Review of behavioral health integration in primary care at Baylor Scott and White Healthcare, Central Region

John B. Jolly, PsyD, Norman R. Fluet, PsyD, Michael D. Reis, MD, Charles H. Stern, MD, Alexander W. Thompson, MD, and Gillian A. Jolly, BS

The integration of behavioral health services in primary care has been referred to in many ways, but ultimately refers to common structures and processes. Behavioral health is integrated into primary care because it increases the effectiveness and efficiency of providing care and reduces costs in the care of primary care patients. Reimbursement is one factor, if not the main factor, that determines the level of integration that can be achieved. The federal health reform agenda supports changes that will eventually permit behavioral health to be fully integrated and will allow the health of the population to be the primary target of intervention. In an effort to develop more integrated services at Baylor Scott and White Healthcare, models of integration are reviewed and the advantages and disadvantages of each model are discussed. Recommendations to increase integration include adopting a disease management model with care management, planned guideline-based stepped care, follow-up, and treatment monitoring. Population-based interventions can be completed at the pace of the development of alternative reimbursement methods. The program should be based upon patient-centered medical home standards, and research is needed throughout the program development process.

The Agency for Healthcare Research and Quality defined integrated care as follows:

A practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization (1).

C. J. Peek, a national leader in care system development, reported that a variety of terms are encountered within research and conceptual writings of this emerging area, such as integrated care, patient-centered care, coordinated care, shared care, collaborative care, colocated care, and integrated primary care or primary care behavioral health (1). Kwan and Nease reported that certain structural features and clinical processes are typical of integrated behavioral health models (2). The common structural features are a care delivery team, a physical space onsite for

behavioral health, information technology, clinical and office management policies and protocols, and education and training. Common processes include access, detection, treatment, practice improvement, and cost containment and sustainability. They stated, “Ultimately, it may not matter what exactly this infrastructure looks like as long as it enables the provision of certain services” (2).

THE PURPOSE OF INTEGRATING BEHAVIORAL HEALTH WITH PRIMARY CARE

There are a variety of forces demanding a change and redesign in how health care is delivered in the United States. These forces include problems in the delivery of health care to patients and their families, financial pressures (including spiraling health costs), and political forces—all pushing to support such changes by delivery and payment reform.

Primary care continues to be the primary setting in which individuals seek mental health treatment, yet treatment is often deficient. Wang and his colleagues reported that based upon findings from the National Comorbidity Survey Replication data, 41.1% of individuals with mental disorders had received treatment in the previous 12 months; 56% of those individuals received treatment within the primary care setting, compared with 44% who received treatment within mental health settings (3, 4). Consistent with a previous epidemiological study, primary care is the “de facto” setting for mental health services in the United States (5). However, Wang et al also found that only 12.7% of individuals who were treated in primary care received even minimally adequate treatment (3).

In addition to the need to become more clinically effective, health care demands financial redesign to “bend the curve” of costs but also to support more effective, efficient, coordinated care. Health care costs are spiraling, and the “sick and disabled consume almost all health dollars” (6). Changes are particularly

From private practice, Jackson, Mississippi (J. B. Jolly); the Departments of Family Medicine (Fluet, Reis, Stern) and Psychiatry (Thompson), Baylor Scott and White Healthcare, Waco and Temple, Texas; and Baylor University, Waco, Texas (G. A. Jolly).

Corresponding author: John B. Jolly, PsyD, 620 N. State Street, Suite 202, Jackson, MS 39202 (e-mail: jollyjohndr@outlook.com).

needed to reduce costs of the chronically medically ill patient with comorbid behavioral health concerns. Gaipa and colleagues described a recent insurance report that demonstrated a significant increase of cost when the particular medical condition had comorbid behavioral health problems (7, 8). The authors of the Air Force's Behavioral Health Optimization Program stated that focusing only on the chronically sick "does nothing for the large pipeline that keeps fueling this fire, and it has little effect on the population's health as a whole" (6). They proposed a combination of addressing not only the sick and comorbid but also the larger, healthier population.

