RESOURCES FOR INTEGRATED CARE
Resources for Plans & Providers for Medicare-Medicaid Integration

Behavioral Health Integration Capacity Assessment (BHICA) User Guide

February 2024

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A. Pre-Assessment Background and Framing

Integrating Behavioral and Primary Care Services

The Case for Integration (and "Reverse Integration")

Behavioral and primary care integration coordinates "appropriately matched interventions for both physical health and behavioral health conditions, along with attention to social determinants of health, in the setting in which the person is most naturally engaged."[1] Evidence suggests that such coordination can improve quality of care and outcomes across several key measures, including patient experience of care,[2] depression severity,[3] and costs.[4]

Most primary and behavioral health integration efforts historically involved bringing mental health care to primary care settings, although the literature documents a growing body of programs initiating in behavioral health settings. The rise of this phenomenon, sometimes called "reverse integration," may be driven by the Substance Abuse and Mental Health Services Administration's Primary Behavioral Health Care Integration program,[5] as well as the Medicaid health home waiver—through which states can integrate general care services into specialty mental health delivery systems.[6]

> "While integration often refers to inclusion of behavioral health services in primary care settings, HHS approaches it more broadly, to also include integration of physical health care into behavioral health settings and integration of behavioral health care with other specialty areas such as OB/GYN care, as well as in social service and other settings." - *U.S. Department of Health and Human Services' Roadmap for Behavioral Health Integration Issue Brief*

Integrating primary health care services into the behavioral health care setting helps providers deliver holistic, coordinated, and efficient person-centered care while simultaneously reducing administrative duplication and associated costs. Because behavioral health conditions are associated with comorbid physical health conditions, insufficient care coordination may lead to avoidable hospitalizations or inappropriate use of prescription medications; conversely, enhanced coordination through integration can result in improved outcomes and cost savings.[7,8] Making both physical and mental health services available at a single location can also improve access and engagement between clinicians and those seeking care.[9]

Why Dually Eligible Individuals May Particularly Benefit from Integration

Individuals with certain characteristics may disproportionately benefit from integrated care. For example, the high rates of comorbid physical conditions among those diagnosed with serious mental illness (SMI) may make integration particularly valuable in treating such individuals.[10]

Likewise, individuals who are dually eligible for Medicare and Medicaid experience mental health diagnoses at twice the rate of the Medicare-only population; one-third of dually eligible individuals (i.e., three times the rate of the Medicare-only population) have an SMI diagnosis (e.g., schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder).[11,12] These conditions are even more common among dually eligible individuals who are under age 65.[13] In fact, dually eligible individuals account for more than half (56 percent) of all inpatient psychiatric facility visits.[14]

The dually eligible population also disproportionately suffers from primary care-sensitive physical conditions. Roughly 25 percent of dually eligible individuals—as compared to only 15 percent of Medicare-only individuals—live with five or more chronic conditions.[15]

Despite the prevalence of comorbid condition diagnoses, many dually eligible individuals with mental health conditions must navigate bifurcated systems of care to meet physical and behavioral health needs, as well as different systems of coverage under Medicare and Medicaid. Fragmented care delivery across multiple providers and funding sources can decrease access and lead to poor health status.[16] Providers practicing in integrated behavioral and primary health care settings may be better positioned to address both aspects of dually eligible individuals' health.

Greater needs translate into greater costs. In 2020, dually eligible individuals represented 14 percent of Medicare fee-for-service (FFS) enrollees but contributed to 26 percent of FFS Medicare spending.[17] In that same year, average total spending for dually eligible individuals was approximately twice that of other Medicare enrollees.[18]

One strategy with the potential to both lower costs and improve outcomes for dually eligible individuals involves integrating behavioral health and primary care delivery.[19,20,21] Typically, individuals receive these services from different clinicians in separate settings, which can pose a challenge to care coordination. Effective coordination of both physical and behavioral care services, a key benefit of integrated primary and behavioral health care, can help support effective treatment courses, which address an individual's holistic wellbeing.[22]

Implications for Health Equity

Communities of color experience behavioral health diagnoses at a higher rate than their white counterparts. Coordinating both physical and behavioral health care, therefore, may be effective in reducing racial and ethnic disparities around improving mental health outcomes.[23] A 2022 Agency for Healthcare Research and Quality topic brief on the role of behavioral health integration in promoting health equity notes that:

> *Mental health, substance use, and physical health have mutually influencing interactions, and all correlate with histories of trauma and with lower income. People with mental health and substance use disorders have a higher prevalence of other chronic conditions, such as cardiovascular disease, stroke, high blood pressure, diabetes, cancer, human immunodeficiency virus and hepatitis, and vice versa…*
>
> *People with multiple chronic conditions have poorer health outcomes, use more health services, and spend more on healthcare. Integrating behavioral health into primary care can provide the collaborative, patient-centered, and whole-person care needed to address biopsychosocial factors that affect health, well-being, and quality of life and reduce disparities in health and healthcare.*[24]

Coupling these data with other statistics about dually eligible individuals (e.g., compared with the Medicare-only population, the dually eligible population has a higher prevalence of both mental health diagnoses and chronic illness,[25] as well as a higher proportion of women, Blacks, Hispanics, those living with disability, and individuals living in poverty),[26] it is clear that integration holds promise for reducing inequities in health care.

Supporting Care Integration with the Behavioral Health Integration Capacity Assessment

The Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office, in collaboration with Resources for Integrated Care (RIC) and the Institute for Healthcare Improvement, originally developed the Behavioral Health Integration Capacity Assessment (BHICA) in 2014. Its developers sought to offer providers—including health plans and care delivery systems—a tool to determine their organizational capacity to integrate primary care services into their behavioral health care practices.

Purpose of the BHICA

The purpose of the BHICA is to assist behavioral health organizations (BHOs) that provide care to the dually eligible population as they evaluate their readiness to implement integrated care and to help evaluate integration over time. After completing the assessment, BHOs will be better positioned to:

- Consider potential approaches to integration to better serve their population;
- Understand how current organizational infrastructure could support greater integration;
- Assess organizational strengths and challenges in implementing integration; and
- Set and prioritize integration goals for the organization.

Audience

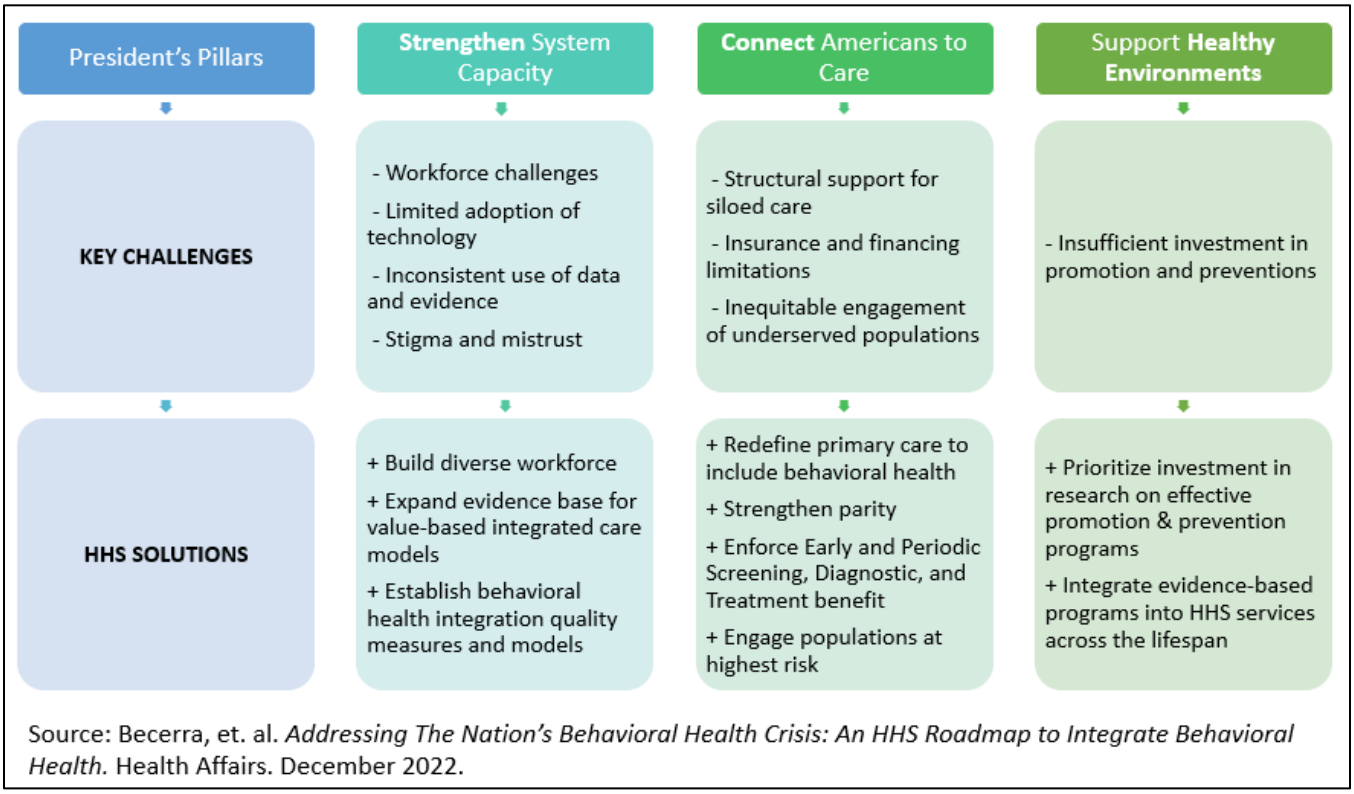
RIC developed the BHICA Tool and this BHICA User Guide for a broad audience of behavioral health care delivery organizations that want to enhance integration of primary care into their service offerings. This can include Certified Community Behavioral Health Clinics (CCBHCs) and Federally Qualified Health Centers (FQHCs). It can help organizations anywhere along the continuum of their integration journey—from those just starting and seeking help defining short term goals to those nearing completion that want a tool to help monitor and evaluate progress. With question prompts throughout Part B of the User Guide directing organizations to consider implications of integration for dually eligible individuals, this Tool can be particularly useful for those working with safety net providers and populations.

