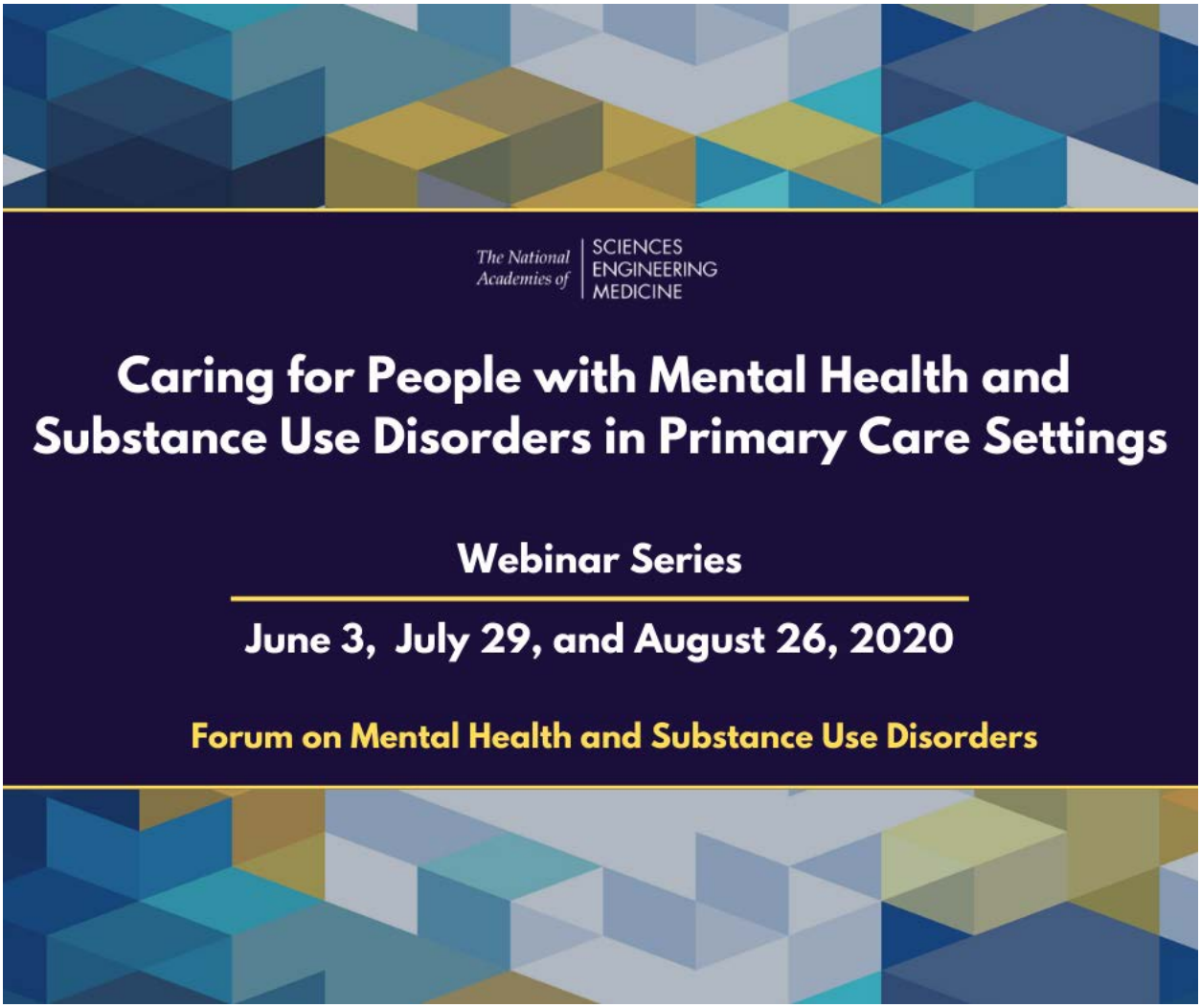

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FORUM ON MENTAL HEALTLH AND SUBSTANCE USE DISORDERS

July 29, 2020

Dear Colleagues:

Welcome to the workshop on *Caring for People with Mental Health and Substance Use Disorders in Primary Care Settings: A Webinar Series,* an activity hosted by the Forum on Mental Health and Substance Use Disorders at the National Academies of Sciences, Engineering, and Medicine.

The workshop will examine approaches to facilitate the delivery of essential components of care for people with mental health and substance use disorders in primary care settings using several illustrative conditions, such as depression, alcohol use disorders, and substance use disorders.

Due to restrictions on travel and public gatherings as a result of the COVID-19 pandemic, the workshop originally scheduled to be held in-person in Washington, DC, has been converted into a series of webinars to be held on June 3, 2020, July 29, 2020, and August 26, 2020.

A recording of the first webinar held on June 3, 2020 can be viewed here: https://www.nationalacademies.org/event/06-03-2020/care-models-and-payment-strategies-to-facilitate-the-delivery-of-essential-components-of-care-for-people-with-mental-health-and-substance-use-disorders-a-workshop

The second webinar on July 29, 2020 will highlight the essential components of care for depression, alcohol use disorders, and opioid use disorders in primary care settings. The webinar will also discuss the key factors that support or impede implementation of these essential components of care.

A summary of this workshop will be published by the National Academies Press. The webinar's meeting materials as well as a video archive of the webinar will be available at: https://www.nationalacademies.org/event/07-29-2020/caring-for-people-with-mental-health-and-substance-use-disorders-in-primary-care-settings-second-webinar

We hope you will find the workshop presentations informative, thought-provoking, and inspiring, and that the suggestions made by the workshop participants will contribute to improved care and informed policymaking regarding people living with mental health and substance use disorders.

Sincerely,

Deidra Roach, MD (Co-Chair)
Medical Project Officer
National Institute on Alcohol Abuse and Alcoholism
Division of Treatment and Recovery Research

Ruth Shim, MD, MPH (Co-Chair)
Luke & Grace Kim Professor in Cultural Psychiatry
Associate Professor, Department of Psychiatry and Behavioral Sciences
University of California, Davis

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FORUM ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Caring for People with Mental Health and Substance Use Disorders in Primary Care Settings: A Webinar Series

Part 2
July 29, 2020
12:00-3:30 PM ET

WEBINAR NOTES

- Join the webcast via this link: https://nasem.zoom.us/j/98251266621?pwd=d01QWU1jeExpbHNrYlNKUHhsVUhKZz09

- An archive of the video webcast and presentation slides will be available at: https://www.nationalacademies.org/event/07-29-2020/caring-for-people-with-mental-health-and-substance-use-disorders-in-primary-care-settings-second-webinar

- Proceedings of the workshop will be published following National Academies procedures. Rapporteurs will compose the proceedings from the workshop transcript and external reviewers will examine the proceedings to make sure it accurately reflects workshop discussions and conforms to institutional policies.

- Interested in receiving updates from the Forum on Mental Health and Substance Use Disorders or the National Academies of Sciences, Engineering, and Medicine's Health and Medicine Division?

  Sign up for the **Forum** listserv at: https://nationalacademies.us8.list-manage.com/subscribe?u=ab74d126b7d2db12591de5c2c&id=211686812e

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FORUM ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Caring for People with Mental Health and Substance Use Disorders in Primary Care Settings: A Webinar Series

Part 2

July 29, 2020 12:00- 3:30 PM EST	
12:00 PM	**Welcome from the Forum on Mental Health and Substance Use Disorders** **Colleen L. Barry, PhD, MPP** Fred and Julie Soper Professor and Chair, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health Co-Director, Johns Hopkins Center for Mental Health and Addiction Policy Research **Howard Goldman, MD, PhD** Professor of Psychiatry University of Maryland at Baltimore, School of Medicine *Co-Chairs, Forum on Mental Health and Substance Use Disorders*
12:05 PM	**Workshop Overview** **Deidra Roach, MD** Medical Project Officer National Institute on Alcohol Abuse and Alcoholism Division of Treatment and Recovery Research **Ruth Shim, MD, MPH** Luke & Grace Kim Professor in Cultural Psychiatry Professor, Department of Psychiatry and Behavioral Sciences University of California, Davis *Co-Chairs, Workshop Planning Committee*
12:15 PM	**ESSENTIAL COMPONENTS OF CARE FOR THREE MHSUD CONDITIONS IN PRIMARY CARE SETTINGS** *Moderator:* **Howard Goldman, MD, PhD** Professor of Psychiatry University of Maryland at Baltimore, School of Medicine

	Speakers: **Richard Saitz, MD, MPH, FACP, DFASAM** Professor, Boston University Schools of Medicine and Public Health Chair, Department of Community Health Sciences, Boston University School of Public Health Editor Emeritus, Addiction Science & Clinical Practice Senior Editor, Journal of Addiction Medicine Associate Editor, Journal of the American Medical Association **Sarah Wakeman, MD** Medical Director, Substance Use Disorders Initiative Program Director, Addiction Medicine Fellowship Massachusetts General Hospital Assistant Professor of Medicine, Harvard University **Lydia Chwastiak, MD, MPH** Professor, Department of Psychiatry & Behavioral Sciences Adjunct Professor, Department of Global Health Co-Director, Northwest Mental Health Technology Transfer Center (NW-MHTTC) University of Washington **Frank deGruy, MD, MS** Professor of Family Medicine Woodward Chisholm Chair University of Colorado, School of Medicine
12:45 PM	**Panel Discussion**
1:15 PM	**Audience Q&A**
1:50 PM	**IMPLEMENTATION OF ESSENTIAL COMPONENTS OF CARE IN PRIMARY CARE SETTINGS** *Moderator:* **W. Perry Dickinson** Director, Practice Innovation Program Professor, Department of Family Medicine University of Colorado *Speakers:* **David Keller, MD** Professor, Pediatrics-Administration