Health care reform is supporting changes in not only clinical delivery systems, but also payment and reimbursement systems. Health care is moving from fee-for-service models to bundled/global payments for populations of patients. The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 demonstrate this intent with the federal health reform agenda. Fabius and colleagues reported that the most significant problem in health care reform is the fee-for-service payment model (9). They noted that fee-for-service deincentivizes the changes needed in delivery and argued for bundling related costs. Under a fee-for-service model, each provider bills separately and "has no incentive to manage their use efficiently" (9). By bundling or receiving global payments, providers are compensated based upon the combined performance of all involved. The PPACA supports the testing of this payment reform model to "determine if providers can be incentivized to manage costs by taking responsibility for the costs of both acute conditions/procedures and chronic conditions" (9). Medicare, Medicaid, and commercial insurance programs are in the process of creating and releasing innovative bundled and global payment plans to support models that are clinically and cost-effective (10).

CONCEPTUAL DIMENSIONS USEFUL FOR INTEGRATION

In an effort to guide our process of behavioral integration at Baylor Scott & White Central Region, we considered important conceptual dimensions in this emerging field. Examining efforts in terms of an integration continuum, patient populations (whether in terms of level of pathology or even insurance status), or conceptual models of collaborative activities provided a direction (11–14).

Doherty described five levels of integration: minimal collaboration, collaboration at a distance, basic collaboration on site, close collaboration in a partly integrated system, and a fully integrated system (11). The first two integration levels suffer from a lack of communication, particularly involving comorbid mental health and physical health problems, while a fully integrated system requires a change in reimbursement methods that is currently unavailable. Basic collaboration on site occurs when behavioral health providers (BHP) and primary care providers (PCP) have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture. In the fourth level of integration, some organizations have close collaboration in a partly integrated system; BHPs and PCPs share

the same facility and have some systems in common, such as scheduling appointments or medical records. They have regular face-to-face communication. There is a sense of being part of the larger team. The fifth level of integration is a close collaboration in a fully integrated system. The BHP and PCP are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care. There is a population-based focus with primary prevention in addition to integrative case management.

Another conceptual dimension that affects integration efforts considers the importance of patient populations. Mauer proposed the four-quadrant model (12), which divides patients into four categories based upon behavioral and physical "needs" and "risks." Patients with *low behavioral health needs/risks* and *low physical health needs/risks* are typically served in primary care. Patients who have *high behavioral health needs* and *low physical health needs* are typically served in specialty behavioral health programs with linkages to primary care. Patients who have *low behavioral health needs* and *high physical health needs* are served in primary care and in the medical specialty system. Finally, patients who have *high behavioral health needs* and *high physical health needs* are typically served in both specialty behavioral health settings and primary care.

Another patient population model places integration in the context of behavioral health reform to determine what type of model of care best financially incentivizes integration for particular patient populations. Bao et al discussed grouping patients based upon severity of mental health problems and insurance status (13). If a patient's behavioral/mental health is paid by Medicaid, access is poorer, there is typically a greater need for social and human services, and coordination and collaboration between primary and behavioral health care is traditionally lacking. The Affordable Care Act's health home provisions incentivize coordinated care for Medicaid patients who have chronic and comorbid clinical conditions. For patients, regardless of health status, whose health is paid for by commercial insurance and Medicare programs, patient-centered medical homes (PCMHs) and accountable care organizations best incentivize integration efforts (15). The Agency for Healthcare Research and Quality reported that a PCMH has five functions and attributes: providing care that is a) comprehensive, b) patient-centered, c) coordinated, d) accessible, and e) has a commitment to quality improvement (16). Bao et al reported that PCMHs have the greatest potential to serve patients with mild to moderate behavioral health conditions (13). The Patient-Centered Primary Care Collaborative Payment Reform Task Force has offered a range of payment plans with fidelity to the PCMH model; at the highest level, global payments with bonuses are proposed to lessen the need for patient volume and incentivize value creation (17, 18). Accountable care organizations have shared savings for coordinating medical and behavioral health care but are payer-specific; they lack incentives to improve quality and reduce costs for Medicaid patients (13).

