for BH specialist, information for patient portal)</li> <li>Incorporate feedback from patients via advisory group or other venue</li> <li>Assess patient language data for site to ensure material(s) are translated, if needed</li> </ul>	<ul style="list-style-type: none"> <li>Patient Education Materials Assessment Tool (AHRQ; 4 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li><b>Review library of patient education materials</b> from improvement collaborative participants</li> </ul>
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**3.11 Define your organization’s business case by identifying financing sources and revenue streams** 💰 🗨️

<ul style="list-style-type: none"> <li>Complete the AIMS Center Financial Modeling Workbook, to plan budget and program capacity for implementing the Collaborative Care Model internal to a practice, using CoCM CPT codes</li> <li>Determine if your organization is, or could be, paid for integrated care through other means in addition to fee-for-service reimbursement using CoCM CPT codes</li> <li>Consider the team staffing model for care in the CoCM, that would meet patients’ needs and be financially sustainable in the short term</li> <li>Ensure executive sponsor is involved in business case analysis completion and next steps</li> </ul>	<ul style="list-style-type: none"> <li>Financial Modeling Workbook, (AIMS Center at University of Washington; Excel; <a href="#">link</a>)</li> <li>“Get the Balance Right, Part 1: Business Case Considerations” (CQC; 9 pages; <a href="#">link</a>)</li> <li>“Get the Balance Right, Part 2” report from interviews with California experts, which includes advice on using the AIMS Center Workbook (CQC; 13 pages; <a href="#">link</a>)</li> <li>Financial Planning: Quantifying the Impact of Behavioral Health Integration (American Medical Association; 7 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Analyze results of business case analysis, documentation and internal next steps with coach (including executive sponsor)</li> <li>Grouped by like organizations (e.g., FQHC and commercial), discuss the most significant challenges your organization faces with the business case, including startup funding and sustainability</li> </ul> <p> Webinar</p>
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**3.12 List out necessary elements for training plan** 🗨️ 🗨️ 🗨️ 🗨️

<ul style="list-style-type: none"> <li>Identify relevant training needs based on BHI project needs from previous activities, including BHI knowledge and attitudes, clinical and EHR workflows, use of technology</li> </ul>	<ul style="list-style-type: none"> <li>Training Plan Review (CQC; 1 page; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Analyze training needs with coach to identify who and how to update or create the organizational resources</li> </ul>
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**3.13 Identify how to execute and evaluate project tests of change (PDSA)** 🗨️






<ul style="list-style-type: none"> <li>Review Plan-Do-Study-Act (PDSA) principles</li> <li>Identify one PDSA to prioritize as a team based on planning activities and driver diagram (<a href="#">Activity 2.10</a>)</li> </ul>	<ul style="list-style-type: none"> <li>What is a PDSA and Why Use It? (Center for Care Innovations’ Academy website; <a href="#">registration required</a>; 8:45 video; <a href="#">link</a>)</li> <li>CQC: PDSA Worksheet (3 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Identify possible two to three PDSAs with coach based on Phase 3 planning activities and commit to launching at least one</li> </ul>
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- 🗨️ Health equity: addressing disparities in care and outcomes

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- To be created during collaborative



## Phase 4

## Implement care model Months 10 – 15

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### 4.1 Continue project planning activities P

<ul style="list-style-type: none"> <li>Review all activities and tasks within this phase and determine timing (e.g., identify what tasks happen in parallel versus sequentially)</li> </ul>	<ul style="list-style-type: none"> <li>Review Curriculum (<a href="#">Activity 1.1</a>) and update Work Plan, as needed (<a href="#">Activity 3.2</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Share updated project plan with coach and align on timing and assignments</li> </ul>
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### 4.2 Roll out behavioral health integration pilot project at practice/site with local team P

<ul style="list-style-type: none"> <li>Work with local leads to understand and document pilot practice/site culture and norms</li> <li>Identify one practice/site strength to build on during pilot implementation</li> <li>Onboard rest of practice regarding project goals and milestones</li> </ul>	<ul style="list-style-type: none"> <li>Commons Barriers and Strategies to Support Health Care Teams for Integrated Behavioral Health (Safety Net Medical Home; 4 pages; <a href="#">link</a>)</li> <li>Update Team Description (<a href="#">Activity 1.1</a>) and Communication Plan, as needed (<a href="#">Activity 3.2</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Making the Case for Change and Overcoming Resistance (Safety Net Medical Home; 4 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Create list of ways to build on-site strengths during implementation with coach</li> </ul>
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**4.3 Understand current capacity and begin to build practice/ site-level implementation team** (W)