	Vice Chair of Clinical Strategy and Transformation University of Colorado, School of Medicine **Stacy Sterling, DrPH, MSW, MPH** Research Scientist II Division of Research Kaiser Permanente Northern California **Suzanne Snyder, LCSW** Director of Behavioral Health Access Community Health Network **Laura K. Murray, PhD** Senior Scientist Department of Mental Health Johns Hopkins Bloomberg School of Public Health
2:25 PM	**Panel Discussion**
3:00 PM	**Audience Q&A**
3:25 PM	**Closing Remarks**
3:30 PM	**Webinar Adjourns**

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Caring for People with Mental Health and Substance Use Disorders in Primary Care Settings: A Webinar Series

Part 2 Speakers and Panelists

Colleen L. Barry, PhD, MPP (*Forum Co-Chair*)
Fred and Julie Soper Professor and Chair
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health
Co-Director, Johns Hopkins Center for Mental Health and
Addiction Policy Research

Lydia Chwastiak, MD, MPH
Professor, Department of Psychiatry & Behavioral Sciences
Adjunct Professor, Department of Global Health
Co-Director, Northwest Mental Health Technology Transfer Center (NW-MHTTC)
University of Washington

Frank deGruy, MD, MS
Professor of Family Medicine
Woodward Chisholm Chair
University of Colorado, School of Medicine

W. Perry Dickinson
Director, Practice Innovation Program
Professor, Department of Family Medicine
University of Colorado
12631 East 17th Avenue, Mail Stop F496
Aurora, CO 80045
303-724-9754

Howard Goldman, MD, PhD (*Forum Co-Chair*)
Professor of Psychiatry
University of Maryland at Baltimore School of Medicine
1501 South Edgewood Street, Suite L
Baltimore, MD 21227

David Keller, MD
Professor, Pediatrics-Administration
Vice Chair of Clinical Strategy and Transformation
University of Colorado, School of Medicine

Laura K. Murray, PhD
Senior Scientist
Department of Mental Health
Johns Hopkins Bloomberg School of Public Health

Deidra Roach, MD (*Planning Committee Co-Chair*)
Medical Project Officer
National Institute on Alcohol Abuse and Alcoholism
Division of Treatment and Recovery Research

Richard Saitz, MD, MPH, FACP, DFASAM
Professor, Boston University Schools of Medicine and Public Health
Chair, Department of Community Health Sciences, Boston University School of Public Health
Editor Emeritus, Addiction Science & Clinical Practice
Senior Editor, Journal of Addiction Medicine
Associate Editor, Journal of the American Medical Association

Ruth Shim, MD, MPH (*Planning Committee Co-Chair*)
Luke & Grace Kim Professor in Cultural Psychiatry
Professor, Department of Psychiatry and Behavioral Sciences
University of California, Davis

Suzanne Snyder, LCSW
Director of Behavioral Health
Access Community Health Network
600 W. Fulton, Suite 200
Chicago, IL 60661

Stacy Sterling, DrPH, MSW, MPH
Research Scientist II
Division of Research
Kaiser Permanente Northern California

Sarah Wakeman, MD
Medical Director, Substance Use Disorders Initiative
Program Director, Addiction Medicine Fellowship
Massachusetts General Hospital
Assistant Professor of Medicine, Harvard University

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FORUM ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

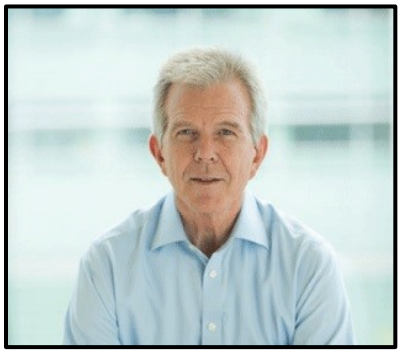
Caring for People with Mental Health and Substance Use Disorders in Primary Care Settings: A Webinar Series

PART 2 SPEAKERS AND PANELISTS

Colleen L. Barry PhD, MPP (*Forum Co-Chair*) is the Fred and Julie Soper Professor and Chair of the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. She has a joint appointment in the Department of Mental Health. Professor Barry's research focuses on how health and social policies can affect a range of outcomes for individuals with mental illness and substance use disorders, including access to medical care and social services, care quality, health care spending, financial protection and mortality. She is involved in numerous research studies examining the implications of health insurance expansions and health care delivery system reform efforts on the treatment of mental illness and substance use disorders. She also conducts empirical research to understand how communication strategies influence public attitudes about opioid addiction, mental illness, gun policy, and obesity and food policy. One focus of this work is to identify evidence-based approaches to reducing stigma. She has authored over 180 peer-reviewed articles on these topics. Dr. Barry is founding co-Director (with Elizabeth Stuart) of the Johns Hopkins Center for Mental Health and Addiction Policy Research and is a core faculty member in the Johns Hopkins Center for Gun Policy and Research. Professor Barry received her Ph.D. in health policy from Harvard University and her masters degree in public policy from the John F. Kennedy School of Government at Harvard.

Lydia Chwastiak MD, MPH, FACLP is a Professor in the UW Department of Psychiatry and Behavioral Sciences and an Adjunct Professor in the Department of Global Health in the UW School of Public Health. She received her MD degree from the University of Pennsylvania, completed residencies in both internal medicine and psychiatry, and obtained research training through an NRSA-funded fellowship in psychiatry and primary care at the University of Washington. Over the past eighteen years, her research has focused on improving the care and outcomes of complex patients who have serious mental illness and co-morbid chronic medical conditions. She has authored or co-authored more than 80 peer-reviewed publications and has been the Principal Investigator or a co-Investigator on numerous (federally- and non-federally) funded research projects to develop and implement integrated care interventions to improve outcomes among complex patients in low resource settings. Since 2014, Dr. Chwastiak has been a faculty member in the Advancing Integrated Mental Health Solutions (AIMS) Center in the UW Department of Psychiatry, and has led implementation projects and education and training efforts nationally. She is the Principal Investigator and co-Director of the SAMHSA-funded Northwest Mental Health Technology Transfer Center (NW-MHTTC), which aims to support the implementation

of evidence-based practices for patients with serious mental illness across a variety of settings in HHS Region 10. She leads the training activities related to integrated care for the NW-MHTTC, which includes training of a broad workforce (psychiatrists, nurses, primary care providers, social workers) in both primary care community mental health settings.



Frank Degruy, MD, MS has served as the Woodward-Chisholm Professor and Chair of the Department of Family Medicine at the University of Colorado's School of Medicine since 1999, prior to which he served for three years as the University Distinguished Professor and Chair of Family Medicine at the University of South Alabama's College of Medicine. His career is characterized by a number of national and international leadership positions, such as past president of the North American Primary Care Research Group, past president of the Collaborative Family Health Association, and past board chair of the Family Physicians Inquiries Network. He was trained as a health services researcher, and conducted a number of extramurally-funded studies on somatization, depression, and other mental disorders in the primary care setting. These early research efforts included the development of psychometrically sound measurements and the use of mixed-methods designs and analyses. Frank's research career more recently has been characterized by addressing difficulties in implementing behavioral healthcare into primary care, and in producing comprehensive, integrated primary care practices. He has served as a reviewer of grant applications for the NIMH, AHRQ, HRSA, the Robert Wood Johnson Foundation, and others. He is on the editorial boards of the Annals of Family medicine and Families, Systems, and Health. He has served on about thirty national advisory boards and steering committees, including the MacArthur Foundation's Depression in Primary Care Initiative, the RWJF's Depression in Primary Care Program, and the National Network of Depression Centers. Frank has been a consultant to 34 Departments of Family Medicine. He was elected into the Institute of Medicine in 2010.

Perry Dickinson, M.D., is a Professor in the University of Colorado, Department of Family Medicine, and Director of the Practice Innovation Program at the University of Colorado. He is also is the Director of the Colorado Health Extension System (CHES), a statewide cooperative of the major practice transformation organizations, state agencies, and other related groups involved in practice and health system transformation support and community health improvement. The Practice Innovation Program and CHES have provided practice transformation support to over 900 primary care and specialty practices over the past five years in large scale implementation and research projects that include the AHRQ-funded EvidenceNOW

Southwest and the CMMI-funded Colorado State Innovation Model and Transforming Clinical Practice initiatives, all with Dr. Dickinson as the principal investigator or director of practice transformation. Dr. Dickinson has led multiple other studies investigating the process of practice transformation, particularly focusing on the implementation of advanced primary care models, self-management support, and integrated behavioral health services in primary care practices. His research expertise particularly lies in the area of health services research and implementation science, often blending traditional research, evaluation, and quality improvement methodologies in studying system and practice changes in response to large-scale transformation projects. Dr. Dickinson is Past President of the Society of Teachers of Family Medicine, the North American Primary Care Research Group, the Board of Directors of the Annals of Family Medicine, and the Council of Academic Family Medicine. He is the 2018 recipient of the Curtis Hames Award, an annual award from the Society of Teachers of Family Medicine and the Curtis Hames Foundation recognizing lifetime contributions to family medicine and primary care research.

Howard H. Goldman, MD, PhD, (*Forum Co-Chair*) is a professor of psychiatry at the University of Maryland School of Medicine. His expertise is in evaluating mental health services and financing programs and policies. Dr. Goldman's recent research has focused on evaluating employment demonstrations for people with severe mental disorders who are connected to the disability programs of the Social Security Administration (SSA). He has also been involved in various studies related to early intervention services for individuals experiencing a first episode of psychosis. In the past he served as principal investigator of the study team conducting the Evaluation of the Implementation and Impact of Mental Health and Substance Abuse Parity in the Federal Employees Health Benefits program, sponsored by the government. Dr. Goldman served as the senior scientific editor of the Surgeon General's Report on Mental Health from 1997 to 1999, for which he was awarded the Surgeon General's Medallion. During 2002 and 2003, Dr. Goldman was a consultant to the President's New Freedom Commission on Mental Health. From 2004 to 2016 he served as editor of Psychiatric Services, a mental health services research and policy journal published monthly by the American Psychiatric Association. He has served on the editorial boards of several other journals, including Health Affairs, the American Journal of Psychiatry and the Journal of Mental Health Policy and Economics. He is a member of the National Academy of Social Insurance, having served on its disability policy panel. Dr Goldman is a member of the NAM, who currently chairs a Standing Committee providing advice to SSA on its disability programs. He has also served as a member or consultant on numerous NASEM consensus committees related to disability policy. Dr. Goldman received joint M.D.-M.P.H. degrees from Harvard University and a Ph.D. in social policy research from the Heller School at Brandeis University.