The Case for Updating the BHICA

Since RIC published the BHICA, evidence supporting primary and behavioral health integration has grown exponentially. Provider demand and political support have also increased for what is now widely considered the "gold standard" for care delivery.[27]

President Biden highlighted integration in his 2022 State of the Union address as a key national strategy to help address the post-pandemic mental health crisis.[28] The subsequent Department of Health & Human Services (HHS) Roadmap to Integrate Behavioral Health (see Exhibit 1) labels the topic "an HHS strategic priority" and outlines opportunities across HHS to drive implementation and, as a result, improve health equity.[29,30]

Exhibit 1. HHS Solutions to Achieving Integrated Behavioral Health Care



Source: Becerra, et. al. *Addressing The Nation's Behavioral Health Crisis: An HHS Roadmap to Integrate Behavioral Health.* Health Affairs. December 2022.

RIC updated this BHICA Guide in 2024 to help providers caring for dually eligible individuals access the most current evidence-based strategies for behavioral health and primary care integration. This revised BHICA Guide (PDF document) and interactive scoring BHICA Tool (Excel file) reflect the evolving landscape of behavioral health care delivery. In addition to updated content, the re-released BHICA Guide and Tool provide BHOs with improved usability and readability.

Putting the BHICA into Context: Frameworks and Assessments

In recent years, researchers and practitioners that want to help care delivery organizations integrate behavioral and primary care have created two different kinds of supports: theoretical frameworks and operational assessments. These can be instructive to those planning and monitoring integration efforts. This section explains how RIC considered such advances in its 2024 update.

Overview of Integration Frameworks

Several frameworks have emerged in the past decade to help organizations operationalize behavioral health and primary care integration. Two key examples include: 1) the Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions' Standard Framework for Levels of Integrated Healthcare (CIHS Framework) and 2) the National Council for Wellbeing's Comprehensive Healthcare Integration (CHI Framework).

Both the CIHS and CHI Frameworks accommodate organizations at different stages of integration by offering a range of approaches and resources and, in doing so, illustrate that integration occurs along a continuum.[31,32] These frameworks are not mutually exclusive and the BHICA aligns with both.

CHI Framework (2022)

The CHI Framework identifies elements across eight domains:

1. Integrated screening, referral, and follow-up
2. Evidence-based care for prevention or intervention
3. Ongoing care coordination and management
4. Self-management support
5. Multi-disciplinary team
6. Quality improvement
7. Linkages with community and social services
8. Sustainability

In the final section of this User Guide, a green light bulb icon indicates areas of BHICA and CHI Framework alignment.

Note: the CHI Framework is bi-directional—it can guide BHOs seeking to integrate primary care services or primary care practices seeking to integrate behavioral health care. In contrast, the BHICA is tailored to BHOs integrating primary care.

The CIHS framework, published in 2013, differentiates six levels of integration (minimal through full collaboration) across three care options: coordinated, co-located, and integrated, as described in Exhibit 2. Section 4 of the BHICA (see Appendix A) leverages these three options to help organizations understand the type of integration that may be both desirable and feasible.[33]

Exhibit 2. Characteristics of the SAMSHA-HRSA CIHS Framework's Three Main Levels of Integration

Coordinated Care	•Maintain separate facilities, screening and treatment practices, and billing models •Collaborate and consult with other providers about shared patients and specific health issues only when necessary •Communicate and share data on an as-needed basis to coordinate care between separate health care providers •May engage in larger community interactions to share resources
Co-Located Care	•Close physical proximity (same site or campus); integration may involve shared systems •Provide team-based care with referrals, collaborative treatment planning, and regular communication to support patient follow-up •Increased sharing of data and information, which can develop the opportunity for trust and relationship building
Integrated Care	•Seek system-wide solutions to barriers, communicate frequently, and use collaborative team care approach to treatment planning •Standardized screenings and use of evidence-based practices across disciplines •Moving toward a blended organziation, requiring organizational change and the melding of cultures where no one discipline dominates

RIC used this paradigm to inform the BHICA's organizational structure.

Overview of Organizational Integration Assessment Tools

Theoretical frameworks like those RIC describes above define key practice domains critical to integrating behavioral health and primary care. Organizational assessment tools, another resource, also offer vital support for organizations seeking either to initiate or to measure ongoing progress toward integration.

RIC reviewed the BHICA and six additional prominent organizational assessment tools (listed in Appendix B) and found the BHICA to stand out in several ways. First, only the BHICA is specifically designed to support reverse integration (that is, primary care into BHOs rather than behavioral health into primary care settings) and, as such, is tailored to a BHO audience. Most tools seek to help organizations place their practices on a continuum and monitor progress toward greater integration. In contrast, the BHICA's primary objective is to support practices as they initiate integration. The BHICA is among the most comprehensive tools of this type, requiring organizations to examine internal data and compare options before determining how to proceed. It guides its users to assess what they need to prepare for integration and helps them make discrete decisions about how best to integrate care in their specific context. Also unique is the BHICA's focus on understanding the financial aspects of integration. While other tools briefly address fiscal considerations, the BHICA devotes Section 5 to evaluating opportunities, practices, and gaps that can help guide financial decisions.

Finally, none of the frameworks or tools explicitly addressed issues unique to the dually eligible population. However, the guidance for each BHICA section includes a text box with suggestions for how BHOs can address issues specific to dually eligible individuals (see below).

Value Proposition for Completing the BHICA

BHICA users will gain insights that can inform their decisions about where to focus resources to achieve successful integration. Understanding where on the integration continuum an organization stands can help it to:

- Make progress within or among the three integrated care approaches (i.e., coordinated care, co-located care, and integrated care).
- Tailor its integration efforts on the most urgent organizational workflows related to process improvement, staffing, electronic health record (EHR) use, and strategic partnership building with community-based organizations.
- Prioritize person-centered care and improve outcomes by focusing on individual choice and autonomy.
- Implement care management and coordination strategies that may reduce hospitalizations and increase cost savings.
- Support coordinated care quality metrics and improvement initiatives as part of federal or managed health plan quality enhancement programs.
- Bolster efforts to meet regulatory requirements or attain accreditation or designations related to integrated care. For example:

- New York State offers an *Integrated Outpatient Services* license and some dedicated managed care plans focus on coordinating care among physical health, behavioral health, and substance use services.[34,35]
- CCBHCs must coordinate care across acute and chronic physical health and behavioral health care, as well as related social service needs like housing, education, and employment opportunities to support holistic wellness.[36]

Long-Term Sustainability: Financing and Other Challenges

Integration is not easy. Common challenges include adherence to information sharing regulations and other state-level guidelines, difficulties securing sufficient financial support to complete necessary integration work, and managing cultural differences between primary care and behavioral health providers. Despite these obstacles, many BHOs have successfully integrated with primary health care to create a holistic care setting.

Identifying sustainable financing is a critical element for meaningful long-term integration. In a changing health care environment, new models and demonstrations are opening new financing options for BHOs to further integrate primary care services. Because these models are changing and may be state- or area-specific, the BHICA includes questions about financing and the business case for integration. Additionally, the BHICA offers links to useful financing resources that may help organizations identify possible funding pathways.

Organizations completing the BHICA could engage financial staff when deciding on a potential financing model and assessing the organization's integration readiness. Though this assessment prompts consideration of these issues, BHOs may wish to explore supplemental resources when considering strategies to finance integration.

Using the BHICA to Enhance Care Integration

Structural Overview

Many of the BHICA's questions address overcoming common integration barriers. This User Guide includes a recommended process for completing the BHICA to ensure that BHOs gather the most appropriate individuals across various departments to enable meaningful collaboration. Note that BHOs can complete the BHICA multiple times, using initial scores to determine readiness and subsequent scores to monitor progress or identify opportunities for improvement.

This section of the User Guide serves as a companion resource that provides additional context for BHOs completing the accompanying BHICA Tool. The corresponding, Excel-based Tool includes section-specific interactive grids and a scoring model.

Both the BHICA Tool and this BHICA User Guide follow the same five-section structure, as described in Exhibit 3. The BHICA User Guide provides useful context to frame the assessment process. The Tool allows BHOs to input responses for each question. The scoring tab displays responses to each question and summarizes performance across each domain. Together, these products will help BHOs identify both successes and areas they may direct resources to further strengthen.

Exhibit 3. The Five Sections of the BHICA Tool and Guide

Section 1: Understanding Your Population
Understanding your organization's population can inform your integration approach**.** For some organizations, these questions will identify opportunities to collect additional information on the population.
Section 2: Assessing Your Infrastructure
Assess the organization's infrastructure within five core operational capabilities: • *Data Collection* – i.e., organizational capacity to collect data, share information, and monitor population health • *Data Analysis* – i.e., organizational capacity to track integration progress and outcomes • *Communication* – i.e., organizational processes for engaging and communicating with individuals and families • *Referrals* – i.e., organizational capacity to provide individuals with community wellness resources • *Cultural Factors* – i.e., how well the organization's culture supports integration
Section 3: Identifying the Population and Matching Care
Define and identify the organization's target population, then develop a strategy for reliably identifying and tracking those individuals. This includes applying a comprehensive screening tool at regular intervals to support providers in tailoring a care plan and identifying appropriate services.
Section 4: Assessing the Optimal Integration Approach
Consider three approaches to behavioral health and primary care integration: • Coordinated care, including enhanced communication among providers • Co-located care within a single facility • Integrated, in-house primary care capability
Section 5: Financing Integration
Identify the financial issues that correspond to the organization's chosen integration approach and think creatively about collaborative financing solutions.

Recommended Process for Completing the BHICA

This self-assessment is designed to facilitate a candid analysis of the current practices and processes within your organization that support integration. The accompanying BHICA Tool will help organizations understand how their current practices and processes map to the different integration approaches and will assist in identifying possible next steps. It is not necessary to complete all sections of the BHICA at once, or in order. Please modify the process detailed below to best suit your organization's needs.