<ul style="list-style-type: none"> <li>Evaluate staff expertise by having key roles complete Self-Assessment</li> <li>Analyze results as team</li> <li>Invite relevant staff to have role on multidisciplinary implementation team</li> </ul>	<ul style="list-style-type: none"> <li>Team Member Self-Assessment (AIMS Center; 1 page; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Review documentation of current capacity with coach and identify how to match with existing resources or create new solutions</li> </ul>
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**4.4 Review treatment and internal and external care pathways, including:** (C)

Screening: PCP treatment; BH services: counseling, health education, support groups, patient materials; Referrals to specialty mental health; Referrals to community-based organizations; Suicidal ideation






<ul style="list-style-type: none"> <li>Using clinical condition(s) selected in <a href="#">Activity 2.5</a> and target populations selected in <a href="#">Activity 3.6</a>, for each clinical condition of focus, establish or refine:             <ul style="list-style-type: none"> <li>Levels of care (e.g., what triggers a step-up to a higher level of care or a step-down to a lower level of care)</li> <li>Referral criteria for higher levels of care</li> <li>Screening criteria and determine roles and responsibilities</li> </ul> </li> <li>Create care pathways for relevant clinical conditions, inclusive of care transition points and warm handoffs</li> <li>For pathways that involve external organizations, invite their input (e.g., communication that goes along with referral)</li> <li>Select metrics and targets to monitor effectiveness of care pathways</li> </ul>	<ul style="list-style-type: none"> <li>Toolkit for Designing and Implementing Care Pathways (The National Council; 22 pages; <a href="#">link</a>)</li> <li>A Path to Value: Strategies for Developing Care Pathways (Care Transitions Network; 45 slides; <a href="#">link</a>)</li> <li>Suicidal Interventions in Primary Care: A Selective Review of the Evidence (Families Systems &amp; Health, May 2018; 9 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Developing Protocols for Suicide Prevention in Primary Care (AIMS Center; 5 pages; <a href="#">link</a>)</li> <li>The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions (CHCF; 13 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Discuss internal and external care pathways with coach to identify improvements</li> <li>Panel discussion featuring two to three teams that share their experience in optimizing relationships and communications with frequent referral sources</li> <li>In large group, identify and capture <b>list of successful practices</b> that address suicidal ideation</li> </ul> <p> Webinar</p>
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#### 4.5 Map clinical workflows for various staff involved C

<ul style="list-style-type: none"> <li>Define the set of workflows to be created</li> <li>For each workflow map, convene those involved in every step of the workflow, get input and revise accordingly</li> <li>Finalize workflow maps</li> </ul>	<ul style="list-style-type: none"> <li> Overview of Workflow Mapping (University of California, San Francisco; 3 pages; <a href="#">link</a>)</li> <li> CQC: Workflow Mapping Worksheet (2 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Present <b>submitted workflows</b> to visualize variation among organizations and highlight successful practices</li> <li><b>Share peer workflows</b> with cohort on program website</li> <li>Optional opportunity: “office hours” to bring workflow questions to peers</li> </ul> <p> <b>Webinar</b></p>
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#### 4.6 Adapt health IT, including EHR, decision support, registries 1






<ul style="list-style-type: none"> <li>Continue assessing gaps between current state and IT needs associated with full integration</li> <li>Develop implementation plan for outstanding requirements</li> <li>Ensure effectiveness of patient registry and caseload tracker for conditions of focus</li> </ul>	<ul style="list-style-type: none"> <li> Implementation Guide: Behavioral Health Patient Tracking System (AIMS Center; 2 pages; <a href="#">link</a>)</li> <li> Registry Strategies in Medical Settings (AIMS Center; 4 pages; <a href="#">link</a>)</li> <li> Integrating Behavioral Health &amp; Primary Care: Health IT (AHRQ; 4 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li> AIMS Caseload Tracker for implementation (low-cost; <a href="#">link</a>)</li> <li> Case Studies of Health Information Technology for Behavioral Health Integration (AHRQ; 4 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li> Optional coaching session with HIT expert focused on system optimization</li> </ul>
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4.7 Evaluate billing and coding activities to maximize revenue and enable performance reporting (S) (\$) (W) (P) (C) (I)

