Integrating Primary Care & Behavioral Health

Training for Providers

March 2026

The information in this presentation is current as of the published date noted below and is subject to change.

- Current Health Care System
- Integrated Care
- Importance of Integration
- Impact of Integration
- Integration for Children & Youth
- Integration Tools

Current Health Care System

Mental Health in America

A Snapshot of Impact and Cost

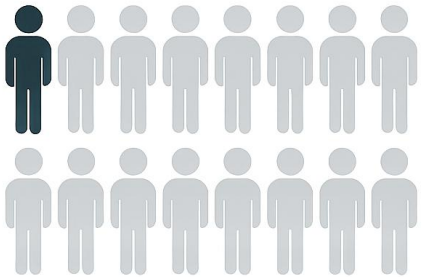
90% of the $4.5 trillion spent on health care in 2002 was for individuals with chronic physical and mental health

2.8% OF ADULTS LIVE WITH BIPOLAR DISORDER

<1% of adults live with schizophrenia

19.1% experienced an anxiety disorder

In 2023, more than 1 in 5 high school students seriously considered suicide and 1 in 10 attempted suicide



1 IN 20 ADULTS EXPERIENCES SERIOUS MENTAL ILLNES (SMI)

8.3% EXPERIENCED

ONE MAJOR DEPRESSIVE EPISODE

1 in 5 adults experiences mental illness

Challenges Faced When Living with Serious Mental Illness

Less nutritious food

Higher BMI levels (obesity)

Exercise less

Use Emergency Rooms more often

Increased rates of diabetes, arthritis, asthma, and heart disease

See physicians and other healthcare providers less

More likely to underuse, overuse, or misuse medication

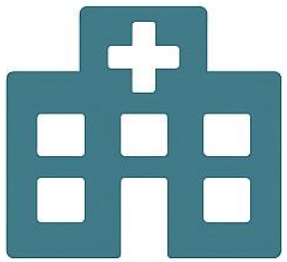
Often live in neighborhoods that makes health lifestyle changes difficult

Use antipsychotic drugs (presciption) linked to increased incidence of obesity, diabetes, and hyperlipidemia in patients with SMI

Serious Mental Illness (SMI) has an impact on overall well-being, including physical health and social determinants of heath.

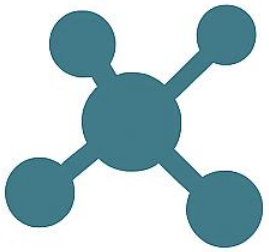
Physical Health and Mental Health Interconnection

Having a chronic health condition can make you more likely to have a mental health condition due to:



hospitalization or reduced mobility resulting in isolation

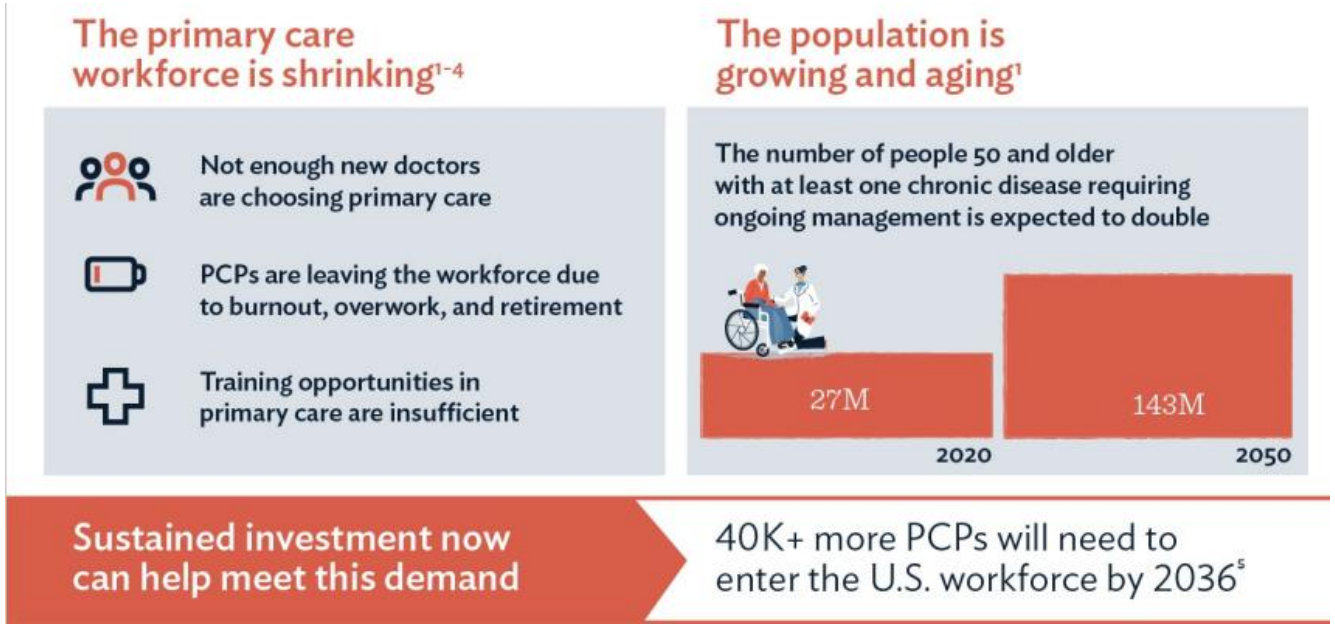
excessive worry about managing a chronic health condition



chemical and hormonal changes

inflammation from long-term stress

PC Gaps & Comorbidities



As of 2021,

over **4.6M** children under 18 have been diagnosed with asthma, the leading illness among US children

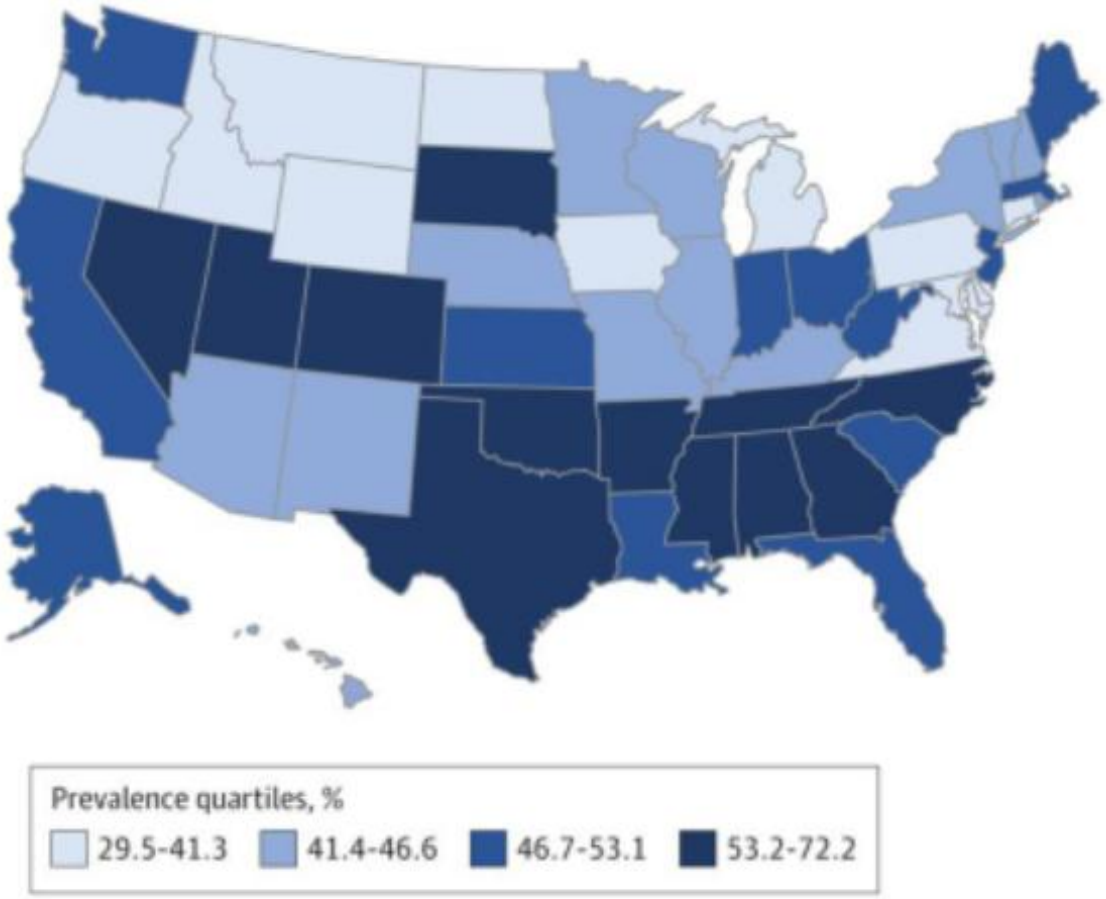
Asthma leads to **14M** school absences annually and is the 3rd leading cause of hospitalizations for children under 15