Before You Begin

Consider the following prior to completing the BHICA to support a smooth self-assessment process:

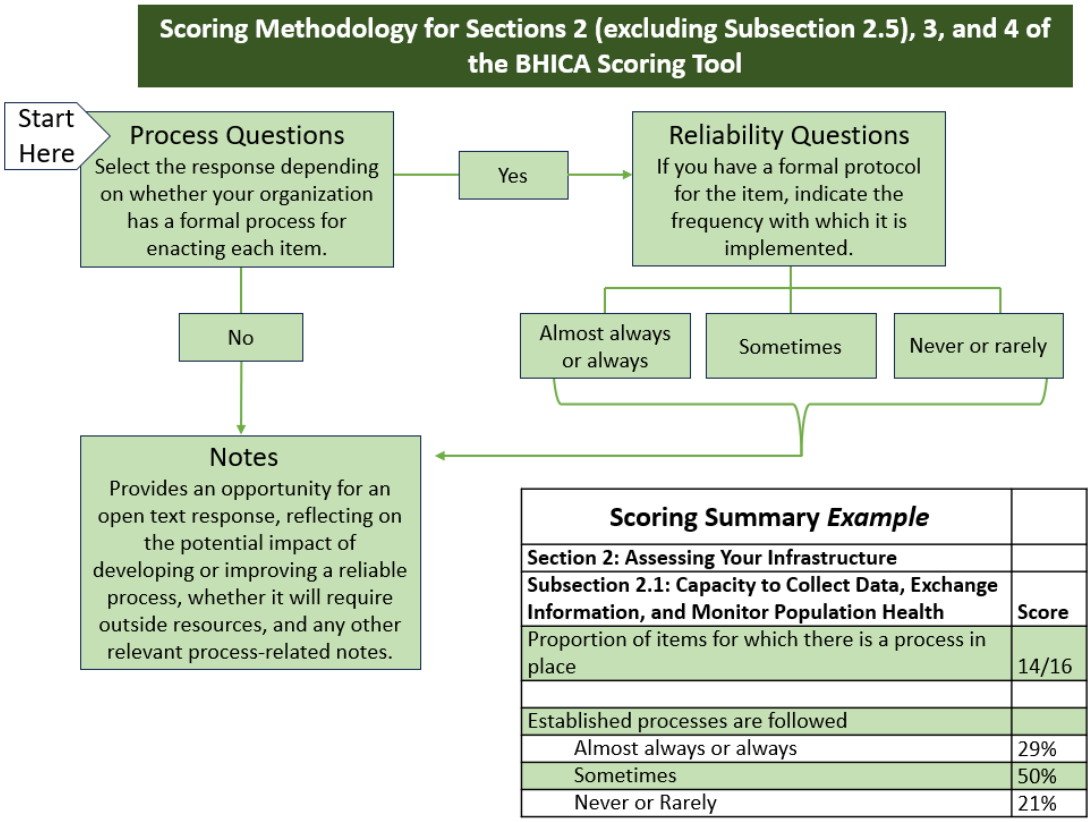
- For Section 1 (Understanding Your Population), consider collecting data on demographics, service utilization, and other characteristics of your current population (whom you serve, what you deliver, and how often). If your organization has already selected an integration approach, or has already conducted similar analyses, you do not need to complete this section.
- For both Section 2 (Assessing Your Infrastructure) and Section 3 (Identifying the Population and Matching Care), gather information on current clinical, operational, and cultural practices and processes.

- For Section 4 (Assessing the Optimal Integration Approach), decide whether to assess processes related to one, multiple, or all approaches.
- For Section 5 (Financing Integration), collect information about how existing services are funded (e.g., Medicare and Medicaid reimbursement, commercial insurance, grants) and where opportunities exist to add or change organizational services.

Completing the BHICA Tool

1. Select a group of leaders and staff who collectively have expertise on all levels of the organization (e.g., finances, operations, clinical processes, leadership practices, staff practices) to complete the self-assessment.
    a. The time needed to complete the assessment will vary depending on how many sections are completed. It could take between 90 minutes for a cursory review or a full day or more for in-depth analysis and conversations. Again, it is not necessary to complete all sections at once, nor is it necessary to complete each section in order.
    a. You may ask specific individuals to complete specific sections of the assessment, or you may ask a few individuals to complete as much of the assessment as possible. Some examples of staff who may help complete the assessment include senior leadership, office or program managers, referral coordinators, behavioral health providers, nurses, and any staff providing care (if applicable).
2. Each sheet includes section-specific directions for completing and scoring the evaluation.
    a. **Section 1:** These open-ended questions will provide insights that help deepen your organization's understanding of its patient population. You will not score this section.
    b. **Sections 2-4:** These sections will help you determine to what degree your organization has formal processes to address each topic. The questions use either a three-point or a five-point scale. You can also use the "notes" column within each section to capture insights or clarifications that can inform next steps to improve your score.
        i. Note that the questions in **Section 4** address an organization's current capacity to implement one of three integration approaches. Since there is no "right" way to integrate care, responses in this section will offer you insights into the suitability of three different strategies: 1) coordinated care—including enhanced communication among providers, 2) co-located primary care services, or 3) integrated primary care capability. If your organization has an approach in mind, you can complete just the relevant section or select items within each to complete. Note that questions repeat across each approach.
    c. **Section 5** uses a combination of "yes" or "no" and a written response tool to capture any insights or clarifications around each item.

Exhibit 4. Response and Scoring Process for the BHICA



Scoring Summary *Example*	
Section 2: Assessing Your Infrastructure	
Subsection 2.1: Capacity to Collect Data, Exchange Information, and Monitor Population Health	**Score**
Proportion of items for which there is a process in place	14/16
Established processes are followed	
Almost always or always	29%
Sometimes	50%
Never or Rarely	21%

Scoring and Next Steps

For Sections 2 through 5, see the "Responses Summary" tab of the BHICA Tool (i.e., the Excel file) for details regarding progress toward integration and resources to support the BHO moving forward. The scoring tool provides a summary of responses for each section, providing immediate value and clarity even if an organization does not complete all sections of the assessment.

After completing the self-assessment and accompanying scoring tool, RIC suggests that the BHO debrief with key leaders to discuss the results, identify goals, and define next steps. Common next steps include conducting an environmental scan to identify potential external funding sources, setting feasible integration goals for the next six to 12 months, and determining the necessary resources to implement short- and long-term integration goals.

The next part of this User Guide, A Roadmap for Using the BHICA, goes through each section of the BHICA and provides detailed instructions on how to prepare for using the Tool, what users can reflect upon when answering the questions, and special considerations they may make to specifically address the needs of dually eligible populations.

B. A Roadmap for Using the BHICA

Section 1: Understanding Your Population

The questions in this section are intended to help organizations consider how individual needs may affect potential approaches to integration. Organizations may not be able to answer all questions. However, gaining a comprehensive understanding of an organization's population can help better inform your integration approach (see examples in Exhibit 5). For some organizations, these questions will identify opportunities to collect additional information on their population.

Exhibit 5. Integration Approaches Based on Data

Example 1: If 75 percent of the population already has established relationships with primary care providers (PCPs), building integration in-house may not be necessary.
Example 2: A population with significant physical health needs and low primary care access may benefit from a more intensive integration approach.

This section is not "scored." Rather, organizational leaders and staff are encouraged to use this data to reflect on the needs of the population and the current organizational capacity to measure those needs. Each of the three subsections in Section 4 (Assessing the Optimal Integration Approach) includes notes about how to use this information to identify a path forward.

Consideration for BHOs Serving Dually Eligible Individuals

If it is possible to segment your data to examine your dually eligible population, review the question in the assessment for this population in addition to your general patient population.

- When comparing with your general population, can you identify unique needs among dually eligible individuals?
- Based on the data, what unique opportunities and challenges might you face in integrating care for your dually eligible population?

Section 2: Assessing Your Infrastructure

The questions in this section will help organizations assess their infrastructure within five core operational capabilities:

- Capacity to collect data, exchange information, and monitor population health
- Progress and outcome tracking capability
- Process for engaging and communicating with individuals, family members, and natural supports
- Capacity to provide individuals with community wellness resources
- Culture to support integration

Capacity to Collect Data, Exchange Information, and Monitor Population Health

Organizations competent in this operational capability use an EHR or other methods to collect individual and organization-level data, which allows them to identify, track, and segment the population. Ideally, organizations have a reliable system for collecting data that supports aggregation of data, information sharing, and identification of high-risk populations.

Progress and Outcome Tracking Capability

Organizations competent in this operational capability can measure the effectiveness of the provided treatment. Ideally, organizations can track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.

Engaging and Communicating with Individuals, Family Members, and Natural Supports

Organizations competent in this operational capability have supportive, consistent, and clear communication with individuals and their families or natural supports.[*]

Capacity to Provide Individuals with Community Wellness Resources

Organizations competent in this operational capability provide individuals with resources that promote wellness. Examples of community wellness resources include materials to encourage individuals to ask providers about physical health problems, wellness programs, and a list of local wellness activities.

Culture to Support Integration

Organizations competent in this operational capability have developed a leadership culture, including staff and provider engagement, which facilitates integration activities. Please note that Culture to Support Integration uses a different scoring methodology in the BHICA Tool. Each statement is evaluated on a scale from "strongly agree" to "strongly disagree." As you answer the extent to which

[*] In the BHICA, the term "families" refers to immediate family and natural supports identified by the individual. When considering questions under Subsection 2.3, we recommend that your organization confirms that the individual (or their family or primary caregiver) granted permission to communicate with the individual's providers on their behalf.

you agree, it may be helpful to think of a specific instance or interaction with leadership or staff that illustrates the statement.

Leadership Culture

Administrative support and buy-in among leadership and frontline staff are important to maintaining a culture that supports organizational change. For most BHOs, behavioral health and primary care integration requires a fundamental shift in strategic planning and operations. To be effective, leaders must have—and share—a vision that articulates why these changes will be beneficial. Staff need a clear understanding of the end goals, as well as how integration will affect their day-to-day work.

Provider and Staff Engagement

Organizations can demonstrate competency in this area by engaging staff and providers to answer questions and obtain their buy-in. When those with responsibility for implementing integration efforts have an opportunity to share concerns and feel that their leaders value their input, they may be more committed to making changes than if leadership does not consult them. Relatedly, leadership's efforts to adjust organizational culture may be necessary to accommodate integration efforts. It is important to have processes in place that help each team identify roles and responsibilities for each team member, as well as new skills that each may need to develop to successfully implement behavioral health and primary care integration.