<ul style="list-style-type: none"> <li>Convene with billing staff to review relevant CPT codes, documentation requirements and reimbursement rates, including checking with commercial payers to validate which codes generate payment</li> <li>Establish monthly meetings with billing team to review denials and appeals</li> <li>Assess documentation gaps that may impact coding and billing</li> </ul>	<p><b>Implementation of following tools will differ based on organization type (FQHC or commercial)</b></p> <ul style="list-style-type: none"> <li>Behavioral Health Integration Services, a Guide for Using CoCM CPT Codes and HCPCS Code G2214 (Centers for Medicare and Medicaid Services; <a href="#">link</a>)</li> <li>Cracking the Codes: State Medical Approaches to Reimbursing Psychiatric Collaborative Care (Health Management Associates; 27 pages; <a href="#">link</a>)</li> <li>Basic Coding for Integrated Behavioral Health Care (AIMS Center; 2 pages; <a href="#">link</a>)</li> <li>“Get the Balance Right, Part 2” Report from interviews with California experts, which includes advice on using the AIMS Center Workbook (CQC; 13 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <p><b>For California Providers</b></p> <ul style="list-style-type: none"> <li>Psychiatric Collaborative Care Management Benefit in Medi-Cal (CHCF; 2 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Coding expert facilitates discussion with teams about common documentation errors and missed revenue</li> </ul> <p> Webinar</p>
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4.8 Roll out new workflows with job aids and other resources (W) (P) (C) (I)






<ul style="list-style-type: none"> <li>Begin updating and track changes needed to internal training manual with information about program, HIT and workflow changes, clinical screening tools and resources</li> </ul>	<ul style="list-style-type: none"> <li>Update Training Plan Review (<a href="#">Activity 3:12</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Peruse other cohort members’ <b>organizational training plans and manuals</b></li> <li>Review changes made and needed for staff training resources with coach, including monitoring plan</li> </ul> <p> Webinar</p>
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4.9 *Design and conduct trainings supportive of behavioral health integration, including trauma-informed care and implicit bias, for implementation team members* W Q

<ul style="list-style-type: none"> <li>Develop trainings on trauma-informed care, stigma, patient engagement and other key BHI concepts as issues, as needed</li> <li>Using results of the staff expertise evaluation (<a href="#">Activity 4.3</a>), augment trauma and stigma trainings that address gaps in knowledge and attitudes about each person's role</li> <li>Develop survey tool to evaluate effectiveness of training</li> <li>Schedule and conduct at least three trainings</li> <li>Conduct survey to determine effectiveness of trainings</li> </ul>	<ul style="list-style-type: none"> <li><span style="color: green;">▶</span> Physicians Leading the Charge: Dismantling Stigma Around Behavioral Health Conditions and Treatment (American Medical Association; 1:01 video; <a href="#">link</a>)</li> <li><span style="color: green;">📄</span> Trauma-Informed Care Primary Care: Fostering Resilience and Recovery Initiative (The National Council; 86 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li><span style="color: green;">📁</span> Implicit Bias Resources (American Association of Family Physicians; <a href="#">link</a>)</li> <li><span style="color: green;">📁</span> Trauma-Informed Telehealth in the COVID-19 Era and Beyond (The Playbook; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li><span style="color: green;">💬</span> Prioritize training plan with coach</li> <li>Panel discussion by teams about optimizing trainings and meeting staff needs: factors that make trainings more effective, how to tailor trainings by role, measure impact and how to support problem solving, resiliency and self-care</li> </ul> <p><span style="color: green;">📅</span> Webinar</p>
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4.10 *Assess the physical space of the pilot practice and care team so that it is conducive to BHI and trauma-informed care* P Q

<ul style="list-style-type: none"> <li>Conduct walk-through of the pilot site's physical space to evaluate for appropriateness and accessibility for all patients and families</li> <li>Identify elements that can be adapted (e.g., signage, privacy)</li> </ul>	<ul style="list-style-type: none"> <li><span style="color: green;">📄</span> Trauma-Informed Environmental Scan (Trauma Transformed; 2 pages; <a href="#">link</a>)</li> <li><span style="color: green;">📁</span> Trauma-Informed Design for Health Care (Soderstorm, 10 pages; <a href="#">link</a>)</li> <li><span style="color: green;">▶</span> Setting the Stage for ACEs Screening and Trauma-Informed Care in Small Practices: The Physical Environment and the Front Desk (Primary Care Development Corporation; 1:21 video; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>External site with BHI experience shares filmed on-site walk-through, highlighting options to adapt environment on webinar with Q&amp;A</li> </ul> <p><span style="color: green;">📅</span> Webinar</p>
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4.11 *Engage patients and families in design and implementation* E