Children living with asthma are **18x** more likely to have mental health problems and **14x** more likely to have developmental difficulties

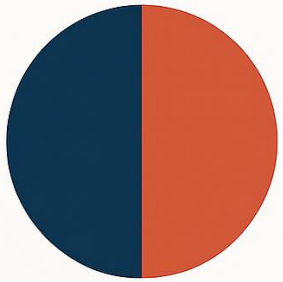
2M adolescents in the US have a chronic health condition that limits daily activity, while depression is a leading cause of overall disability

Access to BH Care

Prevalence of Not Receiving Care in Children with Mental Health Disorders



US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children (2019)

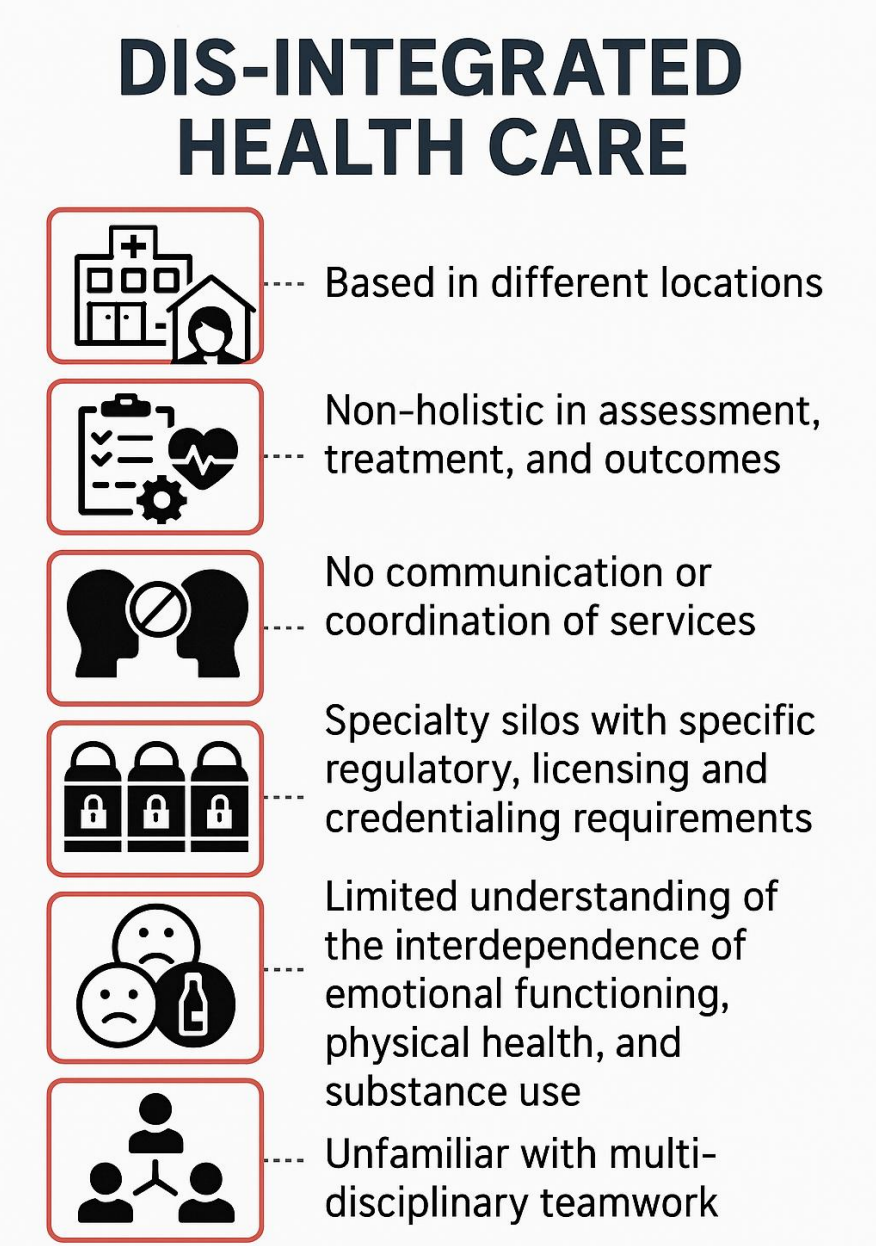


50% of the ~7.7M children in the United States with a treatable mental health disorder do not receive needed treatment

Some states report rates of treatment gaps **70%**

Integration Current State

Physical Health and Behavioral Health conditions are treated separately, and the physical set-up of practices and training of Providers reinforces dis-integration.



Present Condition: Fragmented

Medical Care

- Nurse takes vitals and initiates inquiry around the purpose of the visits (5 minutes)
- Individual medical practitioner diagnoses, prescribes further tests and provides treatment or refers to a specialist (10-15 minutes)
- Nurse may follow up with a call
- Focus on a narrow complaints of the patient

Behavioral Health Care

Mental Health

- Intake interview with many life areas covered (60-90 minutes)
- Individual therapist assigned and sets up first meeting (45 minutes)
- Psychiatrist identified and sets up first mental status and psychiatric diagnosis and medication (15-30 minutes)
- Sets up follow-up meetings on a monthly, bi-monthly or quarterly basis
- Individual, group or more intensive treatments including full day services
- Focus primarily on mental health-related symptoms and functional problems

Substance Use Disorder

- Intake interview with many life areas covered (60-90 minutes)
- Individual therapist assigned and sets up first meeting (45 minutes)
- Psychiatrist identified and sets up first mental status and psychiatric diagnosis and medication (15-30 minutes)
- Sets up follow-up meetings on a monthly, bi-monthly or quarterly basis
- Individual, group or more intensive treatments including full day services
- Focus primarily on mental health-related symptoms and functional problems

Integrated Care

The Body must be treated as a whole and not just as a series of parts.

– Hippocrates, 300 BC

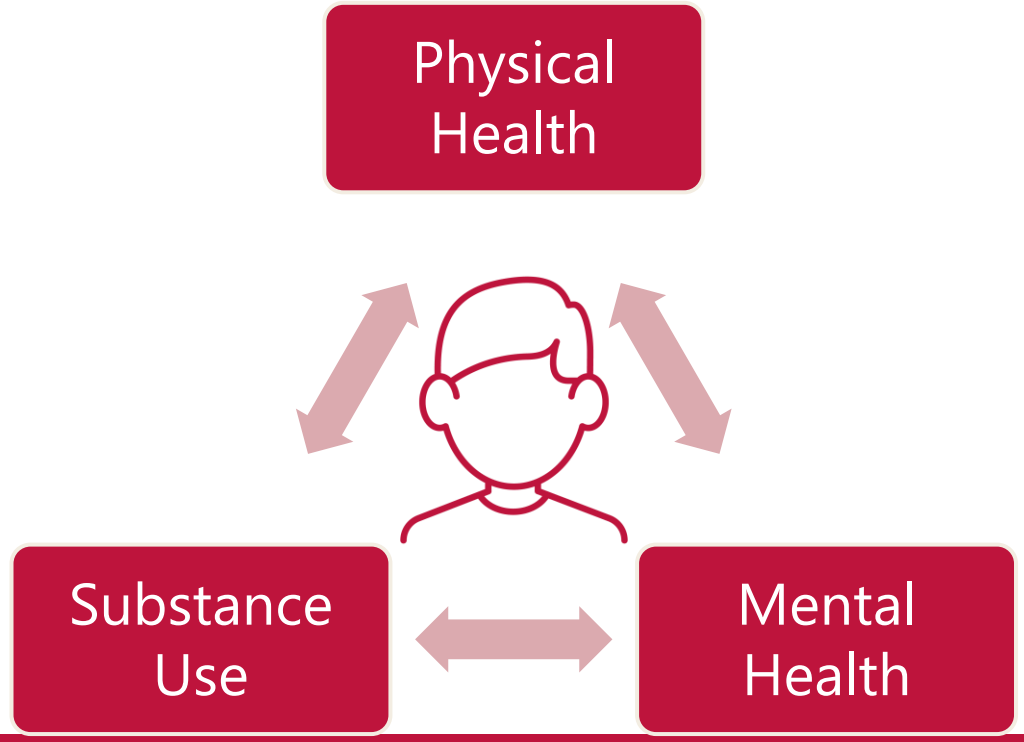
End Goal: Whole Person Care & Triple Aim

Integration enables these outcomes:

1. Improving the Health of Populations of People
2. Bending the Cost Curve
3. Improving the Patient's Experience/Quality of Care

Integrated Behavioral Health

The care a patient experiences as a result of a team of Primary Care (PC) & Behavioral Health (BH) clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.