David M. Keller, MD is Professor and Vice Chair for Clinical Strategy and Transformation in the Department of Pediatrics at the University of Colorado School of Medicine and Children's Hospital Colorado, where he works to develop value-based systems of care for children and adolescents. He currently advises the State of Colorado on practice transformation, payment reform and behavioral health integration by chairing and serving on advisory committees within the administration. On a national level, he serves as co-chair of the Advocacy Committee of the American Pediatric Society. He is an active member of the American Academy of Pediatrics (AAP), the Council on Community Pediatrics and the Colorado Chapter of the AAP, where he serves as chair of the Legislative and Policy Committee. Prior to moving to Colorado, Dr. Keller spent 22 years on the faculty of the University of Massachusetts School of Medicine, where he practiced primary care pediatrics, initiated novel community-based programs with a variety of collaborators, served as an Associate Medical Director for Medicaid in Massachusetts and administered Rhode Island's All-Payer Primary Care initiative. He was a Robert Wood Johnson Foundation Health Policy Fellow in the office of the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services, served as President of the Academic Pediatric Association (APA) and is a psst Chair of the Federation of Pediatric Organizations.

Dr. Laura Murray is a Senior Scientist at Johns Hopkins University, School of Public Health in the Department of Mental Health and International Health; a clinical psychologist by training. Dr. Murray has extensive expertise in a wide range of evidence-based treatments for mental and behavioral health problems. She has conducted research ranging from qualitatively understanding mental health, to full randomized trials of treatments focusing on low and middle income countries globally such as Zambia, Democratic Republic of Congo, Ethiopia, Myanmar, Ukraine, Iraq, Cambodia, Papua New Guinea and many others. She is a developer of the Common Elements Treatment Approach, which was recently shown to significant reduce alcohol abuse in Zambia. She is passionate about thinking about more scalable sustainable models and systems of mental health care in LMIC. Dr. Murray publishes extensively on global mental health in top journals, trains globally, regularly speaks at conferences and organizations, and consults with organizations to improve functioning through skills training on stress, substance use, resiliency and leadership.

Deidra Roach, MD (*Planning Committee Co-Chair*) has more than 30 years of experience in the field of addiction treatment. She currently serves as a medical project officer for the National Institute on Alcohol Abuse and Alcoholism where, among other responsibilities, she manages research portfolios addressing the treatment of co-occurring mental health and alcohol use disorder and alcohol-related HIV/AIDS among women. She also serves on the Interagency Coordinating Committee on Fetal Alcohol Spectrum Disorders (ICCFASD), the NIH Coordinating Committee for Research on Women's Health, and the Extramural Advisory Work Group, Subcommittee on Inclusion Governance, a trans-NIH committee to advise the Office of the Director/NIH on matters related to ensuring diversity in research participation. Dr. Roach co-chairs the Interagency Work Group on Drinking and Drug Use in Women and Girls, a trans-DHHS committee which promotes collaborative research and other activities focused on the prevention and treatment of substance use and co-occurring mental health disorders among women and girls.

Richard Saitz MD, MPH, FACP, DFASAM, is Chair and Professor of Community Health Sciences at Boston University (BU) School of Public Health, Professor of Medicine at BU School of Medicine, and multiple principal investigator (MPI) of the BU Clinical Translational Science Institute. He is a general internist primary care physician, and an addiction medicine specialist at the Grayken Center on Addiction and the Clinical Addiction Research and Education Unit, Section of General Internal Medicine, at Boston Medical Center. He Chaired the Treatment and Services review committee for the National Institute on Alcohol Abuse and Alcoholism, is associate editor of JAMA, and Editor in Chief of Journal of Addiction Medicine, Section Editor and sole author of key chapters in UpToDate on unhealthy substance use, editor of the ASAM Principles of Addiction Medicine textbook, founding Editor Emeritus of Addiction Science & Clinical Practice, former editor of the BMJ's Evidence-Based Medicine, and author of about 350 publications. He was President of the Association for Medical Education and Research in Substance Abuse (AMERSA), and is President of the International Society of Addiction Journal Editors (ISAJE). Major awards include Alpha Omega Alpha Honor Society, Boston Jaycees Ten Outstanding Young Leaders Award, Best Doctors in America®, AMERSA's W. Anderson Spickard, Jr. Excellence in Mentorship Award, the R. Brinkley Smithers Distinguished Scientist Award (ASAM), and the Research Society on Alcoholism Distinguished Researcher Award.

Ruth Shim, MD, MPH (*Planning Commmitee Co-Chair*) is holder of the Luke & Grace Kim Professorship in Cultural Psychiatry in the Department of Psychiatry and Behavioral Sciences at the University of California, Davis School of Medicine. She is an Associate Professor of Clinical Psychiatry, Director of Cultural Psychiatry, and Chair of the Vice Chancellor's Advisory Committee on Faculty Excellence in Diversity at UC Davis Health. Dr. Shim received an MPH in health policy from Rollins School of Public Health at Emory University and an MD from Emory University School of Medicine. She is a member of the Board of Trustees of the Robert Wood Johnson Foundation and the American Association of Community Psychiatrists. She serves on the Editorial Boards of Psychiatric Services, Community Mental Health Journal, and American Psychiatric Publishing, and is co-editor of the book, The Social Determinants of Mental Health. She is also a 2018-2019 Fellow of the Executive Leadership in Academic Medicine (ELAM) Program. Dr. Shim's research focuses on mental health disparities and inequities, and she provides clinical psychiatric care in the UC Davis Early Diagnosis and Preventative Treatment (EDAPT) Clinic.

Dedicated to working with some of Chicago's most vulnerable communities that face challenges around trauma and health equity, **Suzanne Snyder, L.C.S.W.**, has been a practicing social worker for more than 25 years. Serving Access Community Health Network(ACCESS) since 2001, Ms. Snyder serves as ACCESS' Director of Behavioral Health and shepherds the development and implementation of ACCESS' integrated behavioral health services and programs, leading a comprehensive team of clinicians, community health specialists, and a chaplain. Ms. Snyder has been integral in evolving ACCESS' patient centered primary care model which integrates behavioral health services and programs across the care spectrum from universal screening for social determinants of health, mental health and substance use needs to establishing psychiatric and Medicated Assisted Treatment services across ACCESS' network of 35 health centers. Through her guidance, ACCESS initiated an educational campaign for care teams and patients to destigmatize behavioral health and strengthened the bidirectional consultation and referral process between medical and behavioral health providers. Ms. Snyder also played a critical role in the recent rollout of telehealth services as part of ACCESS' COVID-19 response. Suzanne earned her Master of Arts degree in Social Service Administration at the School of Social Service Administration at the University of Chicago and her Master of Divinity at Chicago Theological Seminary.

Stacy Sterling, DrPH, MSW, MPH, is a Research Scientist and Co-Director of the Center for Addiction and Mental Health Research at the Kaiser Permanente Northern California (KPNC) Division of Research. She received her doctoral training at the University of North Carolina, Chapel Hill, Gillings School of Global Public Health, and master's degrees in Public Health and Social Welfare at the University of California, Berkeley. Her research focus is on developing health policies and interventions to increase treatment access to health, substance abuse and mental health services, and improve outcomes for vulnerable populations, including adolescents, women, and patients with co-occurring disorders. She is the Principal Investigator of a number of NIH- and foundation-supported studies focused on identification and early intervention for adolescent behavioral health problems, in pediatric primary care and other non-specialty treatment settings, and the implementation, sustainment and health outcomes related to screening and brief intervention approaches in adult primary care.

Sarah E. Wakeman, MD is the Medical Director for the Mass General Hospital Substance Use Disorder Initiative, program director of the Mass General Addiction Medicine fellowship, and an Assistant Professor of Medicine at Harvard Medical School. She is also the Medical Director of the Mass General Hospital Addiction Consult Team, co-chair of the Mass General Opioid Task Force, and co-chair of the Mass General Brigham Substance Use Steering Committee. She is the Chief Medical Officer of RIZE Massachusetts, a nonprofit foundation working to address the overdose crisis. She received her A.B. from Brown University and her M.D. from Brown Medical School. She completed residency training in internal medicine and served as Chief Medical Resident at Mass General Hospital. She is a diplomate and fellow of the American Board of Addiction Medicine and board certified in Addiction Medicine by the American Board of Preventive Medicine. She served on Massachusetts' Governor Baker's Opioid Addiction Working Group. Nationally, she serves on the American Society of Addiction Medicine Ethics Committee. Clinically she provides specialty addiction and general medical care in the inpatient and outpatient setting at Mass General Hospital and the Mass General Charlestown Health Center. Her research interests include evaluating models for integrated substance use disorder treatment in general medical settings, low threshold treatment models, recovery coaching, physician attitudes and practice related to substance use disorder, and screening for substance use in primary care.