<ul style="list-style-type: none"> <li>Develop a strategy to engage at least one patient/family member in care model implementation</li> <li>Design role for patient or family advisor and specify time commitment</li> <li>Revisit current patient/family satisfaction surveys and ensure BHI is included</li> </ul>	<ul style="list-style-type: none"> <li>Working with Patients and Families as Advisors: Implementation Handbook (AHRQ; 62 pages; <a href="#">link</a>)</li> <li>Patient and Family Engagement Framework (BC Mental Health and SU Services; 23 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>College for Behavioral Health Leadership — Patient Engagement Resources (<a href="#">link</a>)</li> <li>Patient Engagement Toolkit (University of Washington; 40 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Panel discussion: Organizations with PFE strategies in place describe how it has worked for their organization, highlighting adaptations needed for BHI</li> </ul> <p> <b>Webinar</b></p>
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4.12 *Monitor equity improvement project, surfacing challenges and how to align with pilot progress* Q P

<ul style="list-style-type: none"> <li>Revisit disparity improvement identified (<a href="#">Activity 2.3</a>) and targets from aim statement (<a href="#">Activity 2.10</a>)</li> <li>Understand and capture one to two opportunities for increased cultural competence and additional training to improve health equity</li> </ul>	<ul style="list-style-type: none"> <li>Identity and Cultural Dimensions (National Alliance on Mental Illness; 2 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li>Bringing Light and Heat: A Health Equity Guide for Healthcare Transformation and Accountability (Health Begins; 37 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li> Review progress on disparity plan and dive further into ways site could increase cultural competence (e.g., translation services, hiring)</li> <li>Analyze successful practices and approaches in <a href="#">peer project tracking list</a></li> </ul>
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4.13 *Optimize reporting and measurement systems* D






<ul style="list-style-type: none"> <li>Review available measure definitions for selected measures, identify data sources and map data collection process for each</li> <li>Revisit feasibility of various measures and finalize measure set, definitions and data collection processes</li> </ul>	<ul style="list-style-type: none"> <li>See <a href="#">Activity 2.2</a></li> <li>How Axis Community Health Improved Patient Care by Tracking Behavioral Health Data and Quality Outcomes (Center for Care Innovations; 17 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li> Analyze improvement efforts and assess for progress and roadblocks with coach</li> </ul>
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4.14 *Design data reports to measure performance against applicable benchmarks* D

<ul style="list-style-type: none"> <li>Identify the data visualizations that are most useful to your team and create these visualizations</li> <li>Improve BHI dashboard with relevant measures for different users</li> </ul>	<ul style="list-style-type: none"> <li> Building a Data-Driven Culture: Data Visualization and All About Dashboards (Center for Care Innovations; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>In breakouts, teams share dashboards and get feedback on how to improve them</li> </ul> <p> Webinar</p>
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4.15 *Improve rates of BH screening and associated follow-up care* C D

<ul style="list-style-type: none"> <li>Create care gap reports or review existing reports inclusive of BH screenings and follow-up</li> <li>Develop QI strategy to address gaps in care, including providers that are positive and negative outliers</li> </ul>	<ul style="list-style-type: none"> <li> Creating a Workflow for Depression Screens and Follow-Up Treatment (CoAccess; 13 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li> Improve Depression Screening webinar (CQC; 1:02; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Discuss effective methods in closing care gaps, including what can be done in virtual visits versus in-person visits</li> </ul> <p> Webinar</p>
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4.16 *Identify community organizations that can help meet patients' social determinants of health* P






<ul style="list-style-type: none"> <li>Map community assets related to social risk factors</li> </ul>	<ul style="list-style-type: none"> <li> Using Asset Maps to Match Community Supports for Patients with Complex Care Needs: An Interview with the Camden Coalition's Lauran Hardin. (M. Asiedu-Frimpong, November 5, 2019. Better Care Playbook blog post, Center for Health Care Strategies; 7 pages; <a href="#">link</a>)</li> <li> Healthy City map-making tool, using data curated by the Advancement Project (<a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Optional opportunity to discuss and share asset maps</li> </ul> <p> Webinar</p>
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## Phase 5

## Evaluate and spread

Months 16 – 17

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### 5.1 Continue project planning activities (P)

<ul style="list-style-type: none"> <li>Review all activities and tasks within this phase and determine timing (e.g., identify what tasks happen in parallel versus sequentially)</li> <li>Check in to identify what's working as a team and identify possible improvements</li> </ul>	<ul style="list-style-type: none"> <li>Revisit <a href="#">Activity 1.1</a></li> <li>Common Barriers and Strategies to Support Effective Health Care Teams for Integrated Behavioral Health (Safety Net Medical Home; 3 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Conduct project check-in meeting with coach and capture any ways to increase team accountability and collaboration</li> </ul>
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### 5.2 Evaluate pilot project success and capture improvements for future implementation (P) (S)