Core Components of Integrated Models

Patient-Centered Care Teams

- Team-based care: effective collaboration between PCPs and behavioral health providers
- Nurses, social workers, psychologists, psychiatrists, licensed counselors, pharmacists, and medical assistants can all play an important role

Population-Based Care

- Behavioral health patients tracked in a registry: no one “falls through the cracks”

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient
- Treatments are actively changed until the clinical goals are achieved

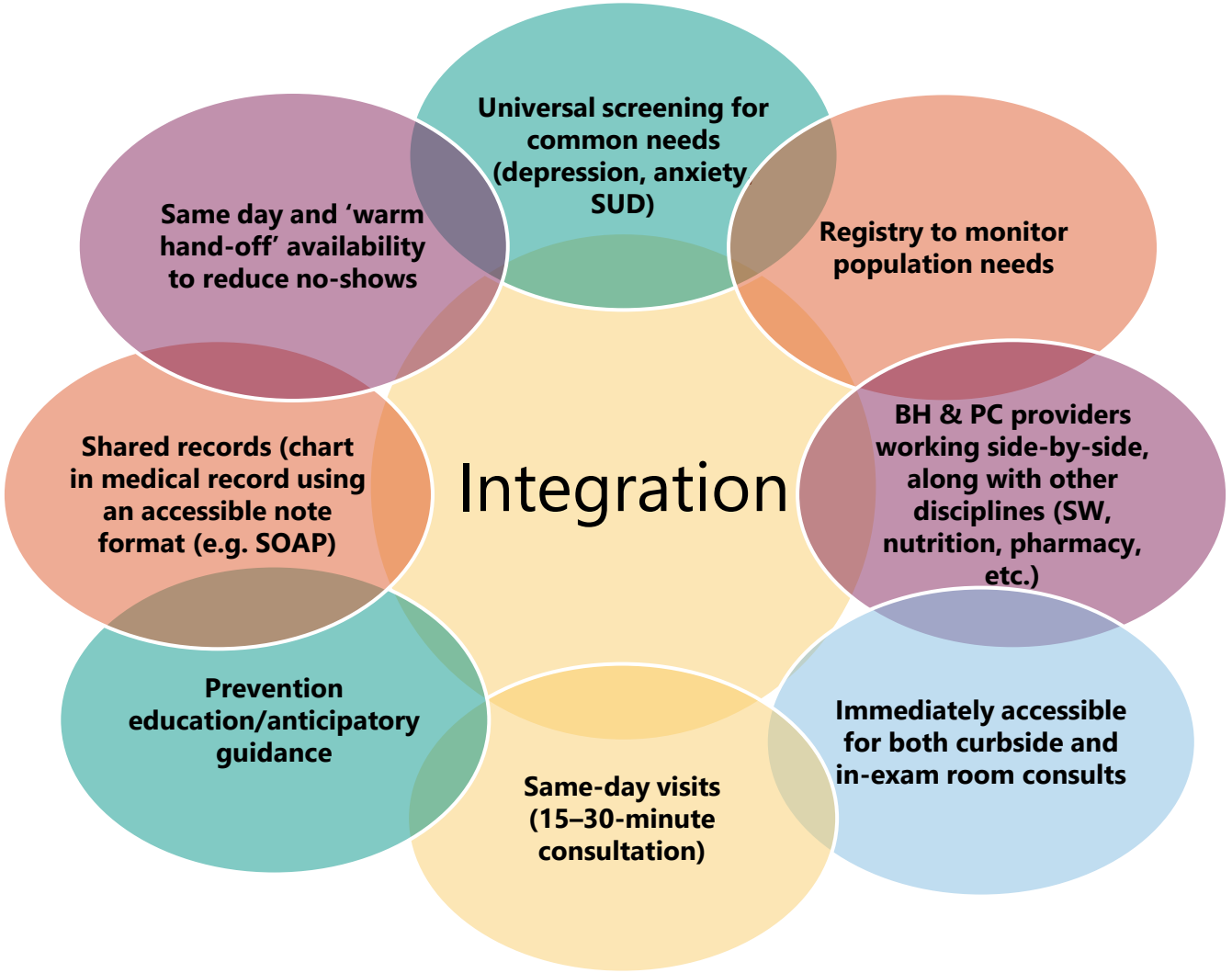
Evidence-Based Care

- Treatments are evidence-based

Core Integrated Care Components for Youth

Family and Youth-Guided Teams with Care Coordination Capability	• A coordinator is designated to communicate, coordinate, and educate. Family members and youths are considered important participants and advisors throughout the process.
Individualized and Coordinated Care Plans	• Care plans are individualized & guided by family/youth input, including their values, preferences, & available resources.
Use of Evidence-Based Guidelines	• Use EBPs, screening, & assessment tools, follow the guidance of *Bright Futures initiative of American Academy of Pediatrics* for well child visits until the age of 21
Established & Accountable Relationships with Other Entities	• Organizations establish relationships with outside entities including formal agreements on topics such as communication standards, wait times, or responsibility for development of care plans.
Data-Informed Planning	• Organizations have clinical information systems that support proactive planning & informed decision making on both individual and population levels

What Can Integration Look Like?