Consideration for BHOs Serving Dually Eligible Individuals

- Can your organization identify and track the unique needs of dually eligible individuals?
- Can your organization track and monitor the care it provides specifically to dually eligible individuals and, if so, can it compare outcomes between the dually eligible and general populations?
- Are leadership and staff aware of specific challenges affecting dually eligible individuals? Does your organization have protocols in place to ensure it prioritizes those needs?
- Are your providers aware of which community wellness services are covered benefits for dually eligible populations? Do they exclusively refer dually eligible individuals for such covered benefits?

Section 3: Identifying the Population and Matching Care

Organizations can use a comprehensive screening tool to identify populations of interest and help match individuals' needs to the appropriate care. Once organizations decide on a target population (e.g., individuals with more than one chronic health condition, all individuals with diabetes, smokers), they can develop a strategy for reliably identifying and tracking those individuals. Screening tools are used to consistently identify individuals at risk for different health issues, in addition to identifying multiple conditions so providers can tailor individual services and treatment. The questions in this section help organizations consider their practices in three core operational capabilities:

- Screening
- Staffing for screening
- Identification of high-risk and high-need individuals and care matching

Screening (and Staffing for Screening)

BHOs competent in the Screening operational capability provide comprehensive, universal screening of the population that allows for identification of the individuals to receive focused tracking and intervention. Organizations competent in the Staffing for Screening operational capability designate an appropriate staff member to reliably carry out each function related to screening. Alternatively, BHOs may also choose to designate a group of staff members to take on this task in addition to their clinical responsibilities.

Begin by assigning staff members to carry out different functions related to screening. Depending on the components of the screening, these functions can be performed by different staff, including a behavioral health care provider, behavioral health care-specific nurse, social worker, medical assistant, primary health care nurse, or PCP (physician, nurse practitioner, or physician assistant).

Identification of High-Risk and High-Need Individuals and Care Matching

Organizations competent in this operational capability use screening results and other data to segment the population into groups based on care needs.

After identifying individuals within the target population, BHOs can match care needs with appropriate services. Successful organizations must be able to take the results of the screening and identify different sub-populations, as well as conditions that need to be addressed at the individual and aggregate levels. Treatment and recovery support goals are set for each individual, based on their existing conditions and their assessed risk for other health concerns. Depending on the organization, the population may be narrower (e.g., individuals with diabetes) or broader (e.g., individuals with multiple conditions).

Consideration for BHOs Serving Dually Eligible Individuals

- Are resources available to staff about network providers accepting new dually eligible beneficiaries in case of a referral? Are protocols in place for a warm hand-off to support dually eligible beneficiaries through the process of connecting to care?

Section 4: Assessing the Optimal Integration Approach

There is no "right" way to integrate care; the process and degree of integration will be specific to each organization. The appropriate approach will depend on an organization's aims, resources, capacity, and financial arrangements.

Questions in this section are intended to assess an organization's current capability to implement one of three integration approaches. These approaches are intended to serve as useful anchor points. In many cases, the elements included in each approach are not mutually exclusive or are interdependent:

- Coordinated care, including enhanced communication among providers
- Co-located primary care services
- Integrated primary care capability

Questions in this section align with each of these approaches.

There are various ways that an organization can approach this section:

- Answer questions for just one or up to all three of the integration approaches, depending upon the BHO's goals and interests. (Note that some common questions repeat in each approach).
- Answer questions related to key processes in each approach.
- For organizations experienced in integration and interested in improving processes, identify where and how to improve the reliability of processes already in place.

Coordinated Care

An organization working to integrate behavioral and primary care services coordinates with PCPs, community organizations, and other providers to address the health needs of their population. To accomplish this, a BHO can develop relationships with PCPs through contracts or by establishing informal networks of PCPs and specialty providers. BHOs also can develop relationships with community organizations that address the health, wellness, or social needs of individuals (e.g., YMCA, peer support centers, low-income housing advocates). It is helpful for BHOs to share as much data between providers as is permitted by state and federal privacy rules.

Organizations competent in this capability have behavioral health and primary health providers who seamlessly communicate with one another. Integrating care can add another layer of administrative burden to providers, so seamless communication between different types of providers is integral to providing high quality, integrated care.

Reflecting on Section 1 (Understanding Your Population), this integration approach may be most appropriate if an organization serves a relatively small population with few primary care needs. In addition, this integration approach works well if a high percentage of the organization's population already has a PCP and feels connected to that provider.

While responding to these questions in the BHICA Tool, users may find it helpful to include in the "notes" column the individual or provider type that is responsible for each task. If a task is not currently included in an organizational process, consider noting the individual or provider type that might be responsible for this work.

Co-Located Primary Care Services

An organization that provides behavioral health services may also integrate care by being on the same site or campus with a PCP or FQHC. In this approach, the co-located organizations provide team-based care with referrals between behavioral care providers and PCPs and, when possible, warm hand-offs (i.e., providers either in person or over the phone introducing the individual to the other provider at the time of the individual's visit). The co-located organizations share as much data and information as possible.

Reflecting on Section 1 (Understanding Your Population), this integration approach may be appropriate if an organization serves a population in a relatively small geographic area and the individuals seen by the organization have moderate health needs. In addition, this approach may be appropriate if a moderate number of individuals have identified a PCP, but a small percentage of individuals report a meaningful connection to their provider.

Integrated Primary Care Capability

A BHO can hire PCPs, permanently or on a contract basis, to address the physical health needs of individuals seen by the organization. In this scenario, the BHO offers on-site general screening and wellness checks either by scheduled or walk-in appointments. Behavioral and physical health providers work together to comprehensively address each individual's health care needs.

As you reflect on Section 1 (Understanding Your Population), this integration approach may be appropriate if a high percentage of the population served has significant physical and behavioral health needs. In addition, this approach may be appropriate if a small percentage of individuals served by the organization have identified PCPs, and if these individuals report that they do not feel connected to their provider.

Section 5: Financing Integration

A common challenge in implementing a new integration effort is the lack of a sustained financial model to support it. When assessing which integration approach is most appropriate, BHOs should consider the financial issues or opportunities specific to that approach. Organizations may need to strategize on creative and collaborative financing solutions. For additional information, consider reading the business case resources in Appendix B, which are summarized below.[37,38] Note: the direction of integration in these resources (i.e., behavioral health into primary care) do not diminish their applicability for BHOs seeking to integrate primary care into their practices.

The Business Case for the Integration of Behavioral Health and Primary Care proposes the following equation for integrating behavioral health into primary care: Cost of Screening (S) + Cost of Intervention Services (I) + Transition Costs (T) must be less than or equal to Screening Reimbursement (X) + Productivity Gains (P) + Reimbursement for Treatment.®

- Estimating reasonable parameters for each of these elements can help organizations judge the financial viability of integration efforts.

The Behavioral Health Integration into Primary Care: A Microsimulation of Financial Implications for Practices details useful steps to promote behavioral health integration, including key steps to take prior to approaching payers regarding reimbursement practices.

- Research that modeled the financial implications of behavioral health integration into primary care with FQHCs found that the financial viability of integration depended on the approach. This implies the need for creative and thoughtful consideration of the financial implications of integration.

This section is intended to help guide conversations and planning within the organization. When going through these questions, an organization should consider both primary care and behavioral health functions. Please use the "notes" column in the BHICA Tool to capture any insights or clarifications around each item.

Consideration for BHOs Serving Dually Eligible Individuals

- Are there any unique funding opportunities or considerations when working with dually eligible populations?
- Are there any unique funding challenges with integrating care for dually eligible populations?
- What strategies might your organization use to support integrated financing for dually eligible populations?

Appendices

Appendix A: BHICA Assessment Questions

Section 1: Describe the Population You Serve

Section Number	Question Text
1.1	Total number of individuals seen in past 12 months:
1.2	Total number of visits in past 12 months:
1.3	Average proximity of individuals to your organization:
1.4	Most prevalent (top five) mental health diagnoses:
1.5	Most prevalent (top five) substance use disorder diagnoses (for the purpose of this data collection, please include tobacco and alcohol):
1.6	Most prevalent physical health diagnoses for all individuals seen in your organization (e.g., cardiovascular disease, diabetes, asthma, etc.):
1.7	Percentage of your population with multiple chronic conditions (e.g., diabetes, kidney disease, coronary heart disease, etc.):
1.8	Percentage of your population with long-term (>6 months) treatment with antidepressants, mood stabilizers, or antipsychotic drugs:
1.9	Percentage of your population receiving long-term (>6 months) sedative-hypnotic drugs such as benzodiazepine or sleeping pills such as zolpidem:
1.10	Percentage of your population receiving long-term (>6 months) opioid management for chronic pain:
1.11	Percentage of your population receiving long-term substance use disorder treatment medications:
1.12	Percentage of your population with stable, affordable, permanent housing:[39]
1.13	Percentage of your population currently working (separately report full-time and part-time percentages):
1.14	Percentage of your population that does not have a primary care provider (PCP): *Providers can obtain this information either directly from an individual's self-report at intake or by analyzing proxy indicators in claims data (e.g., calculating excess emergency department utilization).*
1.15	Percentage of your population that reports not having a connection to a PCP: *Providers can obtain this information directly by asking upon intake if individuals feel they have a "meaningful connection" to a PCP—or by asking individuals to rank on a scale of 1-5 the quality of their relationship with their PCP. Such subjective measures provide insight into an individual's likelihood to seek primary care services in the community. Providers can also obtain quantitative data by asking individuals for the number of return visits to the same PCP.*

Section Number	Question Text
1.16	Total number of individuals seen in your organization who visited the emergency department (ED) within the last year: Total number of ED visits: Number of patients admitted to the hospital from the ED: *This information is available in electronic health records (EHRs) or from individuals' PCPs.*

Section 2: Assessing Your Infrastructure

Section 2.1: Capacity to Collect Data, Exchange Information, and Monitor Population Health

Section Number	Question Text
2.1.1	Does your organization routinely collect individual-level data? *For example, data on an individual's visits, diagnoses, and clinical outcomes.*
2.1.2	Does your organization routinely aggregate individual-level data? *For example, does it compile individual-level data to assess how well it is meeting treatment and recovery goals for all individuals seen in your organization.*
2.1.3	Does your organization record the name of an individual's primary care provider (PCP)?
2.1.4	Does your organization record the date of an individual's last primary care visit?
2.1.5	Does your organization record progress notes or information on the nature of an individual's last primary care visit?
2.1.6	Does your organization record the name of an individual's home and community-based supports?
2.1.7	Does your organization record the number of times an individual has been hospitalized in the past year for both psychiatric and medical reasons?
2.1.8	Does your organization record the number of times an individual has visited an emergency department (ED) in the past year for both psychiatric and medical reasons?
2.1.9	Does your organization securely exchange information with other organizations that provide health care services to a mutual individual? *For example, through secure messaging or faxing.*
2.1.10	Does your organization use an EHR? *If your organization does not use an EHR, skip to Section 2.2.*
2.1.11	Does your organization's EHR meet meaningful use criteria under the Medicare Promoting Interoperability Program?
2.1.12	Can your organization track chronic conditions in the EHR?
2.1.13	Can your organization's EHR interface with external systems?