<ul style="list-style-type: none"> <li>Assess current measures and performance around project aim statement, provider and staff feedback, cost and patient satisfaction</li> <li>Capture challenges and opportunities with the previous rollout and integrate into plan</li> </ul>	<ul style="list-style-type: none"> <li>Review most current data, including:             <ul style="list-style-type: none"> <li>Aim statement measure targets (<a href="#">Activity 2.10</a>)</li> <li>Surveys of providers and staff (<a href="#">Activity 4.3</a>)</li> <li>Patient satisfaction and experience surveys (<a href="#">Activity 2.4</a>)</li> <li>Budget planning (<a href="#">Activity 3.11</a>)</li> </ul> </li> <li>Project Debrief (CQC; 1 page; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Review completed Project Debrief Worksheet with coach and agree how improvements can be made in next phase of project</li> <li>In breakouts, teams discuss major challenges they face during rollout and get advice from cohort</li> <li><a href="#">Webinar</a></li> </ul>
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##### Colored text

Activities for virtual improvement collaborative


To be created during collaborative

Learning Objectives	Virtual Improvement Collaborative & Self-Paced Learners (On-Demand)	Virtual Improvement Collaborative (Live Sessions & Peer Network)
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**5.3 Refresh criteria and determine plan for next phase of implementation** P S W \$

<ul style="list-style-type: none"> <li>Select next site for implementation, starting at the care team level and expanding practice-wide</li> <li>Identify clinical and administrative champions at new site</li> <li>Reassess budget, including staffing, health IT and other cost categories that would be impacted by broader scale implementation</li> </ul>	<ul style="list-style-type: none"> <li>Spread Plan <a href="#">Guide</a>; <a href="#">Worksheet</a>; <a href="#">Spread and Sustain Worksheet</a> (Signal Key)</li> <li>Revisit Work Plan (<a href="#">Activity 3.2</a>)</li> </ul>	<p>Teams share their priorities for new care team or site selection and discuss the process for evaluating new sites with coach</p>
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**5.4 Plan how to integrate behavioral health services into existing population management infrastructure to support organization-wide rollout** P C






<ul style="list-style-type: none"> <li>Define approach to risk stratification based on outcome and corresponding services and follow-up for each risk level</li> <li>Assess implications of new criteria on population health management, including impacts on panel management, planned care, and supply and demand</li> <li>Review current processes for risk stratification and develop plan to revise based on new criteria</li> <li>Adjust protocols for panel management and planned care, as needed</li> </ul>	<ul style="list-style-type: none"> <li>Risk Stratification for Behavioral Health: Best Practices and Lessons Learned (Care Transitions Network; 18 pages; <a href="#">link</a>)</li> <li>Population Health Management: Risk Stratification (National Association of Community Health Centers; 5 pages; <a href="#">link</a>)</li> <li>Expanded Care Teams (Clinical Transformation Collaborative of Rhode Island; 24 pages; <a href="#">link</a>)</li> </ul>	<p>Review risk stratification plan with coach to assess for feasibility and capture implementation</p> <ul style="list-style-type: none"> <li>Peers share their risk stratification plans to gather suggestions and improvement and highlight how BHI activities will be woven into existing planned care</li> </ul> <p> Webinar</p>
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5.5 Plan for ongoing training and education aligning with organization-wide efforts and project spread (W)






<ul style="list-style-type: none"> <li>• Network-wide, survey providers and staff on training and education needs for competencies (<a href="#">Activity 3.4</a>)</li> <li>• Sequence rollout of workforce training to additional care teams</li> <li>• Review policies and procedures and other organizational materials to determine all places to integrate workforce training materials</li> <li>• Identify how competency expectations can be incorporated into hiring and performance assessment</li> <li>• Review sample BH training plans from other organizations to determine what elements are applicable to your organization</li> <li>• With input from various disciplines and administrative roles, design plan for ongoing education and training</li> </ul>	<ul style="list-style-type: none"> <li>📁 Sample provider and staff surveys (<a href="#">Activity 4.3</a>)</li> <li>📁 Sustaining Integrated Behavioral Health Services: Strategies and Tools for Recruitment, Retention and Workforce Development (SAMSHA HRSA; three modules; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Access policies and procedures shared by cohort</li> <li>• Share your training plan and give feedback on at least one other organization's training plan</li> </ul> <p> Webinar</p>
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5.6 *Define new roles and responsibilities and reporting structures needed to expand the work, considering Behavioral Specialists, Integrated Care Coordinator, Peer Support* (W)