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FORUM ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Caring for People with Mental Health and Substance Use Disorders in the Primary Care Setting: A Webinar Series

PLANNING COMMITTEE ROSTER

Deidra Roach, MD (*Co-Chair*)
Medical Project Officer
National Institute on Alcohol Abuse and Alcoholism
Division of Treatment and Recovery Research

Ruth Shim, MD, MPH (*Co-Chair*)
Luke & Grace Kim Professor in Cultural Psychiatry
Professor, Department of Psychiatry and Behavioral Sciences
University of California, Davis

Jeffrey Buck, PhD
Senior Advisor for Behavioral Health
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

W. Perry Dickinson, MD
Director, Practice Innovation Program
Professor, Department of Family Medicine
University of Colorado
Representing the American Board of Family Medicine

Richard Frank, PhD
Professor of Health Economics,
Department of Health Care Policy
Harvard Medical School

Howard H. Goldman, MD, PhD
Professor of Psychiatry
University of Maryland School of Medicine

Pamela Greenberg, MPP
President and CEO
Association for Behavioral Health and Wellness

Caren Howard
Advocacy Manager
Mental Health America

R. Kathryn McHugh, PhD
Director, Stress, Anxiety, and Substance Use Laboratory
Associate Psychologist, Substance Use Disorders Division, McLean Hospital
Assistant Professor of Psychology,
Department of Psychiatry
Harvard Medical School
Representing the American Psychological Association

Kathy Pham, PharmD, BCPPS
Director of Policy and Professional Affairs
American College of Clinical Pharmacy

Martin Rosenzweig, MD
Chief Medical Officer
Optum Behavioral Health

Alexander Ross, ScD
Senior Behavioral Health Advisor
Office of Planning, Evaluation, and Analysis,
Health Resources and Services Administration, HHS

Matthew Tierney, MS, NP, FAAN
Associate Clinical Faculty,
UCSF School of Nursing
Representing the American Psychiatric Nurses Association

FORUM ON MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Planning Committee Biographies

Deidra Roach, MD (Co-*Chair*) has more than 30 years of experience in the field of addiction treatment. She currently serves as a medical project officer for the National Institute on Alcohol Abuse and Alcoholism where, among other responsibilities, she manages research portfolios addressing the treatment of co-occurring mental health and alcohol use disorder and alcohol-related HIV/AIDS among women. She also serves on the Interagency Coordinating Committee on Fetal Alcohol Spectrum Disorders (ICCFASD), the NIH Coordinating Committee for Research on Women's Health, and the Extramural Advisory Work Group, Subcommittee on Inclusion Governance, a trans-NIH committee to advise the Office of the Director/NIH on matters related to ensuring diversity in research participation. Dr. Roach co-chairs the Interagency Work Group on Drinking and Drug Use in Women and Girls, a trans-DHHS committee which promotes collaborative research and other activities focused on the prevention and treatment of substance use and co-occurring mental health disorders among women and girls.

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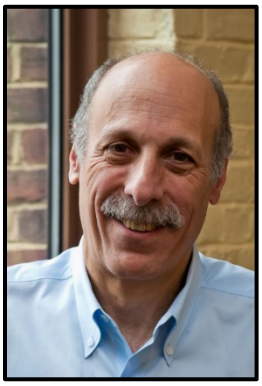
Jeffrey A. Buck, PhD is the Program Lead for the Inpatient Psychiatric Facility (IPF) Quality Reporting Program and the Senior Advisor for Behavioral Health in the Center for Clinical Standards and Quality (CCSQ) at the Centers for Medicare & Medicaid Services (CMS). He serves as the subject matter expert for the QIO Program's behavioral health work. Previously, he served as a senior advisor with the agency's Center for Strategic Planning. Before coming to CMS, Dr. Buck held senior positions in the Substance Abuse and Mental Health Services Administration (SAMHSA). There,

he directed many of SAMHSA's analytic studies of behavioral health services and financing. Dr. Buck's publications have addressed behavioral health issues in the financing and utilization of services, insurance coverage and parity, Medicaid, health care reform and administrative data systems.

W. Perry Dickinson, MD is a Professor in the University of Colorado, Department of Family Medicine, and Director of the Practice Innovation Program at the University of Colorado. He is also is the Director of the Colorado Health Extension System (CHES), a statewide cooperative of the major practice transformation organizations, state agencies, and other related groups involved in practice and health system transformation support and community health improvement. The Practice Innovation Program and CHES have provided practice transformation support to over 900 primary care and specialty practices over the past five years in large scale implementation and research projects that include the AHRQ-funded EvidenceNOW Southwest and the CMMI-funded Colorado State Innovation Model and Transforming Clinical Practice initiatives, all with Dr. Dickinson as the principal investigator or director of practice transformation. Dr. Dickinson has led multiple other studies investigating the process of practice transformation, particularly focusing on the implementation of advanced primary care models, self-management support, and integrated behavioral health services in primary care practices. His research expertise particularly lies in the area of health services research and implementation science, often blending traditional research, evaluation, and quality improvement methodologies in studying system and practice changes in response to large-scale transformation projects. Dr. Dickinson is Past President of the Society of Teachers of Family Medicine, the North American Primary Care Research Group, the Board of Directors of the Annals of Family Medicine, and the Council of Academic Family Medicine. He is the 2018 recipient of the Curtis Hames Award, an annual award from the Society of Teachers of Family Medicine and the Curtis Hames Foundation recognizing lifetime contributions to family medicine and primary care research.



Richard G. Frank, PhD is the Margaret T. Morris Professor of Health Economics in the Department of Health Care Policy at Harvard Medical School. From 2009 to 2011, he served as the deputy assistant secretary for planning and evaluation at DHHS directing the office of Disability, Aging and Long-Term Care Policy. From 2013 to 2014, he served as a Special Advisor to the Office of the Secretary at the Department of Health and Human Services, and from 2014 to 2016 he served as Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services. His research is focused on the economics of mental health and substance abuse care, long term care financing policy, health care competition, implementation of health reform and disability policy. Dr. Frank served as an editor for the Journal of Health Economics from 2005 to 2014. Dr. Frank was awarded the Georgescu-Roegen Prize from the Southern Economic Association, the Carl A. Taube Award from the American Public Health Association, and the Emily Mumford Medal from Columbia University's Department of Psychiatry. In

2011, he received the Distinguished Service Award from the Mental Health Association of Maryland. Dr. Frank also received the John Eisenberg Mentorship Award from the National Research Service Awards. He was elected to the Institute of Medicine (National Academy of Medicine) in 1997. He is co-author with Sherry Glied of the book Better but Not Well (Johns Hopkins Press).

Howard H. Goldman, MD, PhD, is a professor of psychiatry at the University of Maryland School of Medicine. His expertise is in evaluating mental health services and financing programs and policies. Dr. Goldman's recent research has focused on evaluating employment demonstrations for people with severe mental disorders who are connected to the disability programs of the Social Security Administration (SSA). He has also been involved in various studies related to early intervention services for individuals experiencing a first episode of psychosis. In the past he served as principal investigator of the study team conducting the Evaluation of the Implementation and Impact of Mental Health and Substance Abuse Parity in the Federal Employees Health Benefits program, sponsored by the government. Dr. Goldman served as the senior scientific editor of the Surgeon General's Report on Mental Health from 1997 to 1999, for which he was awarded the Surgeon General's Medallion. During 2002 and 2003, Dr. Goldman was a consultant to the President's New Freedom Commission on Mental Health. From 2004 to 2016 he served as editor of Psychiatric Services, a mental health services research and policy journal published monthly by the American Psychiatric Association. He has served on the editorial boards of several other journals, including Health Affairs, the American Journal of Psychiatry and the Journal of Mental Health Policy and Economics. He is a member of the National Academy of Social Insurance, having served on its disability policy panel. Dr Goldman is a member of the NAM, who currently chairs a Standing Committee providing advice to SSA on its disability programs. He has also served as a member or consultant on numerous NASEM consensus committees related to disability policy. Dr. Goldman received joint M.D.-M.P.H. degrees from Harvard University and a Ph.D. in social policy research from the Heller School at Brandeis University.

Pamela Greenberg, MPP is the President and CEO of the Association for Behavioral Health and Wellness (ABHW); she joined the organization in 1998. ABHW is the leading association working to raise awareness, reduce stigma, and advance federal policy to improve mental health and addiction care. ABHW represents major national and regional health plans who care for more than 200 million people. Pamela serves on the Editorial Board of the Bloomberg BNA Health Insurance Report and is a liaison to the National Committee for Quality Assurance Standards Committee. In 2015, Ms. Greenberg joined the Advisory Board of Landmark Health, a company that provides home-based medical care to individuals with multiple chronic conditions, and in 2017 she joined InnovaTel Telepsychiatry's Strategic Advisory Board. She was the Chair of the Coalition for Fairness in Mental Illness Coverage, one of the leading Coalitions that helped develop, advocate for, and get the

Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 signed in to law. Additionally, Pamela served as President of The College for Behavioral Health Leadership. Prior to joining ABHW Pamela was the Deputy Director of Federal Affairs for America's Health Insurance Plans (AHIP). Before joining AHIP Ms. Greenberg was a Legislative Assistant at Capitol Associates, a healthcare consulting firm in Washington, D.C. Pamela has a B.A. from Mount Holyoke College and a Masters in Public Policy from Georgetown University.

Caren Howard currently serves as Advocacy Manager for Mental Health America, and she has 12 years' experience in legislative, political campaign and advocacy work. As Advocacy Manager, Howard builds the MHA Regional Policy Council's four yearly conferences; advises strategy for influencing federal and state policymakers on a wide range of health and social issues including health care, education, and criminal justice; and facilitates relationship-building between MHA affiliates and their state and local elected officials through MHA's Back Home Campaign and Hill Day programs. Howard joined MHA in January 2017 after working as a top fundraiser for several members of the House of Representatives. Prior to fundraising, Howard worked on Capitol Hill serving her hometown representative, Congressman John P. Sarbanes, and former Majority Leader Congressman Steny H. Hoyer. She worked with the successful coordinated campaign in New Mexico during the 2008 election cycle. Howard earned a B.A. in Political Science at Spelman College, the nation's top-ranked Historically Black College and University for ten years. She resides in Takoma Park, Maryland and continues involvement in her hometown school and community affairs in Columbia, Maryland.