Common Integrated Interventions & Issues

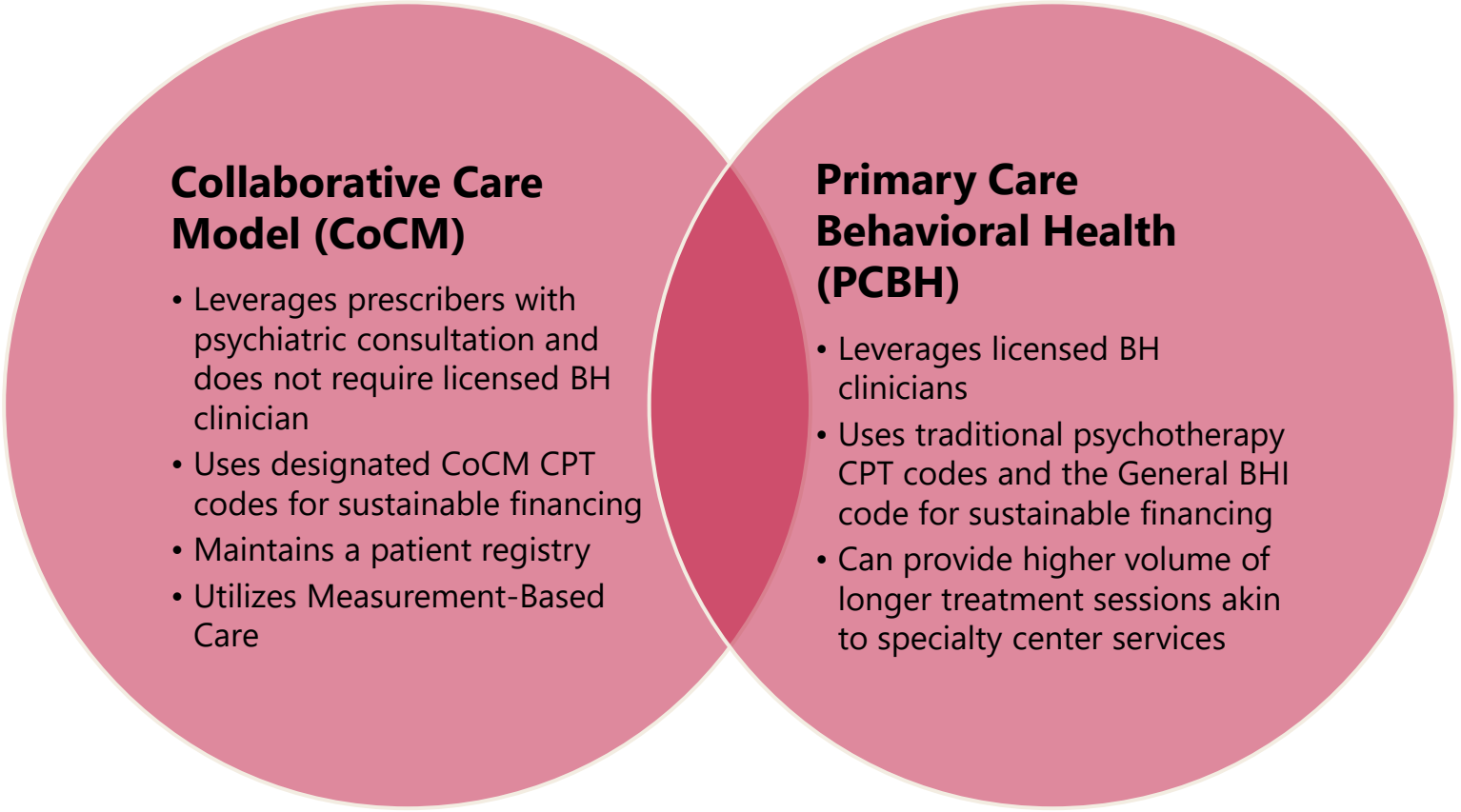
Interventions

- Brief treatments (versus traditional long-term therapies)
- Address a clear problem (depression, insomnia, pain)
- Help patients learn to manage the issues they live with (weight, chronic disease, tobacco use)

Issues

- Involve different types of professionals (doctors and nurses, social workers, psychologists, nutritionist, pharmacists) all addressing a related problem(s) in a single setting
- Disconnect between training and the field practice requires integration
- Inconsistent standards between trade associations and accrediting bodies leaves gaps across specialties
- Integrated care is unique and distinct from traditional methods of thinking about patients' needs delivering services, and organizing clinics

Integration Models



Source: Behavioral Health Integration and Guidance Initiative - MMHPI - Meadows Mental Health Policy Institute

Overlap between models:

- An **interdisciplinary team**-based structure
- Leads to **stigma-reduction** related to help-seeking in community (as opposed to specialty) settings
- Utilize e**vidence-based** measures to guide treatment planning
- Have dedicated reimbursement codes resulting in **longitudinal cost-savings** covered by nearly every commercial payer and most state Medicaid plans
- Maintain a **BH provider on staff** with real-time availability
- Employ brief interventions to **address low- to moderate-acuity** presentations that would otherwise be inappropriate redirected into overloaded community referral pathways

Opportunities for Integrated Care

- Well-child visits are an early intervention opportunity
- Identify and address ACES, ADHD, behavioral problems, and intellectual disabilities
- Offer parent training and support
- Manage chronic health conditions, such as obesity and asthma
- Address Substance Use Disorder (SUD), which may include medication and BH interventions
- Connection to community resources

Importance of Integration

Case for Integration

Improved Patient Outcomes in Primary Care	Reduced Risk for Serious Mental Illness (SMI)	Increased Satisfaction	Cost Savings
Studies examining integration of BH into PC find improvements in: • Anxiety • Depression • Trauma • Sleep • Tobacco	People treated in integrated care with SMI showed greater reductions of risk for metabolic syndrome and physical conditions, such as: • Hypertension • Dyslipidemia • Diabetes • Cardiovascular Disease	Team-based PC-BH care has also been shown to improve Provider satisfaction and decrease Provider burn-out	Individuals participating in PC depression management experienced a reduction in workplace absenteeism by over 28% Overall reduction in number of PC visits
Patients treated in integrated care live better, are more functional, and less distressed		Patients in integrated Primary Care-Behavioral Health (PC-BH) settings have reported high levels (e.g., 97%) of satisfaction and increased functioning	Numerous studies have revealed cost savings due to decreased use of Emergency Department (ED) and hospital admissions • 19% reduction in ED visits is reported from PC-BH integration

Benefits of Integrated Care

- Improvement in Provider satisfaction in quality
- Increased access to services
- High patient and family satisfaction
- Improvement in early recognition and treatment of issues, such as Mental Health
- Promising outcomes for improvement of parenting skills, obesity, sleep, and other issues

High Cost of Care

- Costs for treating patients with chronic medical and comorbid mental health /substance use disorders **can be 2-3 times higher**

- Additional costs incurred by people with behavioral comorbidities estimated to be **$293 Billion in 2012**

- Researchers estimate that IBH could cost as little as **$20k** per practice to implement and save nationwide **$38B to $68B** in health care spending annually

Sources: Integrated Behavioral Health Works and Saves Money. Why Aren't We Doing It? | Milbank Memorial Fund
Economic Impact of Integrated Medical-Behavioral Healthcare Implications for Psychiatry

Integrated Facilities

Article 31 Facilities
Mental Health Clinics

Licensed by NYS OMH

Provides:

- Outpatient Mental Health Services:
  - Assessment
  - Therapy
  - Medication Management
- May integrate Primary Care Screening Services if thresholds are met
- Called Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Program

Article 32 Facilities
Substance Use Clinics

Licensed by NYS OASAS

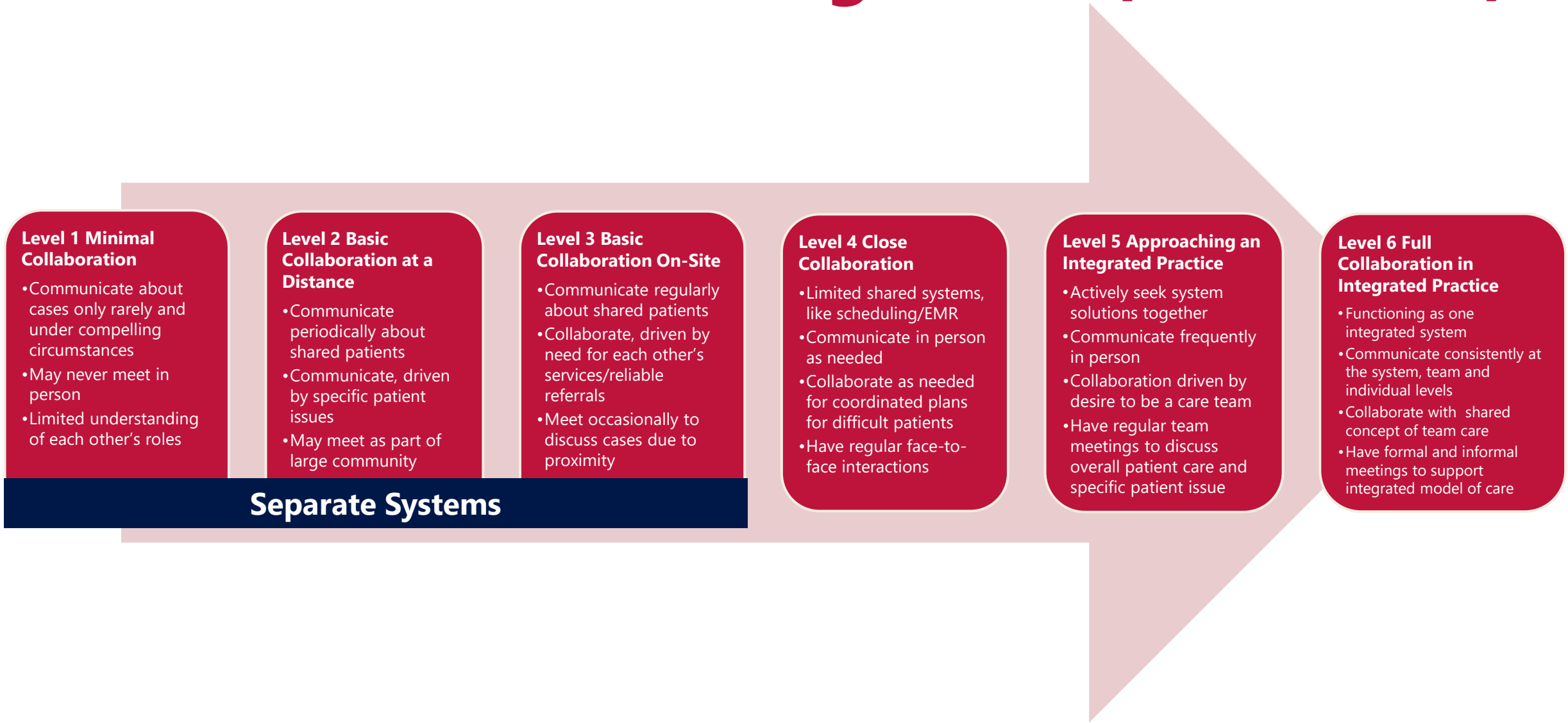
Provides:

- Outpatient Substance Use Disorder Services:
  - Counseling
  - Medication Assisted Treatment (MAT)
  - Recovery Supports
- May include basic Primary Care Screenings and coordinate with PH providers

Integration Rules for Article 31/32 Facilities

- Basic Physical Health Screenings (vitals, BMI, diabetes risk)
- If medical visits exceed 5% of total visits facility must also obtain Article 28 licensure
- Purpose: Ensures clinics expanding into full primary care meet safety/quality standards
- Encourages BH clinics to partner or co-locate with medical providers

SAMHSA Levels of Integration (Levels 1-6)



Innovation in Behavioral Health (IBH) Model

- On January 18, 2024, the Centers for Medicare & Medicaid Services (CMS) announced the Innovation in Behavioral Health (IBH) Model.
- Model implementation began on January 1, 2025, in designated sub-state geographic service areas.
- The IBH Model is:
  - Focused on improving the quality of care and behavioral and physical health outcomes for adults enrolled in Medicaid and Medicare with moderate to severe mental health conditions and substance use disorder (SUD).
  - Bridging the gap between behavioral and physical health. Specialty behavioral health practices under the IBH Model will screen and assess patients for priority health conditions, as well as mental health conditions or SUD, or both.
  - A state-based model, led by state Medicaid agencies, with a goal of aligning payment between Medicaid and Medicare for integrated services
- New York State is implementing a pilot with CMS in Allegheny, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming

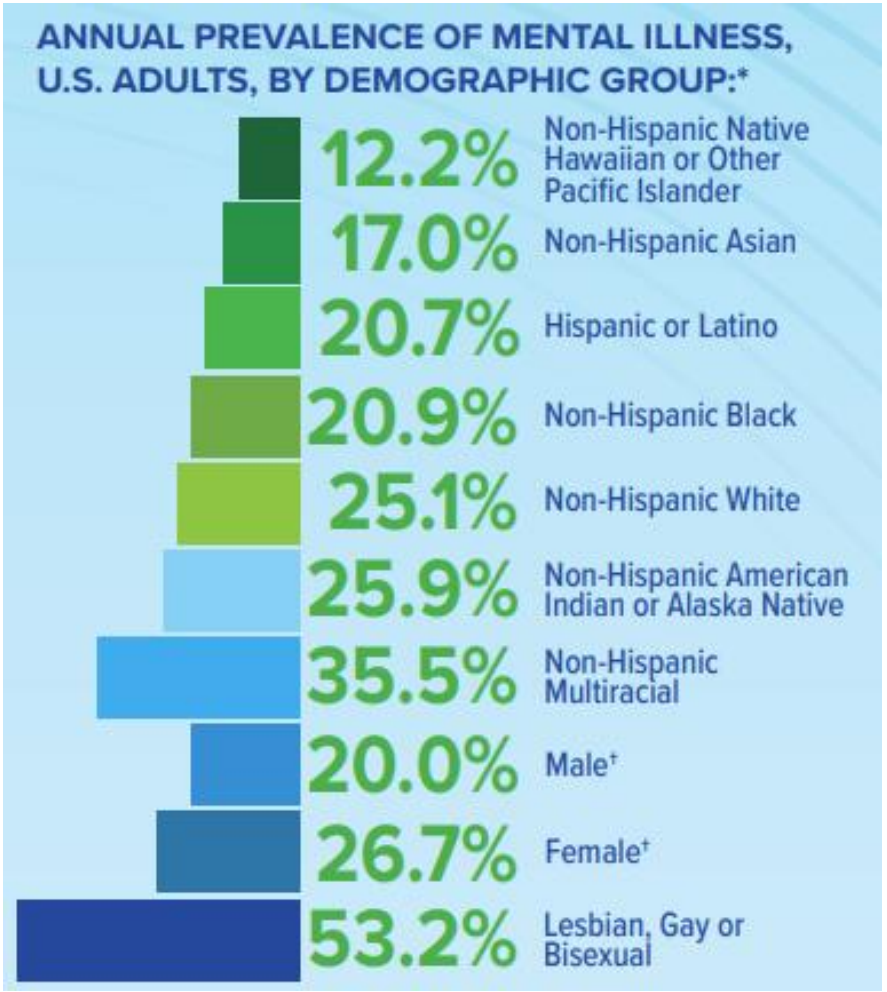
Impact of Integration

People with Serious Mental Illnesses (SMI) are at risk of premature death, largely due to cardiovascular and metabolic disorders associated with obesity, sedentary lifestyle, and smoking. Until very recently, mental health services have neglected prevention and health promotion as a core service need for people with SMI.

- Steve Bartels, MD, Dartmouth Medical Center

Impact of Integration

Integrated Care “can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration.”



Diverse Settings for Behavioral Health (BH)

Integration improves access to care and reduces barriers to care coordination.

Primary Care offices are the first line of defense for identifying and treating many Behavioral Health conditions, such as depression and suicidal ideation.

Increased Access to BH Care in Medical Settings Improves Outcomes & Experience

Integrating behavioral health into primary care leads to better health, lower costs, and improved patient satisfaction.

Why It Matters

- **Depression** is the 3rd most common reason for visits to health centers — after diabetes and hypertension
- **Opioid misuse and overdose** have reached epidemic levels
- Many individuals who **attempt suicide** have recently seen a Primary Care Provider (PCP)

Disparities & Access

- **Populations of color** are more likely to sek BH care in PCP settings than in specialty BH clinics
- **70%** of antidepressant prescriptions are written by PCPs

The Cost of Inaction

- When medical and BH needs are **not addressed** together, outcomes are **worse** and costs are higher

Medical-BH Connection

- Patients with **diabetes, heart disease,** or asthma are more likely to have BH needs, especially depression
- People with **Serious Mental illness** (SMI) die 10-25 years earlier than the general population

Investing in integrated BH care within medical setting is **essential** for improving

Clinical Support for Integrated Care

"Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity."[1]

"People who receive primary care often may have multiple health issues…Integrating behavioral and primary care is especially important to meeting their needs. People with cooccurring disorders may seek primary care services first before seeking behavioral health services…primary care practitioners have unique opportunities to identify people with co-occurring disorders through screening."[2]

"By providing mental health services in primary healthcare, more people will be able to receive the mental healthcare they need."[3]

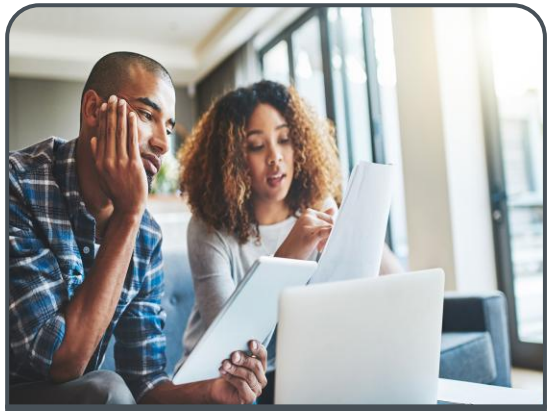
Sources: CDC • SAMHSA • National Library of Medicine

Integration for Children & Youth

Integration in Children's Services

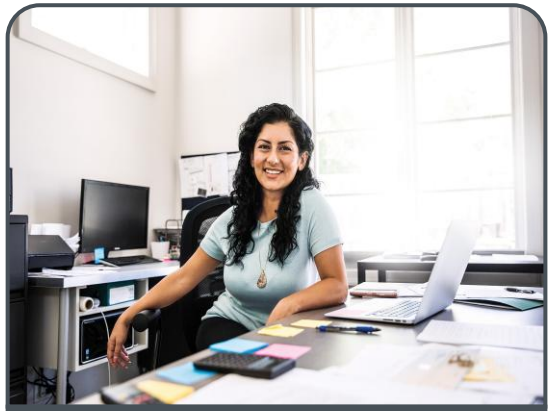
Unaddressed Behavioral Health needs in children and youth can result in more complex health issues later in life.