A particularly useful framework to guide integration efforts was provided by Collins and his colleagues (14). They discussed

eight models of behavioral health integration that described nonintegrated to fully integrated services. The “colocation,” “disease management,” and “primary care behavioral health” models appear to be particularly relevant in discussions of the current status and future transitions of behavioral integration at Baylor Scott and White Healthcare. The colocation model occurs when PCPs and BHPs are at the same site, but have distinct services. This arrangement has the primary advantage of providing better communication. Foy and colleagues suggested that better *interactive* communication, defined as “collaborative arrangements that enable primary care physicians and specialists to converse,” improves outcomes (19). The colocation model is less stigmatizing and provides better access to behavioral health-care for PCPs and their patients. One disadvantage is that patients referred to mental health for physical complaints may interpret symptoms as being “all in my head.” Additionally, if the behavioral service location is separate from the primary care treatment setting, e.g., a different wing of the building, there may be fewer opportunities for interactions and education of PCPs and “warm hand-offs.” These difficulties are intensified if BHP therapeutic hours are not modified for the primary care 15- to 20-minute appointments. Caseloads can quickly become overloaded, and access problems increase.

The disease management model is “an integrated system of interventions to optimize functioning of patients and to impact the overall cost of the disease burden” (14). The chronic care or disease management model is based on Wagner, Austin, and Von Korff’s chronic care model (CCM) (20). Wagner et al suggested that the components of high-quality chronic care consist of the use of explicit plans and protocols, practice redesign, patient change processes, expert input, and information system support (20). Common elements of chronic care include collaboration between service providers and patients, care plans, self-management education, follow-up, treatment monitoring, targeted use of specialty referral, and “stepped care” (21, 22).

The disease management model has advantages over the colocation model. In addition to having all the strengths of being on site, patients are screened for psychological problems in an empirical manner and closely monitored throughout the treatment process; this allows for modification and personalization of the intervention process and results in stepped care. Empirical guidelines are emphasized, saving scarce psychiatric resources to be used more efficiently. One primary disadvantage of this model is the current fee-for-service payment method, which does not reimburse case management services.

The primary care behavioral model is based upon population-based care. Strosahl reported that population-based care is grounded in public health concepts (23). Further, primary care behavioral health is consistent with “the philosophy, goals and strategies of primary care medicine. Specifically, there is an emphasis on early identification and treatment, long-term prevention, and ‘wellness’” (24). Collins et al indicated that the entire primary care patient population is the target of assessment, intervention, and consultative services (14). The primary “customer” is the PCP, then the patient. The goals are to

support providers, improve their effectiveness, prevent chronic problems from occurring, and improve the overall health of the population. The most critical issue in utilizing this model is associated again with reimbursement. While there appear to be new efforts at paying for such population-based services as consultation, case management, and primary prevention, currently medical “offset” savings for this model have not been clearly demonstrated.

CLINICAL EFFECTIVENESS OF BEHAVIORAL HEALTH INTEGRATION

Metaanalyses of behavioral health integration studies have demonstrated the clinical effectiveness of collaborative care models with a variety of clinical conditions. In the most comprehensive metaanalysis completed to date, Woltmann and colleagues examined the clinical effectiveness of collaborative CCMs for mental health conditions across different settings, particularly for depression but also including bipolar disorder, anxiety, and other mental health problems (25). They compared CCMs to usual care for 57 experimental trials across 78 articles, with 140 clinical outcome analyses. To be included in the study, each CCM had to have six components consistent with the CCM: patient self-management support, delivery system redesign, use of clinical information systems, provider decision support (guidelines), health care organization support, and linkage to community resources (25). Of 133 study analyses that reported statistical comparisons, 66 analyses (49.6%) favored the CCMs, 1 favored the control condition, and 66 (49.6%) had no statistically significant differences in the comparisons. The overall findings suggested that there were small to medium effects of CCMs across multiple disorders for clinical outcome (symptoms), mental and physical quality of life, and social role functioning. The authors reported that at this point, we still do not know which components are most important, which are necessary, and what works better for whom.