Section Number	Question Text
2.1.14	Does your organization generate clinical care and recovery-oriented service reports for each individual? *These reports would contain clinical information (e.g., symptoms, diagnoses, and treatment), not service utilization data, and would be available for each individual to keep for their personal records.*
2.1.15	Does your organization participate in your state's Health Information Exchange?
2.1.16	Does your organization participate in a secure, shared electronic messaging service?

Section 2.2: Progress and Outcome Tracking Capability

Section Number	Question Text
2.2.1	Does your organization track medication use?
2.2.2	Does your organization track medication adjustments or changes?
2.2.3	Does your organization track medication fills?
2.2.4	Does your organization track lab work? *This includes tracking the results of lab work.*
2.2.5	Does your organization track communication of results to and follow-up with individuals?
2.2.6	Does your organization track an individual's changes in health outcomes? *For example, changes in blood pressure, cholesterol, body mass index (BMI), or blood sugar.*
2.2.7	Does your organization track an individual's changes in health behaviors? *For example, tobacco use.*
2.2.8	Does your organization track measures of self-reported health outcomes for an individual seen within your organization? *For example, "How's Your Health" questions.*
2.2.9	Does your organization track an individual's changes in substance use behaviors? *For example, urine drug screening results.*
2.2.10	Does your organization track an individual's changes in behavioral health outcomes? *For example, a self-reported change in depressive symptoms.*
2.2.11	Does your organization use the data it collects to assess performance with care delivery?

Section Number	Question Text
2.2.12	Does your organization use individual-level data it collects to determine what improvements or adjustments to make in clinical care or organizational processes?
2.2.13	Does your organization track an individual's measures related to satisfaction with services received? *This includes an individual's perception of or experience with services they receive.*
2.2.14	Does your organization track provider satisfaction measures?
2.2.15	Does your organization provide trauma-informed care as an approach for behavioral health treatment? *For example, reframing questions to find a solution within the context of the individual's history of trauma and avoiding retraumatizing interactions and events.*

Section 2.3: Process for Engaging and Communicating with Individuals, Family Members, and Natural Supports

Section Number	Question Text
2.3.1	Do providers (e.g., behavioral health clinicians, PCPs) engage with an individual or family about setting treatment goals?
2.3.2	Do providers (e.g., behavioral health clinicians, PCPs) communicate with an individual or family about progress towards treatment and recovery support goals?
2.3.3	Do providers (e.g., behavioral health clinicians, PCPs) communicate with an individual or family about medication compliance, Activities of Daily Living, and functional changes?
2.3.4	Do providers (e.g., behavioral health clinicians, PCPs) communicate with an individual or family about diagnoses, level of disability, and level of functioning?
2.3.5	Do providers (e.g., behavioral health clinicians, PCPs) include the individual or family in developing the treatment and recovery support plan?
2.3.6	Do providers (e.g., behavioral health clinicians, PCPs) communicate with an individual or family about key changes to their diagnoses or treatment and recovery support plans?
2.3.7	Do providers (e.g., behavioral health clinicians, PCPs) communicate with an individual or family about missed appointments?
2.3.8	Is there a process to train providers in skills to facilitate engagement such as motivational interviewing (MI)? *Please see Appendix B: Additional Resources by Resource Type (RIC Resources) for additional resources on MI.*

Section Number	Question Text
2.3.9	Is there a system to encourage involvement of individuals and families in ongoing treatment and recovery support activities? *For example, a staff member who calls to remind individuals and families about a group support session.*
2.3.10	Is information about an individual's condition available in multiple formats and provided to the individual in a way that they can understand? *For example, multiple formats might include verbal and written communications, and ensuring that individuals can understand might include using different languages and appropriate reading levels.*
2.3.11	Are Health Insurance Portability and Accountability Act (HIPAA) provisions and consents for sharing protected information in place? *This may include HIPAA protections or other state regulations.*
2.3.12	Does your organization inform individuals of their rights regarding the sharing of information?

Section 2.4: Capacity to Provide Clients with Community Wellness Resources

Section Number	Question Text
2.4.1	Does your organization provide individuals with materials to encourage them to ask providers about physical health problems? *For example, posting signs on exam room walls or making brochures available in waiting rooms or exam rooms.*
2.4.2	Do providers engage individuals in identifying life goals? *There is no need to distinguish between physical, behavioral, spiritual, personal, or professional goals.*
2.4.3	Does your organization support individuals in the self-management of their chronic conditions? *For example, providing consumers options for therapeutic interventions at the appropriate literacy level and in the appropriate language. Please see Appendix B for additional resources on self-management support.*
2.4.4	Does your organization offer wellness programs? *For example, smoking cessation or exercise programs.*
2.4.5	Does your organization maintain a list of local wellness activities that would be appropriate for individuals with mental illness? *For example, yoga classes tailored to individuals with mental illness or other activities such as exercise classes.*

Section 2.5: Culture to Support Integration

Section 2.5.1: Leadership Culture

Section Number	Question Text
2.5.1.1	Leaders actively support the concepts of integration. *Consider your organization's integration champions.*
2.5.1.2	Moving towards integrated care is a key component of your organization's strategic plan.
2.5.1.3	Leaders believe their involvement in primary care is required to optimally care for individuals with complex needs. *Individuals with complex needs have a high level of medical and social need, often have multiple chronic conditions, and have limited access to resources to assist in managing their care.*
2.5.1.4	Your organization has a means for providers to systematically learn from each other. *For example, your organization has periodic team meetings to share successes and failures in a larger setting.*
2.5.1.5	Your organization identifies staff training needs for individuals and teams.
2.5.1.6	Your organization meets identified training needs.
2.5.1.7	Your organization offers ongoing primary care education for behavioral health providers to enhance mutual understanding and knowledge.
2.5.1.8	Your organization's policies allow for flexibility in job roles. *For example, some organizations that have unionized staff or very rigid job descriptions may struggle in implementing integrated care as employees must be cross-functional across job categories.*
2.5.1.9	Your organization hires staff members who are qualified with the requisite skill set to work in an integrated environment. *For example, flexible and collaborative thinkers, staff who focus on whole health, or staff who are cross-trained in behavioral health and primary care environments.*
2.5.1.10	Leaders recognize the need to train the current workforce to meet the needs of individuals and your organization.
2.5.1.11	Leaders encourage active discussions about incorporating changes into your organization.
2.5.1.12	Leaders use standardized, data-driven processes to decide whether to change course or keep going with an existing program.
2.5.1.13	Your organization has a culture of shared leadership, with everyone taking responsibility for change and improvement.
2.5.1.14	Leaders promote the use of evidence-based tools, instruments, and processes to support clinical improvements of individuals.

Section Number	Question Text
2.5.1.15	Financial leaders are involved in creating the business plan for increased integration.
2.5.1.16	Leaders consistently show commitment to organizational transformation.
2.5.1.17	Leaders work to engage all staff in integration.

Section 2.5.2: Provider and Staff Engagement

Section Number	Question Text
2.5.2.1	Staff members have a basic understanding of the principles of integration.
2.5.2.2	Staff members would feel comfortable working with a member of the primary care team in designing a joint treatment and recovery support plan.
2.5.2.3	Staff members are willing to make changes to their work habits to accommodate offering integrated services.
2.5.2.4	Staff members embrace a whole person approach to care.

Section 3: Identifying the Population and Matching Care

Section 3.1: Screening

Section Number	Question Text
3.1.1	Does your organization screen for a full range of mental health and substance use issues and concerns? *For example, alcohol and opiates use.*
3.1.2	If your organization does not directly provide substance use treatment services, does your organization use the Screening, Brief Intervention, and Referral to Treatment approach to ensure effective and timely referral to treatment for an individual experiencing substance use issues?
3.1.3	Does your organization screen for physical health conditions? *For example, diabetes and hypertension.*
3.1.4	Does your organization collect information on general health measures? *For example, body mass index (BMI) and blood pressure.*

Section Number	Question Text
3.1.5	Does your organization collect information on social determinants of health? *For example, homelessness, employment status, and social relationships.*
3.1.6	Does your organization follow screening guidelines for behavioral or physical health issues?
3.1.7	Do staff discuss the results of these various screening and data collection efforts with individuals served by your organization and, if appropriate, family members?
3.1.8	Does your organization record care utilization information in a central place where all providers can access the information? *Care utilization might include emergency department (ED) visits or hospitalizations.*
3.1.9	Does your organization update screening data regularly?

Section 3.2: Staffing for Screening

Section Number	Question Text
3.2.1	Is a staff member assigned to administer a comprehensive intake assessment? *A comprehensive intake may include information about physical health, mental health, substance use, and social needs.*
3.2.2	Is a staff member assigned to administer physical health screenings? *For example, taking blood pressure, listening to the heart and lungs, finger sticks to check blood sugar, and BMI evaluations.*
3.2.3	Is a staff member assigned to interpret data from completed screenings?
3.2.4	Is a staff member assigned to notify all relevant providers that reports are available?
3.2.5	Are screening data readily available to inform an individual's care and support services?
3.2.6	Does your organization provide individuals with the results of the screening tests?