R. Kathryn McHugh, PhD received her B.A. from Harvard College and her Ph.D. from Boston University. She is currently the Director of the Stress, Anxiety and Substance Use Laboratory at McLean Hospital and an Assistant Professor at Harvard Medical School. Dr. McHugh's research focuses on the nature and treatment of anxiety and substance use disorders. Her work is currently funded by grants from the National Institute on Drug Abuse, including a 5-year grant to develop and test a novel cognitive-behavioral therapy for co-occurring opioid use disorder and anxiety disorders. She has published more than 100 manuscripts and book chapters as well as an edited book published by Oxford University Press on the dissemination and implementation of treatment for psychological disorders. Dr. McHugh is a recipient of a number of awards, including the David Shakow Early Career Award for Distinguished Scientific Contribution to Clinical Psychology and the Theodore Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology. She is an Associate Editor of the journals Behavior Therapy and Cognitive Therapy and Research and recently was the Co-Chair of the American Psychological Association Taskforce on Clinical Responses to the Opioid Crisis. Dr. McHugh is also a practicing clinical psychologist, specializing in cognitive-behavioral therapy for the treatment of anxiety, depressive, and substance use disorders.

Kathy Pham, PharmD, BCPPS is the Director of Policy and Professional Affairs at the American College of Clinical Pharmacy (ACCP), a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in practice, research, and education. Dr. Pham came to ACCP from the Pew Charitable Trusts, where she served as Senior Officer of the Drug Safety Project. Her previous clinical experience has been in pediatric pharmacy practice, with the majority of that time spent as the NICU clinical specialist and pharmacy residency director at Children's National Medical Center in Washington, D.C. She is also a board-certified pediatric pharmacotherapy specialist. Dr. Pham earned her Doctor of Pharmacy degree from Rutgers, the State University of New Jersey. After completing her pharmacy residency at the University of Illinois at Chicago, she practiced as a pediatric clinical pharmacist and held faculty appointments at various schools of pharmacy including Long Island University, Rutgers, Creighton University, University of Maryland, and Virginia Commonwealth University. Dr. Pham leads ACCP's engagement, collaboration, and communication with medical, pharmacy, other health professional societies, health quality organizations, and payers/purchasers to promote and help achieve medication optimization for individual patients and populations. She participates as the ACCP representative in working groups and task forces of health policy development and research enterprises at the national level that address issues of interprofessional practice, research, and education.

Martin Rosenzweig, MD is a the chief medical officer of Optum Behavioral Health and has been with the organization for almost 20 years. Dr. Rosenzweig is board-certified in psychiatry and a clinical associate in the Department of Psychiatry at the University of Pennsylvania. In addition to his work with Optum, he maintains a role in active clinical practice focused on the treatment of individuals with mood disorders and other psychiatric disorders. He is a Graduate of the University of the Witwatersrand Medical School in Johannesburg, South Africa and completed his residency and psychiatric residency at Pennsylvania hospital and his fellowship in psychopharmacology at the University of Pennsylvania.

Alexander Ross, ScD is senior advisor on behavioral health in the Office of Planning, Analysis and Evaluation, at the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Service. Alex supports HRSA Bureaus and Offices fostering the integration of behavioral health and primary care. Dr. Ross' work has included an emphasis on financing issues regarding behavioral health/primary care services and assuring that an appropriately trained health care workforce is available to meet the Nation's needs. In addition to his current work, Dr. Ross has held positions at HRSA in the Office of Planning and Evaluation, the Bureau of HIV/AIDS, and the Office of Public Health Practice. Alex has a Doctor

of Science Degree in Health Policy from The Johns Hopkins University Bloomberg School of Hygiene and Public Health.

Matthew Tierney, PhD is Associate Clinical Faculty at the UCSF School of Nursing, and is Clinical Director of Substance Use Treatment and Education for the Office of Population Health at UCSF Health. He represents the American Psychiatric Nurses Association (APNA) on this panel. An educator and active clinician for over 2 decades, his work has focused on increasing access to essential substance use and addictions treatment by developing and implementing innovative clinical treatment programs and by empowering the healthcare workforce through education. As a Nurse Practitioner certified in adult primary care and psychiatric-mental health care, his clinical work has focused on providing evidence-based care to vulnerable and highly-stigmatized populations. His work in clinical program development includes helping create and then direct the nation's first clinic focused exclusively on buprenorphine treatment initiation and stabilization. As an educator, he teaches addictions content at numerous health sciences programs at the University of California San Francisco, and he has helped to build the behavioral health workforce nationally and internationally through multiple venues including: the creation of behavioral health scope and standards of practice for nursing; since 2008, teaching the federally-mandated course content to receive the "DEA waiver" to prescribe buprenorphine; and through educational service at numerous organizations including IntNSA, AMERSA, ASAM, and APNA, where he was inaugural Chair of the Addictions Council and helped create an educational program that is available free-of-charge to all nurses nationwide, conceived in response to the White House ONDCP's call to address the opioid overdose epidemic. His current research includes co-investigator status on two grants: one from SAMHSA to expand/enhance access to medication-assisted treatment (MAT) services for persons with opioid use disorder by ensuring the training of students in the medical, physician assistant and nurse practitioner fields; and a grant from the National Council of State Boards of Nursing (NCSBN) examining whether and how state NP scope of practice regulations impact the supply of NPs providing MAT for opioid use disorder. Matthew received a Master of Science Degree from UCSF in 2000.

Integrating Mental Health and Addiction Treatment Into General Medical Care: The Role of Policy

Emma E. McGinty, Ph.D., M.S., and Gail L. Daumit, M.D., M.H.S.

Interventions that integrate care for mental illness or substance use disorders into general medical care settings have been shown to improve patient outcomes in clinical trials, but efficacious models are complex and difficult to scale up in real-world practice settings. Existing payment policies have proven inadequate to facilitate adoption of effective integrated care models. This article provides an overview of evidence-based models of integrated care, discusses the key elements of such models, considers how existing policies have fallen short, and outlines future policy strategies. Priorities include payment policies that adequately support structural elements of integrated care and incentivize multidisciplinary team formation and accountability for patient outcomes, as well as policies to expand the specialty mental health and addiction treatment workforce and address the social determinants of health that disproportionately influence health and well-being among people with mental illness or substance use disorders.

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Mental illnesses and substance use disorders, known as behavioral health conditions, are significantly undertreated in the United States. About one in every five U.S. adults experience mental illness each year, but in 2018 only 43% of adults with mental illness ages 18 and older received any mental health treatment and only 11% of people with substance use disorders received any addiction treatment (1). Mental illness and substance use disorders are highly comorbid with one another and with general medical conditions, such as cardiovascular and liver disease (1–3). These comorbidities occur along complex and bidirectional pathways involving a range of factors, including but not limited to biological mechanisms, metabolic side effects of psychotropic medications, and shared risk factors, such as poverty (4, 5). Despite the high comorbidity of general medical illnesses, they are frequently undertreated among people with behavioral health conditions (6, 7). Suboptimal care for people with behavioral health conditions has major public health implications. Depression is a leading cause of disability in the United States and worldwide (8). People with serious mental illnesses, such as schizophrenia, bipolar disorder, and major depressive disorder, die 10–20 years prematurely, compared with the overall population, primarily due to cardiovascular disease (9). From 1999 to 2017, more than 200,000 people died from opioid overdose deaths in the United States (10).

Despite the high burden of behavioral health conditions and their comorbidities, the U.S. specialty mental health and addiction treatment systems have historically operated outside the general medical system (11). This fragmentation is an important driver of undertreatment, and development and implementation of models for integrating general medical and behavioral health care (hereafter referred to as integrated care) have been a priority in the clinical and health policy communities for decades (12). Progress has been made: most mental health services are now delivered in primary care settings (13). However, integrated care models shown to be effective in clinical trials have not been widely implemented outside demonstration programs funded through grants or other time-limited mechanisms (14–16). Policy barriers, particularly lack of adequate financing mechanisms, are cited as a major impediment to integrated care (17). However, payment policy initiatives designed to facilitate integration have to date proved inadequate, failing to translate into widespread adoption of evidence-based integrated care models or significant improvements in care access, care quality, or health outcomes among people with mental illness or substance use disorders.

This article has three objectives. First, to briefly summarize the evidence surrounding models for integrating behavioral health services into primary care and other general medical settings. Although integrated care can be based in either general medical or specialty behavioral health settings, we limit our scope to models based in general medical settings, which are the focus of a larger body of research and implementation efforts. Second, we delineate core components of integrated care. Third, we consider how existing policies have fallen short and discuss policy options for overcoming remaining barriers to care integration.

(Because the literature informing this article was more extensive than could be included in the published reference list, we have included a list for further reading in an online supplement to this article.)

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MODELS FOR INTEGRATING BEHAVIORAL HEALTH INTO GENERAL MEDICAL CARE

Most integrated care interventions shown in clinical trials to improve treatment delivery and patient outcomes implement variations of the collaborative care model. Collaborative care is based on Wagner and colleagues' (18) chronic care model, which has been shown to improve chronic illness care through use of a team-based, proactive, and population-oriented approach to identifying and treating chronic disease. In collaborative care, primary care physicians work with a care manager and a consulting psychiatrist to proactively identify, treat, and monitor people with behavioral health conditions (19). Key elements include population-based patient identification; continual symptom monitoring using an electronic registry, measurement-based care to track treatment response and identify patients who are not improving, and a stepped-care approach to systematically adjust treatment for patients who are not meeting targets (19). A large and conclusive body of evidence from randomized clinical trials supports the beneficial effects of collaborative care for depression care access and quality and patient outcomes (20). Smaller bodies of literature support the efficacy of this model for anxiety (20) and comorbid general medical conditions (21), and limited evidence suggests that collaborative care may also improve outcomes for people with bipolar disorder, schizophrenia, alcohol use disorder, or opioid use disorder (22, 23).