Most metaanalyses have cited the contribution of care management in the treatment of mental health problems, particularly for depression. Butler and her colleagues conducted a metaanalysis of 33 clinical trials from 145 articles on the integration of behavioral health and primary care in the treatment of depression (26). They specifically examined integration based upon the use of care managers, the process of care, and the degree that the studies integrated the roles of clinicians. The authors concluded that most studies demonstrated positive outcomes for treatment response and remission rates. However, the level of integration was unrelated to outcomes. Gilbody and colleagues completed a cumulative metaanalysis of 37 randomized collaborative care studies treating depression (27); all studies utilized case managers. They found a significant positive treatment effect, when compared to standard of care, at 6 months. Eleven studies examined effects beyond 6 months; significant treatment effects were found at 12 months, 18 months, and 5 years. Case management supervision and mental health background were found to be significantly related to the size of positive treatment outcome. Gilbody et al

also reported that studies that had a case manager, a PCP, and access to specialist input, consistent with Katon and colleagues' collaborative care model (22), tended to be more effective than other models (27).

Williams et al completed a systematic review of 28 studies that used care management and interventions treating depression within primary care settings (28). Consistent with Wagner and colleagues' CCM, most studies included patient education and self-management, monitoring of symptoms, decision support, registries, and mental health supervision of care managers (20). The authors found that almost all multifaceted interventions led to significant improvements in depression outcomes within 1 year. Gensichen et al found case management to be the primary positive factor in depression outcomes in a metaanalysis of 13 studies within primary care settings (29).

Instead of a specific focus on care management, Foy and colleagues suggested that the important factor in patient success is "interactive" communication of PCPs and specialists (19). In a metaanalysis of 18 depression studies that excluded care managers but incorporated direct communication between PCPs and psychiatrists, the authors found significant reductions in patients' depression. They concluded that collaboration that allows for direct communication between the PCP and specialist improves patient outcomes.

In sum, collaborative care, based upon a CCM, demonstrates clear evidence for effectiveness. The most effective studies consist of care management, a PCP, and some form of specialist consultation and supervision.

COST-EFFECTIVENESS OF BEHAVIORAL HEALTH INTEGRATION

Behavioral health integration is clinically effective. Is it also cost-effective? Woltmann et al argued, "The major focus of health care cost reduction efforts must be in reducing avoidable complications of chronic illnesses, which account for up to 22% of all health care expenditures. Reducing these complications could realistically result in a \$40-billion per-year savings" (25). Strosahl stated, "While improving clinical outcomes in healthcare is obviously an important goal, the 'straw that stirs the drink' is the huge medical offset potential of integrated care" (23). He suggested that integrated care has the potential for cost offset of approximately 20% to 40%.

Woltmann and colleagues examined health care costs in their metaanalysis of collaborative CCMs for mental health conditions (25). They found that among the 21 economic analyses (among 57 clinical effectiveness trials examined), only 10 could be compared; 9 (90%) found no statistically significant difference in costs between the CCM and the control condition. One study found the control condition less expensive. Van Steenberg-Weijnenburg and colleagues found eight studies that met quality criteria examining the cost-effectiveness of collaborative care for major depression (30). They found that all studies demonstrated that collaborative care is effective but, in most cases, more expensive. They concluded that while collaborative care seems promising, "the economic information is insufficient for policy decisions" (30).

BAYLOR SCOTT AND WHITE CLINICS

Clinic patient characteristics

Baylor Scott and White Healthcare-Central Region, Department of Family Medicine, has two primary care clinics that have BHPs. The Waco Clinic (WC) is located in Waco, Texas, a city of 127,000 within a county of 238,000. The Killeen Clinic (KC) is located within a city of 134,000 in a county of 323,000. Fort Hood, one of the largest military installations in the world, is located in Killeen. WC, which has had a psychology presence for the past 20 years, has four providers: three licensed psychologists and one licensed professional counselor. WC has always functioned with an annual profit margin while maintaining traditional 50-minute therapeutic hours. Contrary to Strosahl's concern about therapists being "swamped," WC functions without a long waiting list. In comparison to a non-colocated clinic, WC demonstrated a statistically significant shorter time from PCP referral to first BHP appointment for older patients, with approximately 77% of all patients attending their initial appointment after being referred by the PCP (31). KC hired two licensed psychologists within the past year. The *Table* shows the