<ul style="list-style-type: none"> <li>Analyze staffing and utilization patterns and determine if additional care team roles should be added</li> <li>Identify updates needed to organizational charts (including consideration of adding BH position on the leadership team)</li> </ul>	<ul style="list-style-type: none"> <li> Hiring and Onboarding Integrated Behavioral Health Providers in Primary Care (Rocky Mountain Health Plans: 26 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Access library of cohort job descriptions and organizational charts</li> <li>Panel discussion, featuring speakers representing new possible care team roles (e.g., peer navigators)</li> <li>Post-panel discussion on considerations for hiring, onboarding and sustaining these roles</li> </ul> <p> Webinar</p>
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5.7 *Adapt performance measurement systems and feedback for organization rollout* (D)






<ul style="list-style-type: none"> <li>Assess effectiveness of measure set and identify challenges to data collection analysis</li> <li>Adjust data collection and reporting systems, as needed</li> <li>Develop education about performance measurement updates and data availability</li> </ul>	<ul style="list-style-type: none"> <li> See <a href="#">Activity 2.2</a></li> </ul>	<ul style="list-style-type: none"> <li> Review improvements planned around data collection and reporting with coach</li> <li>In breakouts, teams describe significant gaps in performance measurement systems and receive input from peers</li> </ul> <p> Webinar</p>
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## Phase 6

## Refresh your sustainability plan

Months 18 – 19

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Learning Objectives	Virtual Improvement Collaborative & Self-Paced Learners (On-Demand)	Virtual Improvement Collaborative (Live Sessions & Peer Network)
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### 6.1 Design organization-wide plan to guide implementation P S

<ul style="list-style-type: none"> <li>Create a plan that addresses:             <ul style="list-style-type: none"> <li>The new care model, including target population, protocols, care pathways and workflows</li> <li>Assessment and guidance of readiness for change, including organizational support available to care teams and practices</li> <li>Creation of a practice-level work plan</li> <li>Care team or practice-level implementation checklist</li> </ul> </li> <li>Sequence implementation activities, including major milestones and approximate timeline</li> </ul>	<p> See <a href="#">Activity 5.2</a></p>	<ul style="list-style-type: none"> <li>In dyads, teams provide feedback on draft plan (Prework: reading at least one draft plan)</li> </ul> <p> Webinar</p>
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### 6.2 Update plans to create BHI culture that sustains your workforce, including recruitment, training retention and improving diversity W Q

<ul style="list-style-type: none"> <li>At organizational level, assess how to validate culture of BHI</li> <li>Review demographics of staff and clinic compared to patients to identify differences</li> <li>Consider how you can evaluate and strengthen training approaches</li> </ul>	<p> Moving Toward a More Diverse Behavioral Health Workforce (Behavioral Health Workforce Research Center; 2 pages; <a href="#">link</a>)</p> <p><b>Dive Deeper:</b></p> <p> Health Workforce Training Program Evaluation Toolkit (Behavioral Health Workforce Research Center, 48 pages; <a href="#">link</a>)</p>	<p> In coaching meeting with executive sponsor, discuss plans for measuring and supporting culture of BHI</p> <ul style="list-style-type: none"> <li>Panel discussion on examples of how organizations have strengthened their long-term workforce plans (e.g., recruitment strategies, academic partnerships)</li> </ul> <p> Webinar</p>
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6.3 Continue planning program financing, value-based payment and long-term sustainability (S) (\$) (Q)

<ul style="list-style-type: none"> <li>Revisit your financial modeling work, (<a href="#">Activity 3.11</a>), either the AIMS Center Workbook or your own financial modeling, to understand budget, funding available and funding required for program growth to more patients and/or more care sites</li> <li>Begin review of business case and financial models to assess costs/revenue of BHI</li> <li>Develop goals and criteria for success for a payer or purchaser initiative addressing integration</li> <li>Based on the goals and success criteria, identify and make plan to contact three payers and/or purchasers you would be interested in collaborating with to finance, scale and sustain your BHI</li> <li>Consider the role of virtual care for patient experience and for staff flexibility</li> </ul>	<ul style="list-style-type: none"> <li>“Get the Balance Right, Part 1: Business Case Considerations” (CQC; 9 pages; <a href="#">link</a>)</li> <li>Financial Modeling Workbook, (AIMS Center at University of Washington; Excel; <a href="#">link</a>)</li> <li>“Get the Balance Right, Part 2” report from interviews with California experts, which includes advice on using the AIMS Center Workbook (CQC; 13 pages; <a href="#">link</a>)</li> </ul>	<p>Teams discuss progress on discussions with payers and/or purchasers with coach</p>
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6.4 *Explore supportive clinical technologies and other models that could extend BHI* (S) (I) (E) (C)