40-60% of all pediatric medical visits have a behavioral component



Pediatricians report feeling unable to manage behavioral needs

Limited behavioral health access available for rural/non-urban areas



Pediatricians report they do not have enough time

Sources: Adapted from Austen, J., 2018; (Kessler et al., 2005), (Burka, Van Cleve, Shafer, & Barkin, 2014; Cooper, Valleley, Pohala, Begeny, & Evans, 2006), (Miller, Petterson, Burke, Phillips, & Green, 2024)

Children 0-5 Years Integration

	Behavioral Consultation	Care-Coordination	Co-Location
Health/Development Needs	• Typical Developmental Screenings • Help with toilet training • Help with weaning • Help with diet/nutrition	• Locating services	• In-house Speech Language Pathologist/Occupational Therapy
Mental Health	• ACES (Adverse Childhood Experiences Study) • Attachment/bonding	• Parenting groups • Referrals to mental health or intensive in-home parenting help • Substance Use	• Substance Use Treatment • Family therapy
Complex/Co-Occurring	• Parenting skills for differences in development • Family Support		

Children 6-12 Years Integration

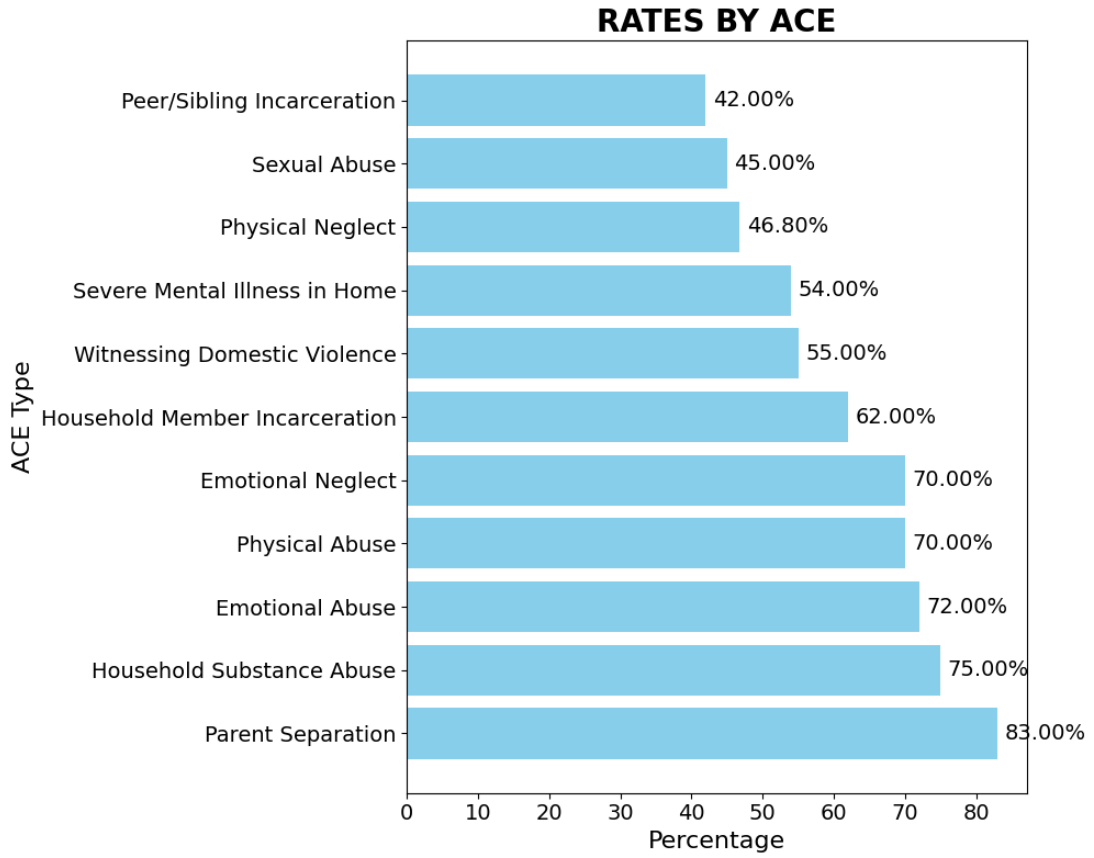
	Behavioral Consultation	Care-Coordination	Co-Location
Health/Development Needs	• Enuresis/encopresis • Needle phobia • Healthy Eating/Picky Eating • Autism Screening	• Referrals for Sleep Studies • Child Development Programs	
Mental Health	• ADHD • Emotional regulation skills • Social Skills • Sleep issues • Brief Grief and Trauma • Behavioral issues	Parenting groups • Referrals to mental health or intensive in-home parenting help • Collaboration with schools and other community stakeholders	• Substance Use Treatment • Family therapy • Individual therapy • Parent-child interaction therapy
Complex/Co-Occurring	• Parenting skills for children with chronic illness • Health Empowerment • Assessing level of needs	• Coordination with youth services • Coordination with schools	• Family therapy • In-home intensive therapy

Adolescents 12-21* Years Integration

	Behavioral Consultation	Care Coordination	Co-Location
Health/Development Needs	• Consent and medical decision-making • Sexual health • Needle phobia • Healthy Eating • Autism Screening	• Referrals to obesity programs, nutritionist, sleep studies, family planning	• Brief therapy for chronic illness, support for pregnancy
Mental Health	• ADHD (still!) • Emotional regulation skills • Social Skills • Sleep Issues • Brief Grief and Trauma • Behavioral Issues • Substance Use • Depression & Anxiety	• Parenting Groups • Referrals to mental health or intensive in home parenting help • Collaboration with schools and other community stakeholders	• Substance Use Treatment • Family Therapy • Individual Therapy • Parent-Child Interaction Therapy
Complex/Co-Occurring	• Parenting skills for children with chronic illness • Health Empowerment • Addressing level of needs	• Coordination with schools juvenile justice • Help with launching, college	• Individual therapy, family therapy, systems-level interventions

Adverse Childhood Experiences (ACE) Study

- ACES measure the relationship of childhood abuse and household dysfunction to many leading causes of death in adults
- It's the largest study of its kind, that examined the health and social effects of adverse childhood experiences over time
  - Initial report involved over 17,000 participants at Kaiser Permanente in California
  - 2025 report analyzes real-world findings with 20-years of data and child victims of ACEs remain underdiagnosed



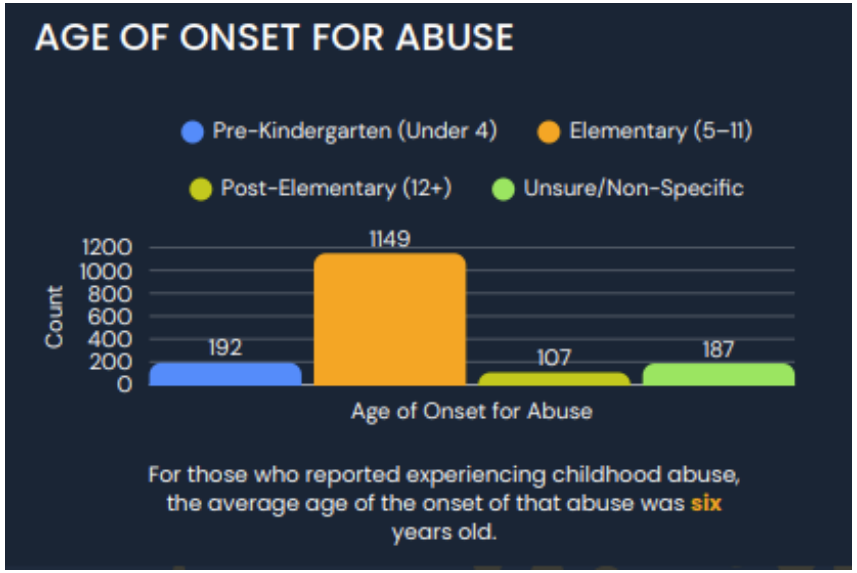
Graphic: 2025 Data

ACES Risks

ACES increase the likelihood of:

- Long term physical health problems (e.g. diabetes, heart attack)
- Risk for suicide, depression, poor sleep, risky sexual behavior
- Poor dental hygiene (beginning in childhood)
- ACE-exposed mothers bearing children with decreased birth weight and early birth, fetal mortality

- The most common age of ACE onset is Elementary School (ages 5-11 years old) according to 2025 data



Project LAUNCH

SAMHSA-funded project supporting integration in primary care for children and families for the integration of BH into Pediatric PC settings:

- Providers must be met “where they are” to establish long-lasting changes
- Behavioral health resources and enhanced referral systems facilities provider buy-in for transitioning to an integrated model
- Embedding mental health consultants supports higher screening rates, increased provider and patient satisfaction, and improved children’s social-emotional functioning
- Leveraging existing infrastructure is key to ensuring integration efforts lead to sustained change

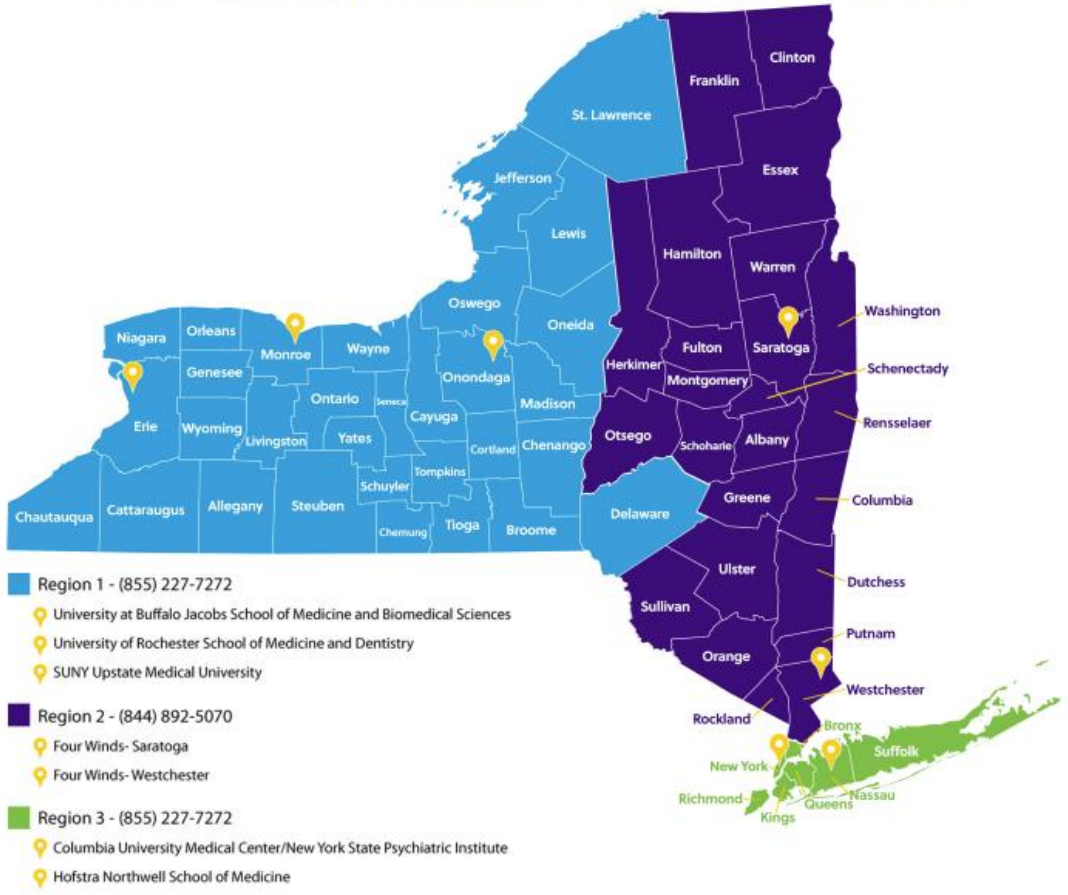
Project TEACH

Project TEACH aims to strengthen and support the ability of New York's PCPs to deliver care to children and families who experience mild-to-moderate mental health concerns in children, adolescents, and young adults up to 22 years of age. It is funded by the New York State Office of Mental Health (NYS OMH).

Project TEACH offers, at no cost:

- **Consultations** PCPs can speak on the phone with child and adolescent psychiatrists to ask questions, discuss concerns, or review treatment options. If indicated, they can also get a face-to-face evaluation
- **Referrals** Linkages and referral services help PCPs and families access community mental health treatment and support services
- **Training** Free CME-certified education and training offered in several different formats relevant to mental health in primary care

Project TEACH divides New York into three distinct regions. Teams of child and adolescent psychiatrists and health experts deliver services in each region. They complete all the consultations, deliver trainings, and provide referrals. These experts represent renowned organizations in each region.

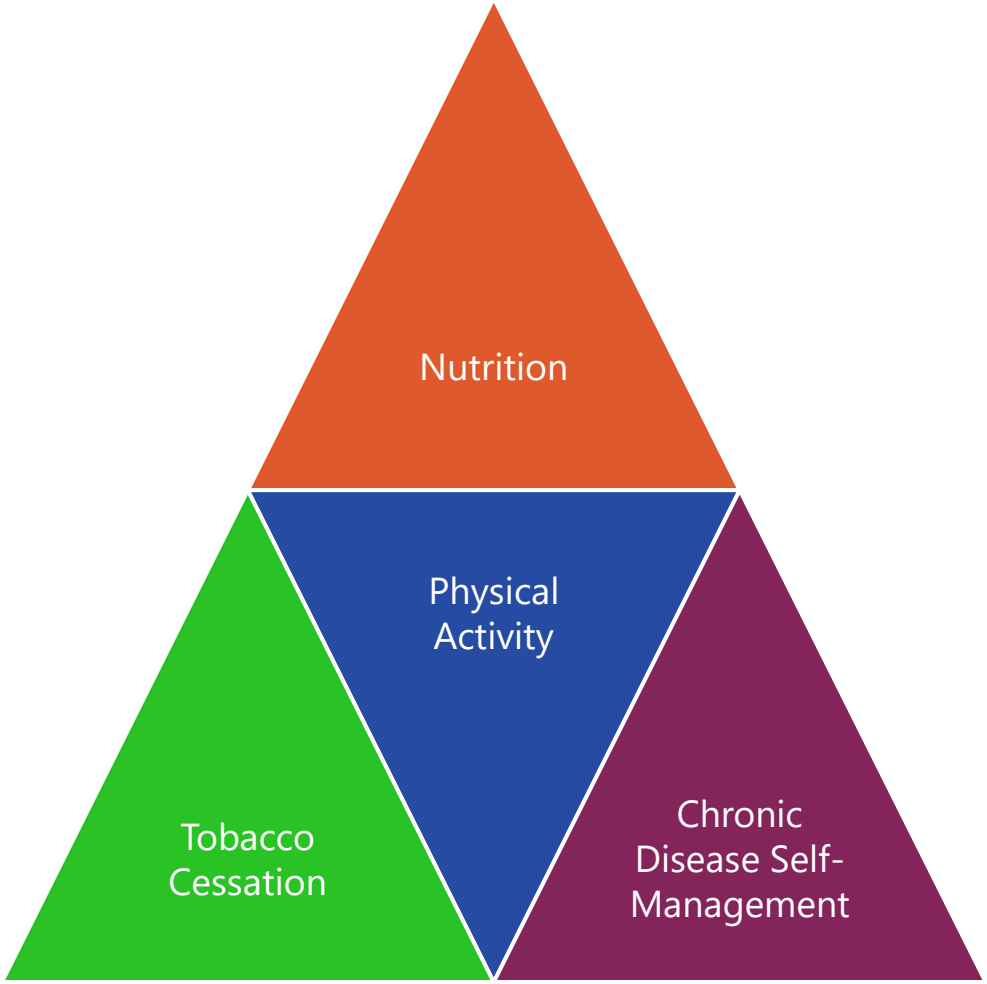


Integration Tools

Addressing High Priority Health Conditions with Effective Treatments

- Managing chronic diseases and conditions
- Tobacco/smoking reduction
- General health promotion, such as physical activity and nutrition
- Substance use disorder treatment