Table. The mental health patient populations of two primary care clinics with behavioral health providers in Baylor Scott & White Central Region, calendar year 2013

	Killeen Clinic	Waco Clinic
Clinic population	28,000	17,000
Demographics		
Female	74%	63%
Caucasian	59%	85%
African American	17%	7%
Median age (years)	44	42
Psychiatric diagnoses (overlapping)		
Anxiety	83%	76%
Depression	68%	59%
Substance abuse	12%	8%
Conduct disorders	7%	16%
Comorbid chronic health conditions		
Obesity	23%	47%
Diabetes	17%	7%
Asthma	14%	9%
Other problems	<5%	<5%
Referrals		
From clinic PCPs	91%	61%
From other BSW-CR clinics		20%
Reimbursement		
Commercial insurance	48%	30%
Scott & White Plan	16%	31%
Medicare	18%	14%
Medicaid	10%	10%

PCP indicates primary care physician; BSW-CR, Baylor Scott & White Central Region.

similarities and differences in the clinics' mental health patient populations.

Clinic structural and process features

Both clinics have a close collaboration within a partly integrated system (11). Both clinics appear to be composed largely of patients with low behavioral health needs/risks and low physical health needs (12). While the clinics use a fee-for-service model of reimbursement, 90% of the payers for both clinics are non-Medicaid; PCMHs and accountable care organizations best incentivize integration efforts (13). At this time, both clinics fit the colocation model with integration enhancements (14).

The Patient-Centered Integrated Behavioral Health Care Principles and Tasks, a qualitative assessment of our adherence to principles and tasks considered important for behavioral health integration, was completed (32). The major strengths of both clinics are that PCPs and BHPs are colocated, they offer evidence-based treatments for their patients and families, and they systematically identify problems for most patients. Advantages of colocated services include easy, nonstigmatizing access for primary care patients, "curbside" consultations and improved communication with PCPs, and shared electronic medical records. Consultations to PCPs are limited, however, by the 50-minute hour; BHPs are not easily accessible except when suicidal/homicidal ideation is prominent. While KC providers share treatment space, WC providers are in separate wings of the clinic. There are many advantages to shared space, but also disadvantages; administrative issues appear less complicated with services in separate wings. Both clinics have a goal of educating PCPs concerning psychological/behavioral issues, given that behavioral health plays such an important role in primary care (3). In both clinics, the PCPs and BHPs collaborate using care plans within the shared electronic medical records. While both clinics use measurement-based identification of behavioral and emotional problems, and develop and modify treatment plans based upon this data, these efforts are not completed systematically at this point. Both clinics use valid measurement tools to screen, diagnose, and even document baseline symptom severity. WC and KC provide initial evaluations that rely primarily on interview and self-report measures, such as the Patient Health Questionnaire-9 and the Generalized Anxiety Disorder 7-item scale (33, 34). WC BHPs offer general psychopharmacology consultation, within their scope of practice, comfort level, and training, and based upon ethical guidelines. Among KC and WC behavioral health care patients, 48% and 31%, respectively, are treated with psychotropic medications. For those patients who have severe mental illness and/or need more complicated psychopharmacological intervention, referrals are made to psychiatrists at Baylor Scott and White in Temple, Texas. This service is located 30 or more miles from WC and KC and has a 2- to 3-month waiting list for nonemergency patients. Less than 5% of behavioral health patients for both clinics were referred to psychiatrists.

While there is active communication among PCPs and BHPs in both clinics, particularly with the shared electronic medical record, there is no formal care coordination or case

management. The lack of case management clearly sets limits on being responsive to patients' changing needs. The clinics' newest electronic medical record has a registry, which will allow both clinics to track and monitor patients who are not improving; neither clinic has begun this process yet. Providers are formally assessed for patient satisfaction, and, while accountable, providers are not reimbursed for quality of care and patient outcomes.