Section 3.3: Identification of High-Risk and High-Need Individuals and Care Matching

Section Number	Question Text
3.3.1	Does your organization identify which individuals appear to have the most complex care needs? *For example, individuals with high ED use or multiple chronic conditions.*

Section Number	Question Text
3.3.2	Can your organization segment the population into different levels of need? *For example, by severity of illness or access to primary care.*
3.3.3	Does your organization tailor services to a population or condition-specific segments of a population?
3.3.4	Does your organization assess progress for an individual with complex needs? *For example, your organization is able to measure improvements in the overall population for certain conditions or health outcomes, such as diabetes.*

Section 4: Assessing the Optimal Integration Approach

Section 4.1: Coordinated Care

Section 4.1.1: Referral and Communication with Community Organizations and Peer Support Agencies

Section Number	Question Text
4.1.1.1	Does your organization partner with community organizations to connect people with population-specific wellness activities? *For example, nutritionists, gyms, or virtual options.*
4.1.1.2	Does your organization follow up on referrals to community organizations?
4.1.1.3	Do community organizations give feedback to providers about individuals?
4.1.1.4	Does your organization refer individuals to peer support agencies, groups, or organizations?[†] *The referral may be to internal or external resources.* *If no, please skip to Section 4.1.2.*
4.1.1.5	Does your organization follow up on referrals to peer support agencies?
4.1.1.6	Are peer support services, groups, and organizations a part of an individual's care? *For example, peer support agencies may share information with providers that might include medication adherence or how well individuals perceive their treatment to be working.*

[†] A peer support agency provides services by and for individuals with mental illness to help with their recovery. Peer support for substance use disorders includes programs like the 12-Step Program, as well as cognitive behavioral therapies, such as SMART Recovery.

Section 4.1.2: Referrals to and Relationships with Physical Health Resources and Tertiary Care Providers

Section Number	Question Text
4.1.2.1	Does your organization refer individuals to primary care providers (PCPs)?
4.1.2.2	If yes, does your organization follow up on referrals to PCPs?
4.1.2.3	Do providers talk with individuals about the release of their information when making a referral?
4.1.2.4	Do providers contact local PCPs for advice about treating an individual? *This question refers to general information sharing rather than specific information about an individual.*
4.1.2.5	Do providers share an individual's history with the PCPs? *For example, diagnoses, medications, and current treatment plans.*
4.1.2.6	Do providers ask individuals about preventative health screenings? *For example, whether they have received flu shots or mammograms.*
4.1.2.7	Does your organization prompt providers to ask about specific services? *For example, an office visit protocol or medical record prompt to remind providers to ask individuals whether they have received preventative or other important health services.*
4.1.2.8	Does your organization track which individuals successfully make it to their referred appointment?
4.1.2.9	Does your organization consistently track progress related to an individual's medical needs? *For example, staff members receive and review updates on an individual's physical health conditions during a visit.*
4.1.2.10	Does your organization help individuals schedule appointments with community care providers, such as PCPs or specialists?

Section 4.1.3: Build Relationships and Exchange Information with PCPs

Section Number	Question Text
4.1.3.1	Does your organization have a formal agreement to share information with a PCP(s) or organization?
4.1.3.2	Does your organization provide individual information to the PCP when the PCP is involved in an individual's care? *For example, patient history, care plan, labs, and medications.*
4.1.3.3	Does your organization have an informed consent process through which individuals agree that their health information can be shared?

Section Number	Question Text
4.1.3.4	Does your organization have a financial relationship for service provision with a PCP(s)?
4.1.3.5	Does your organization have a written memorandum of understanding (MOU) with a PCP(s)? *The MOU defines clear roles and responsibilities for the partnership.*
4.1.3.6	Does your organization share relevant labs and exam findings with PCPs?
4.1.3.7	Does your organization share medication lists or formularies across providers?
4.1.3.8	Do multiple providers contribute to a shared care, treatment, and recovery support plan for each individual?
4.1.3.9	Does your organization track the progress of individuals after a referral?
4.1.3.10	Does your organization follow up with the individual to relay information and recommendations from the referral and help the individual act on it?

Section 4.1.4: Assist Individuals Without PCPs

Section Number	Question Text
4.1.4.1	Does your organization provide information about local PCPs who are taking new patients?
4.1.4.2	Does your organization provide information about which providers accept Medicare, Medicaid, or uninsured individuals?
4.1.4.3	Does your organization include information about organizations that serve a high number of individuals with mental illness?
4.1.4.4	Does your organization track referrals made for individuals without a current PCP?
4.1.4.5	Does your organization track time between referral to primary or specialty care and initiation of treatment?

Section 4.1.5: Enhanced Communication Among Providers

Section Number	Question Text
4.1.5.1	Is there a systematic communication strategy established among team members to communicate about individuals? *For example, electronic health record (EHR) capabilities, email capability, regular team meetings, daily huddles.*
4.1.5.2	Is an individual's treatment plan for behavioral health and primary care integrated and available to all providers on the individual's care team?
4.1.5.3	Do providers communicate with each other about progress toward treatment and recovery support goals?

Section Number	Question Text
4.1.5.4	Do providers communicate with each other about diagnoses?
4.1.5.5	Do providers communicate about missed appointments or referrals?
4.1.5.6	Do providers communicate about changes in diagnoses or treatment plans?
4.1.5.7	Does your organization's EHR contain all records, including behavioral health records, and is it fully integrated with little or no separation among specialties?

Section 4.2: Co-Located Primary Care Services

Section 4.2.1: Access to Primary Care Services

Section Number	Question Text
4.2.1.1	Is there central coordination of scheduling between behavioral health and primary care?
4.2.1.2	Does your organization provide a warm hand-off to primary care? *A warm hand-off occurs when the behavioral health provider directly introduces the individual to the PCP at the time of the individual's visit, which can be done in person or over the phone.*
4.2.1.3	Do behavioral health and PCPs contribute to a shared care and treatment plan for each individual?
4.2.1.4	Is your organization in close physical proximity to a PCP? *For example, the same building or a nearby building.*

Section 4.2.2: Provide Navigation and Care Coordination Services

Section Number	Question Text
4.2.2.1	Is there someone who assists individuals in accessing an array of services within and outside your organization? *Every organization defines this role differently. This may be called a care manager, case manager, care coordinator, outreach worker, health navigator, peer support specialist, or practice coach, and the person is either paid directly by your organization or by a third party, such as a health plan or other health care provider entity.* *If your organization does not have an individual in this role, please skip to Section 4.3.*
4.2.2.2	If yes to 4.2.2.1, is this person on-site?
4.2.2.3	Is there someone that assists individuals in managing medical conditions and related psychosocial problems more effectively?

Section Number	Question Text
	For example, a staff person may help an individual improve nutritional habits to manage their diabetes.
4.2.2.4	Does this person engage with individuals around medical issues?
4.2.2.5	Does this person communicate information between physical and behavioral health providers?
4.2.2.6	Does this person or someone else connect people with the health care and social service resources they need, with the aim of increasing the appropriate use of services and integrating services? *This role helps bridge physical and behavioral health care through techniques such as outreach, care coordination, personalized health coaching, or supported self-management. This person may be called a navigator and be paid directly by your organization or by a third party, such as a health plan or other health care provider entity.*

Section 4.3: Integrated Primary Care Capability

Section 4.3.1: Provide Navigation and Care Coordination Services

Section Number	Question Text
4.3.1.1	Can you identify a staff person who facilitates access for individuals to an array of services within and outside your organization? *Every organization defines this role differently. This may be called a care manager, case manager, care coordinator, outreach worker, health navigator, peer support specialist, or a practice coach, and the person is either paid directly by your organization or by a third party, such as a health plan or other health care provider entity.* *If your organization does not have an individual in this role, please skip to Section 4.3.2.*
4.3.1.2	If yes to 4.3.1.1, is this person on-site?
4.3.1.3	Does this person or someone else assist individuals in managing medical conditions and related psychosocial problems? *For example, a staff person may help an individual improve nutritional habits to manage their diabetes.*
4.3.1.4	Does this person engage with individuals around medical issues?
4.3.1.5	Does this person communicate information between physical and behavioral health providers?
4.3.1.6	Does this or a different person connect people with the health care and social service resources they need to increase appropriate use of services and to integrate services? *This role helps bridge physical and behavioral health care through techniques such as outreach, care coordination, personalized health coaching, and supported self-*

Section Number	Question Text
	management. This person may be called a navigator and be paid directly by your organization or by a third party, such as a health plan or other health care provider entity.
4.3.1.7	Is there physical proximity between behavioral health staff and the medical staff?

Section 4.3.2: Screening Functions

Section Number	Question Text
4.3.2.1	Does your organization take an individual's blood pressure during each encounter?
4.3.2.2	Does your organization measure an individual's height and weight?
4.3.2.3	Does your organization screen for substance use disorders or illicit drug use? *Screening could include substance use questionnaires or blood or urine screens.*
4.3.2.4	Does your organization offer on-site lab services?
4.3.2.5	Does your organization have the capacity to draw blood?
4.3.2.6	Does your organization have the capacity to use a finger stick to draw blood?
4.3.2.7	Does your organization send out bloodwork for lab services?

Section 4.3.3: Provide Primary Care Services

Section Number	Question Text
4.3.3.1	Does your organization offer preventative screenings? *For example, body mass index (BMI), cholesterol, or blood pressure screenings.*
4.3.3.2	Does your organization offer preventative vaccinations? *For example, flu shots.*
4.3.3.3	Do behavioral health and primary care providers contribute to a shared care and treatment plan for each individual?
4.3.3.4	Do behavioral health and medical providers meet regularly to discuss individual cases?
4.3.3.5	Does your organization offer on-site pharmacy services? *On-site pharmacy services are licensed and may be operated directly by or independently from your organization.*

Section 4.3.4: Space, Supplies, and Materials

Section Number	Question Text
4.3.4.1	Does your organization have needed materials to provide primary care services?

Section Number	Question Text
	For example, disposable needle containers, gloves, gowns, blood pressure cuff and monitors, stethoscopes, thermometers, alcohol pads, face masks, cotton swabs, cotton balls, otoscopes, ophthalmoscopes, gauze, medical tape, hand sanitizer, a refrigerator, a sink in offices or exam rooms, exam room tables, examination lights, wiring for Internet access, computers, a printer, a telephone.
4.3.4.2	Does your organization meet state and county licensing requirements for providing primary care? *Many states and counties have specific requirements around providing primary care, which include parameters for the physical space itself (e.g., number of doors, locations of bathrooms). An organization must understand and meet these requirements.*
4.3.4.3	Does your organization have space that can accommodate the activities and equipment necessary to provide primary care? *For example, exam tables and sinks.*
4.3.4.4	Is your organization compliant with the Americans with Disabilities Act?[‡]

Section 4.3.5: Access to Primary Care Services

Section Number	Question Text
4.3.5.1	Does the practice offer expanded hours for primary care services?
4.3.5.2	Does the practice have secure messaging capability between individuals and providers?
4.3.5.3	Do individuals know there are different services on-site? *For example, individuals are aware that they can see a PCP when they are present for a behavioral health visit.*

Section 5: Financing Integration

Section Number	Question Text
5.1	Has your organization identified billing procedures and related processes for each integration-related billing activity?
5.2	Does your organization participate in integration-related activities that are not billable?
5.3	If yes, how are these services financed?
5.4	Are the costs (direct and indirect) of the integrated care program known and tracked?
5.5	Are appropriate billing codes available to the staff who use them?