A much more limited body of research suggests that less complex consultation-liaison approaches to integrated care and approaches that use screening, brief intervention, and referral to treatment (SBIRT) may also have benefits, but the quality of the evidence is low and results are mixed. Some studies suggest that consultation-liaison models, broadly defined as models in which a process exists for general providers to consult behavioral health specialists, can improve depression outcomes and reduce length of general medical inpatient stays among adults with mental illness (24). The screening- and referral-based SBIRT has predominantly been used for alcohol and other substance use problems. SBIRT uses validated screening measures to identify patients and stratify them by level of risk (25). Patients with low-risk substance use behaviors receive brief behavioral therapy or motivational enhancement interventions designed to increase motivation for behavior change. High-risk patients also receive these brief interventions and are then referred to specialist treatment. To date, SBIRT has mostly been tested in primary care and emergency department settings, with mixed results. A high-quality randomized clinical trial found no effects of SBIRT on days of alcohol or drug use at 6-month follow-up (26). However, a 2018 systematic review found moderate-quality evidence supporting the idea that brief interventions delivered in primary care or emergency department settings can reduce alcohol consumption behaviors (27).

KEY ELEMENTS OF INTEGRATED CARE

General medical settings can implement a range of care integration strategies somewhere on the spectrum between the complex, multicomponent collaborative care model and the simpler SBIRT model. Although there is considerable interest in understanding which elements of integrated care models are essential to improving care delivery and patient outcomes, studies seeking to identify key ingredients have had inconclusive results. Two meta-analyses published in 2006 of 37 collaborative care clinical trials suggested that employing a care manager with mental health training and frequent psychiatrist supervision of the care manager were associated with better patient outcomes (28, 29). However, a 2014 meta-regression of 74 collaborative care clinical trials failed to identify an association between these or any other specific model elements and changes in patients' depressive symptoms; systematic identification of patients with depression was associated with increased antidepressant use (30). A study of collaborative care implemented in 2008–2010 in Washington State found that rapid patient engagement by the care manager and timely psychiatric consultation for patients whose depressive symptoms did not improve were associated with clinically significant improvements in depression (31).

In the absence of robust quantitative evidence, we draw upon a richer body of qualitative and expert consensus–based work to propose key elements of integrated care (15, 16, 32, 33). In Box 1, we propose a set of elements derived from Chapman and colleagues' (32) continuum-based framework for behavioral health integration into primary care. Within this framework, we delineate process-of-care elements versus structural elements. The structural elements support the process elements—e.g., a population-based patient registry and decision-support protocols facilitate implementation of measurement-based care.

The extant research demonstrates that models that include all or most of these components are effective, but it provides little insight into whether a smaller subset of elements might be equally effective or, even if less effective than a comprehensive collaborative care–type model, still yield benefits above and beyond usual (nonintegrated) care. This

question is particularly critical for small- or low-resource practices, where the financial investment needed to implement a comprehensive model may not be feasible.

The subset of elements most likely to be feasible in low-resource settings (flagged with asterisks in Box 1) revolves around identification and referral of patients with behavioral health needs. Low-resource settings should be able to institute standard screening for behavioral health issues and use a low-tech registry—e.g., a spreadsheet—to document patients who screen positive and track that those patients have been referred to specialty behavioral health services and also that they have actually connected with specialty services after referral. Low-resource settings should also be able to employ patient-centered care plans, provide self-management support, and link patients to social services. Leaders in the development and implementation of collaborative care have suggested that feasibility of systematic screening in low-resource or small primary care practices could be enhanced through use of self-administered measures and that small practices could direct patients to Web-based self-management resources rather than providing such interventions in-house (16). It is also possible that insurers might take on some elements of integrated care, such as case management. Additional research is needed to build evidence regarding whether and how SBIRT and other referral-based models that are better suited for lower-capacity practice settings can improve care and outcomes among people with behavioral health conditions.

POLICIES TO SUPPORT INTEGRATED CARE: LESSONS LEARNED AND NEXT STEPS

Integrated Care Policy: What Have We Tried?

To date, integrated care policies have focused on overcoming payment barriers. Care processes central to integrated care—such as care management—have not historically been reimbursed by insurers, a major impediment to scale-up. To address this issue, in 2017 the Center for Medicare and Medicaid Services introduced behavioral health integration billing codes allowing general medical providers to bill Medicare; the codes have also been adopted by some state Medicaid and commercial plans for care planning and management services (17). However, uptake has been low: during 2017–2018, only 0.1% of Medicare beneficiaries with mental illness or substance use disorders received a service billed to one of the new integration codes (34). One likely driver of low uptake is that in order to bill, practices must have multiple integrated care process and structure elements already in place (35, 36). In addition, the entire reimbursement flows to the general medical provider that does the billing. In the absence of colocation, this one-sided payment structure places an administrative burden on practices to set up ledger transfers, contracts, or other arrangements to pay behavioral health partners (35). This issue is primarily relevant for single-specialty practices, although even multispecialty practices, including both general medical and behavioral health providers, have cited as an administrative hurdle the need to set up ledger transfer or other strategies to facilitate within-organization financial transfers (35).

Similar types of relatively modest payments—generally in the range of $20–$200 per-beneficiary per-month—to cover care management or other previously nonbillable integrated care activities have also failed to result in meaningful behavioral health integration in federal patient-centered medical home (PCMH) demonstration programs, including the Comprehensive Primary Care (CPC) and Multi-Payer Advanced Primary Care demonstrations (37, 38). PCMHs aim to implement the chronic care model to improve treatment of chronic conditions, including but not limited to mental illness and substance use disorders, and although they are not focused specifically on behavioral health, they include many of the core process and structure elements in Box 1 (39). The limited available evidence suggests that PCMHs have the potential to improve care for people with mental illness (40, 41). Like collaborative care, the PCMH model has struggled with scale-up. The National Commission for Quality Assurance (NCQA) created a PCMH recognition program in 2008 and currently recognizes about 13,000 U.S. primary care practices as PCMHs. The 2015 Medicare Access and CHIP Reauthorization Act created a financial incentive for obtaining this recognition: clinicians practicing in NCQA-recognized PCMHs are eligible for higher fee-for-service Medicare payments (42). In 2017, NCQA introduced a Distinction in Behavioral Health Integration Program as part of its PCMH recognition initiative, but the degree of adoption and effects on care and outcomes among people with mental illness or substance use disorders are unknown.

Like PCMHs, accountable care organizations (ACOs) are not specifically designed to integrate general medical and behavioral health services but have the potential to facilitate such integration, in this case through shared savings and (in two-sided risk arrangements) losses tied to achievement of targets involving quality of care and health care spending. However, the evidence suggests that ACOs have had limited to no impact on care for people with behavioral health conditions (43, 44). Frequently cited weaknesses in existing ACO models are limited inclusion of behavioral health specialty providers and lack of alignment between payments and behavioral health performance metrics (43).

Multiple existing policies operate as barriers to care integration. The federal 21st Century Cures Act of 2016 clarified that federal law does not prohibit organizations or individual clinicians from billing Medicaid for both a primary care service and a mental health service delivered to a single patient on the same day (45). Despite the federal clarification, same-day billing limits persist in many state laws. In the most recent review of state Medicaid laws available, which was conducted in 2015, a total of 24 state Medicaid programs prohibited some or all settings and provider types from same-day billing (46). Since the

clarification to federal law in 2016, some states have introduced and passed legislation to do away with state prohibitions, but they persist in multiple states (47).

Insurance carve-out arrangements, in which behavioral health benefits are administered by an organization different from the one that administers general medical benefits, are commonly cited as a barrier to integrated care delivery. Importantly, "carve-in" arrangements, in which a single organization manages both general medical and behavioral health benefits but still uses internally segregated budgets and separate adjudication practices for general medical and behavioral health claims, have also been cited as impeding integration (48). Multiple state Medicaid plans are considering eliminating carve-outs, although evidence on the effects of doing so on care delivery and patient outcomes is limited. One study found that integrated management of behavioral health and general medical benefits in Illinois Medicaid decreased behavioral health costs without affecting service utilization (49). Other policy barriers exist for specific behavioral health conditions—for example, federal laws limiting primary care physicians' ability to prescribe opioid agonist medications to treat opioid use disorder (50, 51). Although we recognize the significance of such policies, a comprehensive assessment of condition-specific policies is outside the scope of this article.

Integrated Care Policy: What Have We Learned?

Payment policies have to date fallen short of incentivizing widespread adoption of integrated care. Evidence points to a need for multipayer financing arrangements that support not only process-of-care elements but also structural elements of integrated care, adequately incentivize participation of both general medical and specialty mental health providers, and hold multidisciplinary teams accountable for improved care and health outcomes among persons with mental illness or substance use disorders.

Reimbursement mechanisms that provide modest per-beneficiary per-month payments for integrated behavioral health activities appear to be inadequate to cover the costs associated with structural integrated care elements. Difficulty paying for behavioral health staff and lack of needed health information technology (IT) infrastructure are consistently identified as barriers (15, 37, 48). Health IT is critical, because clinical information systems underpin the process-of-care elements included in evidence-based integrated care models. The federal Comprehensive Primary Care Plus initiative, which includes health IT development for primary care practices implementing advanced PCMHs with integrated behavioral health care, may yield important insights into the types of IT systems best suited to supporting integrated care. Financing of structural elements of integrated care could also be achieved through bundled payments; the American College of Physicians has recommended separate prospective bundled payments for structural and process-of-care elements (52).