Integration recommendations for Baylor Scott and White-Central Region

Based upon a review of current concepts and models of behavioral health integration with primary care, the efficacy of certain structures and processes, and the cost-effectiveness of programs in use, the following recommendations are offered.

First, research studies on the efficacy and cost-efficiency of collaborative care clearly support the need and role for a care manager who is responsible for patient education and involving the patient in the treatment process. After initial assessment, patients may be triaged to simple monitoring with education; discussion of guideline-based PCP-provided medication or therapy options; possible initiation of short-term, problem-solving, or cognitive-behavioral treatment; or close continual monitoring. The registry will permit close monitoring and a treatment-responsive approach to care. Patients who are not progressing may be moved to the next level of "stepped care." The primary goal is patient progress for lower cost.

Second, the program should adhere to PCMH standards, which require certain types of tasks to be completed with the majority of patients to ensure that care is patient-centered, coordinated, effective, and efficient (15).

Finally, research is needed to assess and monitor the efficacy and cost-efficiency of Baylor Scott and White's behavioral health integration program. Assessment needs to be completed with empirically based measures that are sensitive to change. Important questions include, for example, whether the program demonstrates greater effectiveness and efficiency than "previous" care. In sum, there is a need for research to assess and guide program changes in order to be more clinically and cost-effective.

1. Peek CJ, The National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus* [AHRQ Publication No. 13-IP001-EF]. Rockville, MD: Agency for Healthcare Research and Quality, 2013. Available at <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>.
2. Kwan B, Nease D, Talen M, Valeras A, eds. *Integrated Behavioral Health in Primary Care*. New York, NY: Springer, 2013.
3. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62(6):629–640.
4. Kessler RC, Merikangas KR. The National Comorbidity Survey Replication (NCS-R): background and aims. *Int J Methods Psychiatr Res* 2004;13(2):60–68.
5. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry* 1993;50(2):85–94.
6. Behavioral Health Optimization Program. *Primary Behavioral Health Care Services: Practice Manual, Version 2.0*. Lackland AFB, TX: Air Force