[‡] More information on the ADA and its standards for accessible design is available at https://www.ada.gov/law-and-regs/design-standards/.

Section Number	Question Text
5.6	Does your organization structure its staffing model so that individuals work "at the top of their license," that is, they perform the highest complexity work that they are credentialed to perform? *For example, psychiatrists spend the majority of their time on what only psychiatrists can do, and various support staff perform other critical functions that do not require a psychiatric credential.*
5.7	Does your organization structure its staffing model and billing procedures to maximize billing opportunities? *For example, billable staff spend the majority of their time on billable activities while various non-billable staff perform other critical functions that are non-billable.*
5.8	Does your organization track billing and monitor payment and denials?
5.9	Does your organization have a relationship with a hospital or health system that is participating in an Accountable Care Organization?
5.10	Is your organization involved in any value based or alternative payment models with payers?
5.11	Is your organization aware of demonstrations or initiatives in the state or region that might be applicable to integration efforts? *See Appendix B: Additional Resources by Resource Type (Glossary or Program Definitions) for additional resources.*
5.12	Is your organization aware of federal rules, regulations, and incentives to integrate care?
5.13	Is your organization aware of any relevant Medicaid waivers received by the state?
5.14	Does your organization collect information on current use of acute care services (e.g., readmissions or emergency department (ED) visits) to build a business case that increased primary care use can decrease overall health care costs?

Appendix B: Additional Resources by Resource Type

This appendix includes additional resources that may be helpful to organizations interested in integrating behavioral health and primary care. The BHICA section (that is, either A. Pre-Assessment Background and Framing or B. A Roadmap for Using the BHICA) to which a resource is relevant is marked below using a check mark (✓). The tables below list the name of the resource, offer a brief description, and identify sections within the BHICA (i.e., in Part A or Section 1 through 5 of Part B) relevant to that resource. Note the topic of each Part B section from the table below.

Section 1: Understanding Your Population
Section 2: Assessing Your Infrastructure
Section 3: Identifying the Population and Matching Care
Section 4: Assessing the Optimal Integration Approach
Section 5: Financing Integration

Glossary or Program Definitions

The following resources provide program information and helpful definitions for terms and Centers for Medicare & Medicaid Services programs that are referenced throughout the BHICA.

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
MedPAC MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid	This 2023 data book contains information about beneficiaries dually eligible for Medicare and Medicaid, such as demographic, eligibility, and enrollment characteristics; program spending and benefits utilization trends; and health status using national Medicare and state-level Medicaid program data sources.	✓	✓		✓		✓
Housing and Urban Development Affordable Housing Glossary	This resource provides a glossary of terms used when describing affordable housing.		✓				
Medicaid Section 1115 Demonstrations	This website contains policy information to support navigating state-level program provisioning						✓

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
	within Medicaid and the Children's Health Insurance Program.						
Medicare Demonstrations	This resource provides information about the Center for Medicare and Medicaid Innovation's demonstration projects and model tests to measure the effect of potential program changes. The demonstrations and model tests study the likely impact of new methods of service delivery, coverage of new types of service, and novel payment approaches on beneficiaries, health care providers, health plans, states, and the Medicare Trust Funds.						✓
ADA Standards for Accessible Design	This page provides resources and guidance on standards and requirements for accessible building design that are compliant with the Americans with Disabilities Act.					✓	
2023 Medicare Promoting Interoperability Program Overview	This presentation describes updates to the Medicare Promoting Interoperability Program, including electronic health record meaningful use criteria, payment and reporting adjustments, scoring calculation, and additional requirements.			✓			

Financial Resources

The following financial resources provide organizations with information to support the business case for integrating behavioral health and physical health. An organization seeking more information regarding the feasibility of primary care integration should reference the two sources below to determine applicability, dependent upon care setting.

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
The Business Case for Behavioral Health Care	This guide explains a business case equation to support behavioral health integration.						✓
The Business Case for Bidirectional Integrated Care	This paper is intended to provide strategies to improve the health of the population, enhance the individual experience of care (including quality, access, and reliability), and reduce, or at least control, the per capita cost of total health care.						✓

Quality Improvement

The following quality improvement tools will support the reliability improvement of organizational processes by leveraging the results of an assessment and creating actionable next steps to overcome barriers.

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
National Council for Mental Wellbeing Quality Improvement Toolkit	Using the Plan-Do-Study-Act (PDSA) model, this toolkit supports a systematic approach to analyzing organizational performance to create measurable improvement by identifying ineffective or inefficient systems with the goal to improve an individual's experience and health outcomes.	✓		✓		✓	

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
IHI's Driver Diagram Tool[§]	A driver diagram is a visualization of steps and processes that "drive" or contribute to achieving project goals. It is useful for communicating about quality improvement projects to stakeholders.	✓		✓		✓	
Plan-Do-Study-Act (PDSA) Method	The PDSA method is a four-step process for breaking down project objectives into manageable steps that can be tested and improved before implementation.	✓				✓	
IHI "Seven Spreadly Sins"[++]	This resource describes seven common issues, or mistakes, facing quality improvement projects and strategies for overcoming them.	✓				✓	
IHI Quality Improvement Project Measures[++]	IHI's worksheet helps identify process, outcome, and balancing measures to support a complex organizations' quality improvement project.	✓				✓	

[§] All Institute for Healthcare Improvement (IHI) resources are available for no cost at https://www.ihi.org/. IHI may require a name, email, and organization name prior to downloading.

Integration and Implementation

The following resources provide a framework that can help guide an organization in pursuing next steps in integration and implementation after completing the BHICA.

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
Comprehensive Healthcare Integration (CHI) Framework	This resource developed by the National Council for Mental Wellbeing and the Medical Director Institute is an implementation guide to the integration of physical health and behavioral health and demonstrates the value of integrated service delivery.	✓		✓		✓	
Approaches to Integrating Physical Health Services into Behavioral Health Organizations	This Resources for Integrated Care (RIC) guide lays out a continuum of primary care and behavioral health integration, beginning with engaging individuals with significant mental illness in discussions about their physical health to full integration.			✓	✓	✓	
Integrating Behavioral Health Competency Within Disability-Competent Teams	This RIC webinar describes the prevalence and importance of addressing participant behavioral health needs and discusses strategies to facilitate timely communication and collaboration between behavioral health providers and disability-competent care teams.			✓	✓	✓	
Key Considerations for Integrating Peer Support Staff in Behavioral Health Organizations	This RIC tip sheet describes key steps and considerations for behavioral health organizations planning to integrate peer staff into their workforce.			✓	✓	✓	
Approaches to Supporting Self-management for Individuals with Serious	This RIC guide describes a continuum of primary care and behavioral health integration, beginning with engaging individuals with severe mental illness in discussions about			✓	✓	✓	

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
Mental Illness	their physical health to full integration.						
Toolkit for Designing and Implementing Care Pathways	This toolkit from the National Council for Mental Wellbeing includes guidance and tools to support an organizational framework for developing and deploying care pathways that align to individuals' needs.			✓	✓	✓	
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.				✓		
12-Step Program	This is a widely adopted program created by Alcoholics Anonymous and used as a treatment tool to help individuals understand the journey into, during, and after recovery.					✓	
Self-Management and Recovery Training (SMART)	This is an addiction recovery method emphasizing movement from addictive substances and negative behaviors to a life of positive self-regard and willingness to change.					✓	

RIC Resources

In addition to previously highlighted resources, the following table provides additional information from RIC to support successful care integration. The tools can be used as a learning opportunity for organizations or can be integrated into an organization's workflow.

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
Addressing Social Isolation and Loneliness Among Older Dually Eligible Individuals	This brief provides information, screening tools, and best practices for reducing the impact of social isolation or loneliness among older adults.				✓		
Podcast: *Foundations of Motivational Interviewing*	This episode explores how a broad range of providers can use motivational interviewing to engage individuals across behavioral health care, primary care clinic, and community settings.			✓			
Motivational Interviewing: Resource Guide	This resource provides information on how individuals working in a variety of settings, including frontline staff at health plans and health systems (e.g., care managers, care coordinators, community health workers), as well as primary care providers, can use motivational interviewing.			✓			
Webinar: *Promising Practices for Utilizing Motivational Interviewing to Improve Care Coordination and Address Social Determinants of Health*	This webinar explores how motivational interviewing can improve communication in integrated care settings and improve relationships between health plans, providers, and members dually eligible for Medicare and Medicaid; promote the increased utilization of motivational interviewing and person-centered techniques to better engage members and understand the complex lifestyle			✓			

Resource	Description	Part A	Part B: Section 1	Part B: Section 2	Part B: Section 3	Part B: Section 4	Part B: Section 5
	factors that impact health behaviors; and encourage the improvement of member retention rates as well as health outcomes for dually eligible individuals.						

Organizational Assessment Tools

Many assessment tools exist to support the integration of primary care and behavioral health. We highlight some tools below and describe when an organization might choose to use them to supplement the BHICA.