Neither general medical nor specialty mental health providers are currently held accountable for "whole person" health outcomes among persons with behavioral health conditions. Value-based financing arrangements structured so that both general medical and specialty mental health providers are subject to the same incentives could address these issues. One approach is to strengthen ACOs through increased inclusion of behavioral health specialists in ACO networks and by aligning payment with behavioral health performance measures. Hub-and-spoke models may also facilitate integrated care. Vermont's hub-and-spoke Medicaid health home program, in which specialty addiction treatment programs serve as "hubs" that collaborate with primary care and other general medical "spokes"—with payment following directly from Medicaid to both hubs and spokes—has increased delivery of buprenorphine for treatment of opioid use disorder (53, 54).

Ideally, all these payment policy options need to be multipayer so that integrated care can be implemented practicewide versus only for a subset of insured patients. There are many common elements across effective integrated general medical–behavioral health models and other chronic care model–informed efforts, such as PCMHs. Lessons learned from the various alternative payment models being tested by public and private insurers to incentivize primary care redesign in alignment with the chronic care model could yield important insights for optimal payment policies to support integrated care (55). The Affordable Care Act Medicaid Health Home Waiver provides opportunity for integrated care payment innovation by giving states flexibility in designing payment methodology to support implementation of health home programs for subsets of high-cost, high-need Medicaid beneficiaries (56). As of November 2019, a total of 13 states had used this waiver to support integration of behavioral health services into general medical settings (56). Importantly, it is unclear whether any of these models will overcome what Pincus and colleagues (57) termed the "cost-effectiveness conundrum" of integrated care models, which require significant up-front investments and, by design, identify previously unmet patient needs, which require additional services; as noted above, this conundrum is particularly salient to small, single-specialty groups and low-resource settings.

Integrated Care Policy: What's Next?

Policies to fund integrated care are necessary but not sufficient to spread implementation of effective integrated care models. This point is illustrated by Minnesota's DIAMOND initiative, which is often held up as a model for collaborative care scale-up. DIAMOND is a multipayer initiative that finances collaborative care through bundled payments designed to cover both structural and process-of-care elements, and the initiative also provides intensive training and an electronic registry to participating practices (58, 59). Although DIAMOND facilitated adoption of collaborative care, it had no effects on depression outcomes (59). This illustrates the challenges to replicating the beneficial effects of integrated care models shown to improve patient

BOX 1. Key elements of integrated general medical and behavioral health care

Panel A: process-of-care elements

*1. **Proactive and systematic patient identification and connection to evidence-based treatment:** Systematic screening of the entire patient panel using validated tools and a standard protocol for initiating treatment.
2. **Team-based care by general medical and specialty behavioral health providers:** Structured and regular communication and collaboration processes, such as standing meetings and case reviews.
3. **Information tracking and exchange among providers:** Systematic tracking of patient information (e.g., diagnoses, treatment plans, and treatment response) shared across general medical and behavioral health providers.
4. **Continual care management:** Ongoing, proactive follow-up of patients.
5. **Measurement-based, stepped care:** Longitudinal measurement of patients' response to treatment and a stepped-care approach to adjust or intensify treatment when measurements show that a patient is not meeting targets.
*6. **Self-management support:** Culturally appropriate strategies to help patients and caregivers understand and manage health condition(s)—for example, motivational interviewing and brief behavioral counseling.
*7. **Linkages with community and social services:** Linking patients to services in the community, particularly services addressing social determinants of health, such as housing and vocational services.
8. **Systematic quality improvement:** Longitudinal measurement of practice- and provider-level performance metrics and use of these metrics to inform quality improvement—for example, through approaches such as audit-and-feedback.

Panel B: structural elements

1. **Multidisciplinary care team:** A team comprising general medical and specialty behavioral health clinicians with the credentials and expertise necessary to provide evidence-based care for the target population. Inclusion of a care manager, often a nurse or social worker, likely enhances successful collaboration.
2. **Clinical information systems:** All care team members should have access to the following:
   *a. **Population-based patient registry:** The registry should longitudinally track screening, diagnoses, services, and treatment response for the entire patient panel.
   b. **Shared electronic health records (EHRs):** All care team members should have access to the EHR.
   c. **Inpatient and emergency department utilization data:** A system for real-time monitoring of inpatient and emergency department utilization.
   d. **Quality improvement data:** A system tracking practice- and provider-level performance metrics.
*3. **Patient-centered care plan:** A care plan jointly developed by the care team and the patient, with individualized treatment goals.
4. **Decision-support protocols:** Standard protocols for delivery of evidence-based treatment.
5. **Financing mechanisms:** Mechanisms to adequately reimburse providers for the process-of-care elements in Panel A and the costs associated with creating and maintaining the structural elements of integrated care in Panel B.

*Elements that may be most feasible for low-resource settings.

outcomes in clinical trials and the need to address remaining barriers. We posit two policy priorities: workforce and social determinants of health.

General medical practices attempting to integrate behavioral health care cite lack of available specialists as a barrier (60). Common policy tools, such as loan repayment programs, for addressing health care workforce gaps may help increase recruitment into the field, but significant expansion will likely require increasing insurance payment for behavioral health services to levels that allow organizations to offer compensation high enough to incentivize people to choose behavioral health careers (61). Siloed general medical and specialty mental health training impedes integration (62). Institutional or graduate medical education accreditation policies could require general medical clinicians to demonstrate key behavioral health competencies and vice versa. Such competencies are critical, given studies showing that general medical providers' discomfort with and potential bias toward patients with behavioral health conditions can translate into suboptimal care (63–67). Policies could also require training in team-based and integrated care for both professions. Telehealth and mobile health (mHealth) applications may ease workforce shortages and facilitate integrated care by reducing the need for in-person services (68, 69). Although robust discussion of the many policy issues surrounding expansion of these strategies (70) is outside the scope of this piece, policies supporting scale-up—for example, insurance reimbursement policies for "telemental" health services and evidence-based behavioral health mHealth applications, such as the Food and Drug Administration–approved prescription digital therapeutic reSET (71)—could support integration.

Finally, it is critical to address social factors that underlie and exacerbate poor health outcomes among people with mental illness and substance use disorders. Integrated care models should go beyond the current focus on general medical–behavioral health integration and also consider integration of social services. ACOs and the more recent accountable health community model may serve as avenues for social service integration (72, 73). Societywide policies strengthening the social safety net are needed, as are policies targeting people with behavioral health conditions specifically, such as state laws allocating resources to evidence-based supportive housing and employment programs (74, 75) or insurance reimbursement mechanisms to pay for these services.

CONCLUSIONS

Integrated care models shown to improve health outcomes among people with mental illness or substance use disorders in clinical trials are complex and challenging to scale up in real-world settings. Payment policies are needed that adequately support both process-of-care and structural elements of integrated care, that incentivize multidisciplinary team formation and accountability for patient outcomes, and that expand the behavioral health workforce and address the social determinants of health that prevent many people with behavioral health conditions from accessing, engaging in, and realizing the full benefits of treatment.

AUTHOR AND ARTICLE INFORMATION

Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health (McGinty), and Division of General Internal Medicine, Johns Hopkins School of Medicine (Daumit), Baltimore. Send correspondence to Dr. McGinty (bmcginty@jhu.edu).

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REFERENCES

1. Key Substance Use and Mental Health Indicators in the United States: Results From the 2018 National Survey on Drug Use and Health. HHS pub no PEP19-5068, NSDUH Series H-54. Rockville, MD, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2019. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf
2. Janssen EM, McGinty EE, Azrin ST, et al: Review of the evidence: prevalence of medical conditions in the United States population with serious mental illness. Gen Hosp Psychiatry 2015; 37:199–222
3. Parker R, Aithal GP, Becker U, et al: Natural history of histologically proven alcohol-related liver disease: a systematic review. J Hepatol 2019; 71:586–593
4. Mueser KT, McGurk SR: Schizophrenia. Lancet 2004; 363: 2063–2072
5. Dasgupta N, Beletsky L, Ciccarone D: Opioid crisis: no easy fix to its social and economic determinants. Am J Public Health 2018; 108:182–186
6. McGinty EE, Baller J, Azrin ST, et al: Quality of medical care for persons with serious mental illness: a comprehensive review. Schizophr Res 2015; 165:227–235
7. Mathers BM, Degenhardt L, Ali H, et al: HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. Lancet 2010; 375: 1014–1028
8. Friedrich MJ: Depression is the leading cause of disability around the world. JAMA 2017; 317:1517
9. Olfson M, Gerhard T, Huang C, et al: Premature mortality among adults with schizophrenia in the United States. JAMA Psychiatry 2015; 72:1172–1181
10. Rx Awareness. Atlanta, Centers for Disease Control and Prevention, 2020. https://www.cdc.gov/rxawareness/index.html. Accessed March 6, 2020
11. Druss BG: The mental health/primary care interface in the United States: history, structure, and context. Gen Hosp Psychiatry 2002; 24:197–202
12. Goldman HH: Integrating health and mental health services: historical obstacles and opportunities. Am J Psychiatry 1982; 139: 616–620
13. Park LT, Zarate CA Jr: Depression in the primary care setting. N Engl J Med 2019; 380:559–568
14. Ramanuj P, Ferenchik E, Docherty M, et al: Evolving models of integrated behavioral health and primary care. Curr Psychiatry Rep 2019; 21:4
15. Overbeck G, Davidsen AS, Kousgaard MB: Enablers and barriers to implementing collaborative care for anxiety and depression: a systematic qualitative review. Implement Sci 2016; 11:165
16. Kroenke K, Unutzer J: Closing the false divide: sustainable approaches to integrating mental health services into primary care. J Gen Intern Med 2017; 32:404–410
17. Press MJ, Howe R, Schoenbaum M, et al: Medicare payment for behavioral health integration. N Engl J Med 2017; 376:405–407
18. Wagner EH, Austin BT, Von Korff M: Organizing care for patients with chronic illness. Milbank Q 1996; 74:511–544
19. Katon W: Collaborative depression care models: from development to dissemination. Am J Prev Med 2012; 42:550–552
20. Archer J, Bower P, Gilbody S, et al: Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev 2012; 10:CD006525
21. Katon WJ, Lin EH, Von Korff M, et al: Collaborative care for patients with depression and chronic illnesses. N Engl J Med 2010; 363:2611–2620
22. Kilbourne AM, Barbaresso MM, Lai Z, et al: Improving physical health in patients with chronic mental disorders: twelve-month results from a randomized controlled collaborative care trial. J Clin Psychiatry 2017; 78:129–137
23. Watkins KE, Ober AJ, Lamp K, et al: Collaborative care for opioid and alcohol use disorders in primary care: the SUMMIT randomized clinical trial. JAMA Intern Med 2017; 177:1480–1488
24. Wood R, Wand AP: The effectiveness of consultation-liaison psychiatry in the general hospital setting: a systematic review. J Psychosom Res 2014; 76:175–192
25. McCance-Katz EF, Satterfield J: SBIRT: a key to integrate prevention and treatment of substance abuse in primary care. Am J Addict 2012; 21:176–177
26. Saitz R, Palfai TP, Cheng DM, et al: Screening and brief intervention for drug use in primary care: the ASPIRE randomized clinical trial. JAMA 2014; 312:502–513
27. Kaner EF, Beyer FR, Muirhead C, et al: Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database Syst Rev 2018; 2:CD004148
28. Gilbody S, Bower P, Fletcher J, et al: Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med 2006; 166:2314–2321
29. Bower P, Gilbody S, Richards D, et al: Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. Br J Psychiatry 2006; 189:484–493
30. Coventry PA, Hudson JL, Kontopantelis E, et al: Characteristics of effective collaborative care for treatment of depression: a systematic review and meta-regression of 74 randomised controlled trials. PLoS One 2014; 9:e108114
31. Bao Y, Druss BG, Jung H-Y, et al: Unpacking collaborative care for depression: examining two essential tasks for implementation. Psychiatr Serv 2016; 67:418–424
32. Chapman E, Chung H, Pincus HA: Using a continuum-based framework for behavioral health integration into primary care in New York State. Psychiatr Serv 2017; 68:756–758
33. Gerrity M: Evolving Models of Behavioral Health Integration: Evidence Update 2010–2015. New York, Milbank Memorial Fund, 2016
34. Cross DA, Qin X, Huckfeldt P, et al: Use of Medicare's behavioral health integration service codes in the first two years: an observational study. J Gen Intern Med (Epub ahead of print, Dec 16, 2019)