- Medical Operations Agency, 2011. Available at <http://www.integration.samhsa.gov/images/res/2011%20BHP%20Manual%20-%20PDF%207.28%20updates.pdf>.
7. Gaipa M, Pathy V, Sonn E. *Paying for Integrated Primary Care and Behavioral Health: Identifying Barriers and Developing Strategies to Overcome Them*. Denver, CO: Center for Improving Value in Health Care, 2013. Available at http://www.civhc.org/getmedia/d607a579-6864-4c10-86eb-f40e27a39166/Paying-for-Integrated-Primary-Care-and-Behavioral-Health_9.2013_1.aspx/.
 8. Kathol R. Health and cost impact of comorbidity and integrated care. In Gaipa M, Pathy V, Sonn E, eds. *Paying for Integrated Primary Care and Behavioral Health: Identifying Barriers and Developing Strategies to Overcome Them*. Denver, CO: Center for Improving Value in Health Care, 2013.
 9. Fabius R, Maccracken L, Pritts J. *Vocabulary of Healthcare Reform Glossary*. Ann Arbor, MI: Truven Health Analytics, 2012. Available at <http://truvenhealth.com/portals/0/assets/VocabHealthReformGlossary.pdf>.
 10. Druss BG, Mauer BJ. Health care reform and care at the behavioral health–primary care interface. *Psychiatr Serv* 2010;61(11):1087–1092.
 11. Doherty WJ. The why's and levels of collaborative family healthcare. *Fam Syst Med* 1995;13(3–4):275–281.
 12. Mauer BJ. *Behavioral Health/Primary Care Integration: Finance, Policy and Integration of Services*. Rockville, MD: National Council for Community Behavioral Healthcare, 2013. Available at <http://www.integration.samhsa.gov/BehavioralHealthandPrimaryCareIntegrationandthePCHM-2006.pdf>.
 13. Bao Y, Casalino LP, Pincus HA. Behavioral health and health care reform models: patient-centered medical home, health home, and accountable care organization. *J Behav Health Serv Res* 2013;40(1):121–132.
 14. Collins C, Hewson DL, Munger R, Wade T. *Evolving Models of Behavioral Health Integration in Primary Care*. New York, NY: Milbank Memorial Fund, 2010. Available at <http://dx.doi.org/10.1599/EvolvingCare2010>.
 15. National Committee for Quality Assurance. *Accreditation*. Available at <http://www.ncqa.org/Programs/Accreditation.aspx>.
 16. Agency for Health Care Research and Quality. *Defining the PCMH*. Available at <http://pcmh.ahrq.gov/page/defining-pcmh>.
 17. Goroll AH, Bagley B, Harbrecht M, Kirschner N, Kenkeremath N. *Payment Reform to Support High-Performing Practice: Report of the Payment Reform Task Force*. Washington, DC: Patient-Centered Primary Care Collaborative, 2010. Available at <https://www.pcpcc.org/sites/default/files/media/paymentreformpub.pdf>.
 18. Levey SM, Miller BF, Degruy FV III. Behavioral health integration: an essential element of population-based healthcare redesign. *Transl Behav Med* 2012;2(3):364–371.
 19. Foy R, Hempel S, Rubenstein L, Suttrop M, Seelig M, Shanman R, Shekelle PG. Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists. *Ann Intern Med* 2010;152(4):247–258.
 20. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *Milbank Q* 1996;74(4):511–544.
 21. Von Korff M, Glasgow RE, Sharpe M. Organising care for chronic illness. *BMJ* 2002;325(7355):92–94.
 22. Katon W, Von Korff M, Lin E, Simon G. Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse. *Gen Hosp Psychiatry* 2001;23(3):138–144.
 23. Strosahl K. Mind and body primary mental healthcare: new model for integrated services. *Behav Healthc Tomorrow* 1996;5(5):93–96.
 24. Strosahl K. The integration of primary care and behavioral health: type II changes in the era of managed care. In Cummings N, O'Donohue W, Hayes S, Follette V, eds. *Integrated Behavioral Healthcare: Positioning Mental Health Practice with Medical/Surgical Practice*. New York: Academic Press, 2001.
 25. Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am J Psychiatry* 2012;169(8):790–804.
 26. Butler M, Kane RL, McAlpine D, Kathol R, Fu SS, Hagedorn H, Wilt T. Does integrated care improve treatment for depression? A systematic review. *J Ambul Care Manage* 2011;34(2):113–125.
 27. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med* 2006;166(21):2314–2321.
 28. Williams JW Jr, Gerrity M, Holsinger T, Dobscha S, Gaynes B, Dietrich A. Systematic review of multifaceted interventions to improve depression care. *Gen Hosp Psychiatry* 2007;29(2):91–116.
 29. Gensichen J, Beyer M, Muth C, Gerlach FM, Von Korff M, Ormel J. Case management to improve major depression in primary health care: a systematic review. *Psychol Med* 2006;36(1):7–14.
 30. van Steenbergen-Weijenburg KM, van der Feltz-Cornelis CM, Horn EK, van Marwijk HW, Beekman AT, Rutten FF, Hakkaart-van Roijen L. Cost-effectiveness of collaborative care for the treatment of major depressive disorder in primary care. A systematic review. *BMC Health Serv Res* 2010;10:19.
 31. Basu R, Phillip KM, Stevens AB. *Psychology in Primary Care: An Examination of Best Practices*. Available at <http://www.slideshare.net/hmorn/psychology-in-primary-care-an-evaluation-of-best-practices-basu>.
 32. Advancing Integrative Mental Health Solutions. *Patient-Centered Integrated Health Care Principles and Tasks*. Seattle, WA: AIMS Center, 2012. Available at http://uwaims.org/files/AIMS_Principles_Checklist_final.pdf.
 33. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* 2001;16(9):606–613.
 34. Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med* 2006;166(10):1092–1097.