Resource	Description
Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration (OATI)	Behavioral health organizations (BHOs) looking to assess their work (especially on partnerships, person-centered care and customer service, administrative infrastructure or processes to support integration, and continuous quality improvement) can use assessments from this tool compendium to understand readiness and progress. These tools require time to implement but offer insights into what is needed to improve integration.
Integrated Practice Assessment Tool (IPAT)	BHOs looking for a high-level snapshot of their level of integration can use this eight-question tool to understand where practices are on the continuum of integration and track integration progress. This provides a quick score but will not provide guidance on steps needed to move to a higher level of integration.
MeHAF: Site Self-Assessment Survey	Organizations interested in understanding the extent of patient-centered primary and behavioral care integration along several dimensions can use this 18-question tool to identify where they are in the continuum of integration and track progress over time.
Self-Assessment Checklist for Integrating Behavioral Health and Ambulatory Care (Integration Self-Assessment Checklist)	BHOs can use this self-assessment checklist before, during, or after integration implementation to make plans and identify opportunities. The tool includes 37 questions and takes about 10 minutes to complete.
Practice Integration Profile	Organizations can use this tool to measure the integration of primary care and behavioral health services. Comprised of 28 questions, it assesses the continuum of integration in the following five domains:

Resource	Description
	Workspace and Integration Methods, Patient Identification, Clinical Services, Patient Engagement, and Practice Workflow.
Advancing Integration of General Health in Behavioral Health Settings	For a more in-depth look at integration and a specific focus on primary care integration into behavioral health, organizations can use this tool to identify where they are on the continuum of integrated care across nine domains: Screening/Referral/Follow-up; Evidence-Based care; Care Management; Self-Management Support; Multi-Disciplinary Team-Based Care; Linkages with Community/Social Services; and Sustainability. These nine domains are based on the evidence base in the literature on integrated care.

References

[1] National Council for Mental Wellbeing. (2022). *Designing, Implementing and Sustaining Physical Health-Behavioral Health Integration The Comprehensive Healthcare Integration Framework*. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2022/04/04.22.2022_MDI-CHI-Paper_Reduced.pdf.

[2] Balasubramanian, B. A., Cohen, et al. (2017). Outcomes of Integrated Behavioral Health with Primary Care. *Journal of the American Board of Family Medicine*, *30*(2), 130–139. Retrieved from https://doi.org/10.3122/jabfm.2017.02.160234.

[3] Ibid.

[4] Ross, K., Klein, B., Ferro, K., McQueeney, D., Gernon, R., & Miller, B. (2019). The Cost Effectiveness of Embedding a Behavioral Health Clinician into an Existing Primary Care Practice to Facilitate the Integration of Care: A Prospective, Case-Control Program Evaluation. *Journal of Clinical Psychology in Medical Settings, 26*(1), 59-67. Retrieved from https://doi.org/10.1007/s10880-018-9564-9.

[5] Scharf, D. M., Eberhart, et al. (2014). Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report. *Rand Health Quarterly, 4*(3), 6. Accessed from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5396204/.

[6] McGinty, E. E., Presskreischer, R., et al. (2021). Improving Physical Health Among People With Serious Mental Illness: The Role of the Specialty Mental Health Sector. *Psychiatric Services (Washington, D.C.), 72*(11), 1301–1310. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8570967/.

[7] Carney, C., Bitton, A., & Romano, P. (2022). Addressing Today's Steep Challenges of Providing High-Quality Behavioral Healthcare. *Agency for Healthcare Research and Quality*. Retrieved from https://www.ahrq.gov/news/blog/ahrqviews/high-quality-behavioral-healthcare.html.

[8] ATI Advisory. (2022). *A Profile of Medicare-Medicaid Dual Beneficiaries*. Retrieved from https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf.

[9] American Psychiatric Association. (n.d.). Learn About the Collaborative Care Model. Retrieved from https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn.

[10] Bouchery, E. E., Siegwarth, A. W., Natzke, B., Lyons, J. M., Ireys, H. T., & Doan, R. (2018). Implementing a Whole Health Model in a Community Mental Health Center: Impact on Service Utilization and Expenditures. *Psychiatric Services, 69*(10), 1075-1080. Retrieved from https://doi.org/10.1176/appi.ps.201700450.

[11] Pena, M. T., Mohamed, M., Burns, A., Biniek, J. F., Ochieng, N., & Chidambaram, P. (2023). A Profile of Medicare-Medicaid Enrollees (Dual Eligibles). *Kaiser Family Foundation.* Retrieved from https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.

[12] Kelly, L., & Soper, M. H. (2019). *Coordinating Physical and Behavioral Health Services for Dually Eligible Members with Serious Mental Illness.* Center for Health Care Strategies, Inc. Retrieved from https://www.chcs.org/media/UPMC-case-study_121119-1.pdf.

[13] MedPAC. (2023). *Medicare Payment Advisory Commission (MedPAC) Data Book, Febuary 2023*. Retrieved from https://www.medpac.gov/wp-content/uploads/2023/02/Feb23_MedPAC_MACPAC_DualsDataBook-WEB-508-SEC.pdf.

[14] MedPAC. (2010). *Aligning incentives in Medicare: Inpatient psychiatric care in Medicare: Trends and issues.* Retrieved from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun10_Ch06.pdf.

[15] Pena, Maria T. (2023).

[16] MACPAC. (2016) *Report to Congress on Medicaid and Chip: Integration of behavioral and physical health services in Medicaid.* Retrieved from https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf.

[17] MedPAC. (2023). *Medicare Payment Advisory Commission (MedPAC) Data Book, July 2023*. Retrieved from https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf.

[18] Ibid.

[19] Nagykaldi, Z., Littenberg, B., Bonnell, L., Breshears, R., Clifton, J., Crocker, A., Hitt, J….van Eeghen, C. (2023). Econometric evaluation of implementing a behavioral health integration intervention in primary care settings. *Translational behavioral medicine, 13(*8), 571–580. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10415735/.

[20] Ross, K. M., Gilchrist, E. C., Melek, S. P., Gordon, P. D., Ruland, S. L., & Miller, B. F. (2019). Cost savings associated with an alternative payment model for integrating behavioral health in primary care. *Translational behavioral medicine, 9*(2), 274–281. Retrieved from https://pubmed.ncbi.nlm.nih.gov/29796605/.

[21] Balasubramanian, Bijal A. (2017).
[22] Doyle, D., Emmett, M., Crist, A., Robinson, C., & Grome, M. (2016). Improving the care of dual eligible patients in rural federally qualified health centers: The impact of care coordinators and clinical pharmacists. *Journal of Primary Care & Community Health, 7*(2), 118–121. Retrieved from https://doi.org/10.1177/2150131915617297.
[23] Hu, J., Wu, T., Damodaran, S., Tabb, K. M., Bauer, A., & Huang, H. (2020). The Effectiveness of Collaborative Care on Depression Outcomes for Racial/Ethnic Minority Populations in Primary Care: A Systematic Review. *Psychosomatics, 61*(6), 632-644. Retrieved from https://www.sciencedirect.com/science/article/pii/S0033318220300608?via%3Dihub.
[24] Agency for Healthcare Research and Quality. (n.d.). Health Equity and Behavioral Health Integration. Retrieved from https://integrationacademy.ahrq.gov/products/topic-briefs/health-equity.
[25] Pena, Maria T. (2023). *See also:* Kuramoto-Crawford, J., & Zodet, M. (2014). Behavioral Health Conditions and Health Care Expenditures of Adults Aged 18 to 64 Dually Eligible for Medicaid and Medicare. *The CBHSQ Report*, 1–6. Substance Abuse and Mental Health Services Administration (US). Retrieved from https://pubmed.ncbi.nlm.nih.gov/27631062/.
[26] MedPAC. (2023). *A Data Book: Health care spending and the Medicare program*. Retrieved from https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_Sec4_SEC.pdf.
[27] Schrager, S. (2021). Integrating behavioral health improves patient outcomes and makes medical practice more satisfying. Here's one way to do it. *Fam Pract Manag., 28*(3), 3-4. Retrieved from https://www.aafp.org/pubs/fpm/issues/2021/0500/p3.html.
[28] White House Press Room. (2022). FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union. Retrieved from https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/.
[29] ASPE. (2022). *HHS Roadmap for Behavioral Health Integration*. Retrieved from https://www.aspe.hhs.gov/sites/default/files/documents/4e2fff45d3f5706d35326b320ed842b3/roadmap-behavioral-health-integration.pdf.
[30] Becerra, X., Palm, A., Haffajee, R. L., Contreras, J., Barkoff, A., O'Connell, D., Valdez, R. O…. Murthy, V. H. (2022). Addressing The Nation's Behavioral Health Crisis: An HHS Roadmap to Integrate Behavioral Health. *Health Affairs Forefront.* Retrieved from https://www.healthaffairs.org/content/forefront/addressing-nations-behavioral-health-crisis-hhs-roadmap-integrate-behavioral-health.
[31] National Council for Mental Wellbeing. (2022).
[32] SAMHSA-HRSA Center for Integrated Health Solutions. (2013). *A Standard Framework for Levels of Integrated Healthcare.* Retrieved from https://thepcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf.
[33] Ibid.
[34] New York State Office of Mental Health. (n.d.). Integrated Services. Retrieved from https://omh.ny.gov/omhweb/clinic_restructuring/integrated-services.html.
[35] New York State Office of Mental Health. (n.d.). Health and Recovery Plans. Retrieved from https://omh.ny.gov/omhweb/bho/harp.html.
[36] SAMHSA. (2022). *Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria-2022.pdf.
[37] SAMHSA-HRSA Center for Integrated Health Solutions. (2013). *The Business Case for the Integration of Behavioral Health and Primary Care*. Retrieved from https://med.fsu.edu/sites/default/files/userFiles/file/SAMHSA_Business_Case_for_Behavioral_Health_Care_Monograph.pdf.
[38] Basu, S., Landon, B. E., Williams, J. W., Jr., Bitton, A., Song, Z., & Phillips, R. S. (2017). Behavioral Health Integration into Primary Care: a Microsimulation of Financial Implications for Practices. *Journal of General Internal Medicine, 32*(12), 1330-1341. Retrieved from https://doi.org/10.1007/s11606-017-4177-9.
[39] The U.S. Department of Housing and Urban Development. (2011). Glossary of Terms to Affordable Housing. Archived. Retrieved from https://archives.hud.gov/local/nv/goodstories/2006-04-06glos.cfm. The U.S. Department of Housing and Urban Development's glossary defines "affordable" as housing on which an occupant pays no more than 30 percent of gross income to cover all housing costs, including utilities. Some jurisdictions may offer other definitions.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. For additional information, please go to https://www.resourcesforintegratedcare.com/. The list of resources in this guide is not exhaustive. Please submit feedback to RIC@lewin.com.

RESOURCES FOR INTEGRATED CARE
Resources for Plans & Providers for Medicare-Medicaid Integration