<ul style="list-style-type: none"> <li>Review and identify supportive technologies that may extend your organization's current and future capabilities, including:                             <ul style="list-style-type: none"> <li>Remote consult</li> <li>McPAP models</li> <li>Clinical peer learning (e.g., Project ECHO)</li> <li>Screening/questionnaire platforms</li> <li>Mobile messaging apps</li> <li>Electronic medication reminders and dispensers</li> <li>Platforms to identify and connect patients to social services</li> </ul> </li> <li>Develop plan to analyze technologies regarding efficiency and patient outcomes/ experience, using relevant criteria (e.g., ease of implementation, interoperability, etc.)</li> <li>Analyze technologies based on criteria defined by your team</li> </ul>	<p><b>General resources</b></p> <ul style="list-style-type: none"> <li>Telehealth Models for Increasing Access to Behavioral and Mental Health Treatment (RHI Hub; <a href="#">link</a>)</li> <li>Telebehavioral Health: Introduction to Telehealth for Behavioral Health Care (Health &amp; Human Services; <a href="#">link</a>)</li> </ul> <p><b>Specific technologies</b></p> <ul style="list-style-type: none"> <li>Remote consult (St. Vincent's Hospital; <a href="#">link</a>)</li> <li>Screening/questionnaire platforms (<a href="#">Springer</a>)</li> <li>Mobile messaging: Utilizing Smartphone Applications to Improve Integrated Care Outcomes Within VBP Environments (Montefiore; <a href="#">link</a>)</li> <li>Electronic medication reminders and dispensers (JMIR Mental Health; <a href="#">link</a>)</li> <li>Massachusetts Child Psychiatry Access Project (McPAP; <a href="#">link</a>)</li> <li>Clinical peer learning (ECHO Institute Program; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Panel discussion highlighting impact and challenges with select technologies (per cohort feedback) from clinical organizations using various technologies</li> </ul> <p> Webinar</p>
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6.5 Consider how to strengthen partnerships key to BHI work (P) (S) (Q)






<ul style="list-style-type: none"> <li>Review the social needs (<a href="#">Activity 2.11</a>) and asset maps (<a href="#">Activity 4.16</a>), and referral pathways (<a href="#">Activity 4.4</a>) documented previously</li> <li>Assess partnerships for two to three organizations to be part of your BHI work</li> </ul>	<ul style="list-style-type: none"> <li> Making Integration Work: Key Elements for Effective Partnerships Between Physical and Behavioral Health Organizations in Medicaid (CHCF, 14 pages; <a href="#">link</a>)</li> </ul> <p><b>Dive Deeper:</b></p> <ul style="list-style-type: none"> <li> American Hospital Association: Behavioral Health Community Partnerships (<a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li> With coach and team, assess current collaboration for two to three partnering organizations and identify how to implement improvements</li> </ul>
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## Phase 7

## Reflect on your journey

Month 20

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### 7.1 Reflect on and document your organization's journey to date, noting wins, challenges, lessons learned, best practices and surprises P

<ul style="list-style-type: none"> <li>Request input from those on the implementation team as well as others, describing wins, challenges, lessons learned, best practices and surprises</li> <li>Organize feedback and review it with the implementation team</li> <li>Develop summary</li> <li>Revisit communication plan</li> </ul>	<ul style="list-style-type: none"> <li>Revisit Communication Plan (<a href="#">Activity 3.2</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Create a playbook collecting your successes, challenges and findings from your first year of implementation and review with coach</li> </ul>
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### 7.2 Identify priorities to continue to improve the behavioral health integration journey P

<ul style="list-style-type: none"> <li>With implementation team, document priorities and next steps, including additional changes to the care model, new target populations, additional services and supports, and ideas for continued testing</li> <li>Review original vision for project as a team to assess progress, recognizing wins and challenges</li> </ul>	<ul style="list-style-type: none"> <li>Review Organization Background (<a href="#">Activity 1.3</a>)</li> </ul>	<ul style="list-style-type: none"> <li>In breakouts, peers share about progress to original vision and priorities for continuing the journey to get input and advice</li> <li>Webinar</li> </ul>
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7.3 *Share final performance data and story with peers* P