35. Carlo AD, Corage Baden A, McCarty RL, et al: Early health system experiences with collaborative care (COCM) billing codes: a qualitative study of leadership and support staff. J Gen Intern Med 2019; 34:2150–2158
36. Behavioral Health Integration Services. Baltimore, Centers for Medicare and Medicaid Services, 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
37. Romaire MA, Keyes V, Parish WJ, et al: Impact of medical homes on expenditures and utilization for beneficiaries with behavioral health conditions. Psychiatr Serv 2018; 69:871–878
38. Zivin K, Miller BF, Finke B, et al: Behavioral health and the Comprehensive Primary Care (CPC) Initiative: findings from the 2014 CPC behavioral health survey. BMC Health Serv Res 2017; 17: 612
39. Jackson GL, Powers BJ, Chatterjee R, et al: The patient centered medical home: a systematic review. Ann Intern Med 2013; 158: 169–178
40. Sklar M, Aarons GA, O'Connell M, et al: Mental health recovery in the patient-centered medical home. Am J Public Health 2015; 105: 1926–1934
41. Domino ME, Wells R, Morrissey JP: Serving persons with severe mental illness in primary care–based medical homes. Psychiatr Serv 2015; 66:477–483
42. MACRA and NCQA Recognition Programs. Washington, DC, National Committee for Quality Assurance, 2020. https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/benefits-support/macra. Accessed March 7, 2020
43. Counts NZ, Wrenn G, Muhlestein D: Accountable care organizations' performance in depression: lessons for value-based payment and behavioral health. J Gen Intern Med 2019; 34:2898–2900
44. Stuart EA, Barry CL, Donohue JM, et al: Effects of accountable care and payment reform on substance use disorder treatment: evidence from the initial 3 years of the alternative quality contract. Addiction 2017; 112:124–133
45. Bluestein J: 21st Century Cures Act: Implications and Opportunities for States. Washington, DC, National Academy for State Health Policy, 2016. https://nashp.org/21st-century-cures-act-implications-and-opportunities-for-states. Accessed Feb 28, 2020
46. Roby DH, Jones EE: Limits on same-day billing in Medicaid hinders integration of behavioral health into the medical home model. Psychol Serv 2016; 13:110–119
47. Behavioral Health in Primary Care. Bethesda, MD, National Association of Community Health Centers, 2018. http://www.nachc.org/wp-content/uploads/2018/10/BH-Fact-Sheet-10-10-18.pdf. Accessed Feb 28, 2020
48. Kathol RG, Butler M, McAlpine DD, et al: Barriers to physical and mental condition integrated service delivery. Psychosom Med 2010; 72:511–518
49. Xiang X, Owen R, Langi FLFG, et al: Impacts of an integrated Medicaid managed care program for adults with behavioral health conditions: the experience of Illinois. Adm Policy Ment Health Ment Health Serv Res 2019; 46:44–53
50. Fiscella K, Wakeman SE, Beletsky L: Buprenorphine deregulation and mainstreaming treatment for opioid use disorder: X the X waiver. JAMA Psychiatry 2019; 76:229–230
51. Samet JH, Botticelli M, Bharel M: Methadone in primary care: one small step for Congress, one giant leap for addiction treatment. N Engl J Med 2018; 379:7–8
52. Kirschner NM, Doherty RB: A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care: A Position Paper of the American College of Physicians. Philadelphia, American College of Physicians, 2006
53. Brooklyn JR, Sigmon SC: Vermont hub-and-spoke model of care for opioid use disorder: development, implementation, and impact. J Addict Med 2017; 11:286–292
54. Rawson R, Cousins SJ, McCann M, et al: Assessment of medication for opioid use disorder as delivered within the Vermont hub and spoke system. J Subst Abuse Treat 2019; 97:84–90
55. Patel KK: Can alternative payment models save primary care? Lessons from Hawaii for the nation. JAMA 2019; 322:35–36
56. Health Home Information Resource Center. Baltimore, Centers for Medicare and Medicaid Services, 2020. https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html. Accessed Feb 28, 2020
57. Pincus HA, Jun M, Franx G, et al: How can we link general medical and behavioral health care? International models for practice and policy. Psychiatr Serv 2015; 66:775–777
58. Solberg LI, Crain AL, Jaeckels N, et al: The DIAMOND initiative: implementing collaborative care for depression in 75 primary care clinics. Implement Sci 2013; 8:135
59. Solberg LI, Crain AL, Maciosek MV, et al: A stepped-wedge evaluation of an initiative to spread the collaborative care model for depression in primary care. Ann Fam Med 2015; 13:412–420
60. Buche J, Singer PM, Grazier K, et al: Primary Care and Behavioral Health Workforce Integration: Barriers and Best Practices. Ann Arbor, MI, Behavioral Health Workforce Research Center, 2017
61. Hoge MA, Stuart GW, Morris J, et al: Mental health and addiction workforce development: federal leadership is needed to address the growing crisis. Health Aff 2013; 32:2005–2012
62. Shalev D, Docherty M, Spaeth-Rublee B, et al: Bridging the behavioral health gap in serious illness care: challenges and strategies for workforce development. Am J Geriatr Psychiatry 2019; 28: 448–462
63. Tai-Seale M, Bramson R, Drukker D, et al: Understanding primary care physicians' propensity to assess elderly patients for depression using interaction and survey data. Med Care 2005; 43:1217–1224
64. Tai-Seale M, McGuire T, Colenda C, et al: Two-minute mental health care for elderly patients: inside primary care visits. J Am Geriatr Soc 2007; 55:1903–1911
65. Mittal D, Corrigan P, Sherman MD, et al: Healthcare providers' attitudes toward persons with schizophrenia. Psychiatr Rehabil J 2014; 37:297–303
66. Corrigan PW, Mittal D, Reaves CM, et al: Mental health stigma and primary health care decisions. Psychiatry Res 2014; 218:35–38
67. Stone EM, Chen LN, Daumit GL, et al: General medical clinicians' attitudes toward people with serious mental illness: a scoping review. J Behav Health Serv Res 2019; 46:656–679
68. Staeheli M, Aseltine RH Jr, Schilling E, et al: Using mHealth technologies to improve the identification of behavioral health problems in urban primary care settings. SAGE Open Med 2017; 5: 2050312117712656
69. Myers CR: Using telehealth to remediate rural mental health and healthcare disparities. Issues Ment Health Nurs 2019; 40:233–239
70. Lerman AF, Kim D, Ozinal FR, et al: Telemental and telebehavioral health considerations: a 50-state analysis on the development of telehealth policy. Telehealth Med Today 2018; 3:1–8
71. Campbell AN, Nunes EV, Matthews AG, et al: Internet-delivered treatment for substance abuse: a multisite randomized controlled trial. Am J Psychiatry 2014; 171:683–690
72. Murray GF, Rodriguez HP, Lewis VA: Upstream with a small paddle: how ACOs are working against the current to meet patients' social needs. Health Aff 2020; 39:199–206
73. Alley DE, Asomugha CN, Conway PH, et al: Accountable health communities—addressing social needs through Medicare and Medicaid. N Engl J Med 2016; 374:8–11
74. Stergiopoulos V, Hwang SW, Gozdzik A, et al: Effect of scattered-site housing using rent supplements and intensive case management on housing stability among homeless adults with mental illness: a randomized trial. JAMA 2015; 313:905–915
75. Mueser KT, Drake RE, Bond GR: Recent advances in supported employment for people with serious mental illness. Curr Opin Psychiatry 2016; 29:196–201