<ul style="list-style-type: none"> <li>Prepare a formal performance story, reflecting the viewpoints of a multidisciplinary team, patients and families</li> </ul>	<ul style="list-style-type: none"> <li> Telling Our Story (CQC; 10 slides; <a href="#">link</a>)</li> <li> Using Storytelling in Healthcare Improvement (The Health Foundation; 3 pages; <a href="#">link</a>)</li> <li> Tiburcio Vasquez Health Center Adapts to Integrate Behavioral Health with Primary Care (Safety Net Medical Home; 2 pages; <a href="#">link</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Two teams share a performance story</li> <li>Access <b>library of all performance stories</b> from teams</li> <li> <b>Webinar</b></li> </ul>
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7.4 *Support spread of BHI beyond improvement collaborative* P S

<ul style="list-style-type: none"> <li>Identify one opportunity to share achievements and learning in a public forum outside the learning community</li> </ul>		<ul style="list-style-type: none"> <li>In pairs, share idea on how you will highlight achievements and learning in a public forum outside the learning community</li> <li> <b>Webinar</b></li> </ul>
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7.5 *Celebrate organization and learning community achievements* P






<ul style="list-style-type: none"> <li>Design a celebratory event for the organization</li> </ul>		<ul style="list-style-type: none"> <li>Host celebratory event</li> <li>Peruse <b>gallery of photos</b> from other teams' celebratory events</li> </ul>
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## Looking ahead

Behavioral health integration is the future for patients and primary care practices. Those further down the integration path know that integration is a journey that will take time and organizational investment and will require constant adjustments and enhancements. We applaud organizations that are taking steps to launch or improve BHI for their patients. As you wrap up this project, we offer a few pieces of advice from peers that have implemented BHI:

- Be open, flexible and adaptive in your BHI program and model;
- Remember, you may have to make modifications — and even compromises — as you encounter unmet challenges; and
- The work will continue to evolve and grow with your practice needs.

While the work is challenging, BHI will ultimately improve how your practice delivers care and, in turn, the lives of the patients you serve.

## Acknowledgments

The following individuals and organizations contributed to the development of this toolkit and generously shared their time, knowledge and experience:

### Authors:

- Kristina Mody, M.P.H., senior manager of care redesign, Purchaser Business Group on Health
- Crystal Eubanks, M.S., senior director of care redesign, Purchaser Business Group on Health
- Sandra Newman, M.P.H., independent consultant

### Expert Reviewers

Thank you to our panel of expert reviewers, who were each selected to represent a different type of provider organization perspective.



Julie M. Fortune, LMFT, executive director, Mental Health Institute/Southern California, [Providence St. Joseph](#), a health system providing diagnostic, treatment, care and support services for the San Fernando Valley



Brenda Goldstein, M.P.H., chief of integrated services at [LifeLong Medical Care](#), a community health center and safety-net provider of medical, dental, behavioral health and social services in Alameda and Contra Costa counties



Karen Linkins, Ph.D., principal at [Desert Vista Consulting](#), a consulting firm, and director of Integrated Behavioral Health Partners, which spreads integrated behavioral health care through capacity building, training and technical assistance



Alyssa Yasuda, clinical pharmacist at [Desert Oasis Healthcare](#), an IPA serving 60,000 patients in Riverside and San Bernardino counties

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This project was supported by the California Health Care Foundation (CHCF), which works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit [www.chcf.org](http://www.chcf.org) to learn more.

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## About CQC and PBGH

The [California Quality Collaborative](#) (CQC), a health care improvement program of the [Purchaser Business Group on Health](#) (PBGH), is dedicated to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, purchasers and patients to align goals and take action to improve the value of health care for Californians.

The [Purchaser Business Group on Health](#) is a national nonprofit coalition of private employers and public entities that purchase health care services for more than 15 million Americans and their families, and are working to test innovative methods and scale successful approaches that lower health care costs and increase quality.

## Contact Us

If you have any accessibility issues or need to report a broken link, please email [cqcinfo@pbgh.org](mailto:cqcinfo@pbgh.org).

## General Behavioral Health Integration Resources

Organizations may find value in diving deeper to these resource collections from experts supporting behavioral health integration:

- [Advancing Integrated Mental Health Solutions \(AIMS\) Center](#)  
Implementation tools, resources and live office hours supporting collaborative care
- [The Integration Edge](#)  
Regularly updated resource from the SAMHSA-HRSA Center for Integrated Health Solutions for integrated primary and behavioral health care
- [Center of Excellence for Integrated Health Solutions](#)  
Newest evidence-based resources, tools and support for organizations working to integrate primary and behavioral health care
- [10 Building Blocks of High-Performing Primary Care](#)  
Template for high-performing primary care clinics
- For Federally Qualified Health Centers in California: California Primary Care Association's [Behavioral Health Peer Network](#) (membership required)