Evidence Informed Wellness Programs



- Person-centered
- Non-judgmental
- Consider impact of trauma, adversity, and social factors
- Holistic
- Coordination between types of care and Providers

Example Wellness Programs

1. Nutrition/Exercise

- Nutrition and Exercise for Wellness and Recovery (NEW-R)
- Center for Psychiatric Disability and Co-Occurring Medical Conditions
- Diabetes Awareness and Rehabilitation Training (DART)
- National Council for Mental Wellbeing
- Achieving Healthy Lifestyles in Psychiatric Rehabilitation (ACHIEVE)

2. Tobacco Cessation

- DIMENSIONS Tobacco Free Program
- Rutgers Health | Robert Wood Johnson Medical School
- Intensive Tobacco Dependence Intervention for Persons Challenged by Mental Illness: Manual for Nurses
- American Psychiatric Nurses Association

3. Chronic Disease Self-Management

- Whole Health Action Management (WHAM)
- Stanford University Model

Common BH Screenings in PH Settings

Many PCP offices now administer behavioral health screening tools:

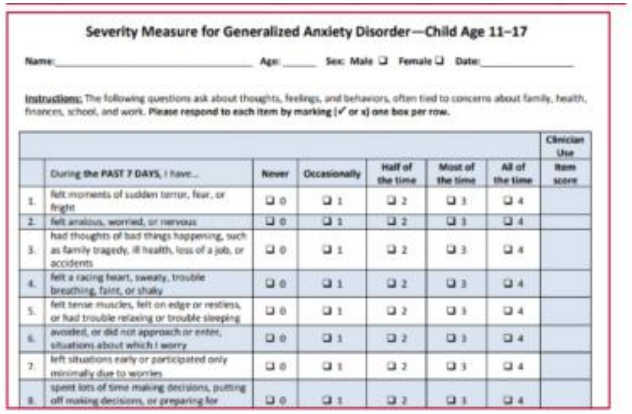
Tool	Description
PHQ-2	Two-question preliminary screening tool, if patients answer positively to either question, PHQ-9 is administered
PHQ-9	Nine-question tool for screening, diagnosing, and monitoring severity of depression
GAD-7	Seven-question tool used to measure the severity of generalized anxiety disorder

Limited standardization of metrics for BH and BH Integration Programs.

Source: BH Quality Framework NCQA

Screening & Early Intervention Tools

Severity Measure for Generalized Anxiety Disorder (PDF)



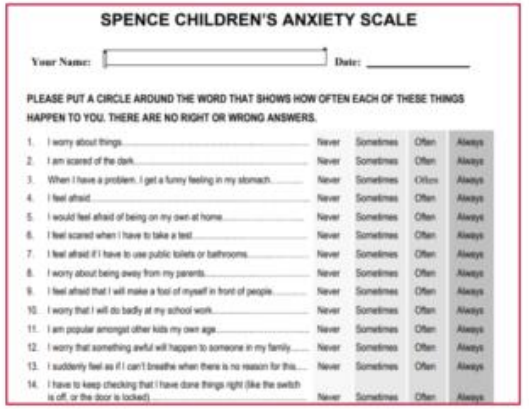
Severity Measure for Generalized Anxiety Disorder—Child Age 11–17

Name:_____ Age:_____ Sex: Male ❑ Female ❑ Date:_____

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Clinician Use Item score
1.	felt moments of sudden terror, fear, or fright	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	felt anxious, worried, or nervous	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	avoided, or did not approach or enter, situations about which I worry	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	left situations early or participated only minimally due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	

SPENCE Child Anxiety Scale



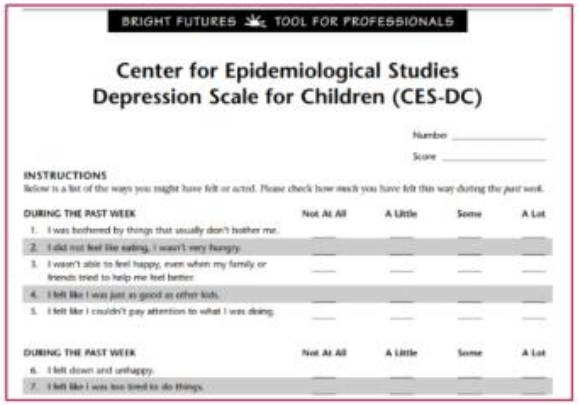
SPENCE CHILDREN'S ANXIETY SCALE

Your Name: _____ Date: _____

PLEASE PUT A CIRCLE AROUND THE WORD THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU. THERE ARE NO RIGHT OR WRONG ANSWERS.

1.	I worry about things	Never	Sometimes	Often	Always
2.	I am scared of the dark	Never	Sometimes	Often	Always
3.	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4.	I feel afraid	Never	Sometimes	Often	Always
5.	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6.	I feel scared when I have to take a test	Never	Sometimes	Often	Always
7.	I feel afraid if I have to use public toilets or bathrooms	Never	Sometimes	Often	Always
8.	I worry about being away from my parents	Never	Sometimes	Often	Always
9.	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
10.	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
11.	I am popular amongst other kids my own age	Never	Sometimes	Often	Always
12.	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
13.	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
14.	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always

Depression Scale for Children (CES-DC) (PDF)



BRIGHT FUTURES TOOL FOR PROFESSIONALS

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

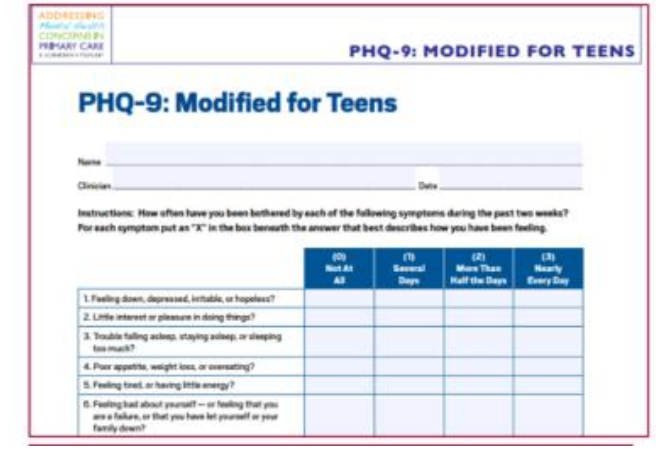
INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how much you have felt this way during the *past* week.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; I wasn't very hungry.				
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.				
4. I felt like I was just as good as other kids.				
5. I felt like I couldn't pay attention to what I was doing.				

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.				
7. I felt like I was too tired to do things.				

PHQ-9 for Teens (PDF)



ADDRESSING Mental Health CONCERNS IN PRIMARY CARE

PHQ-9: MODIFIED FOR TEENS

PHQ-9: Modified for Teens

Name _____

Clinician _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				

Screening & Early Intervention Tools

BEARS Pilot Study

BEARS SLEEP SCREENING ALGORITHM

The "BEARS" instrument is divided into five major sleep domains, providing a compreh
in the 2- to 18-year old range. Each sleep domain has a set of age-appro

B = bedtime problems
E = excessive daytime sleepiness
A = awakenings during the night
R = regularity and duration of sleep
S = snoring

Examples of developmentally appropriate

	Toddler/preschool (2-5 years)	School-aged (6-12 years)	Adolescent (13-18 years)
1. Bedtime problems	Does your child have any problems going to bed? Falling asleep?	Does your child have any problems at bedtime? (P) Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C)
2. Excessive daytime sleepiness	Does your child seem overtired or sleepy a lot during the day? Does she still take naps?	Does your child have difficulty waking in the morning, seem sleepy during the day or take naps? (P) Do you feel tired a lot? (C)	Do you feel sleep a lot during the day? In school? While driving? (C)
3. Awakenings during the night	Does your child wake up a lot at night?	Does your child seem to wake up a lot at night?	Do you wake up a lot at night? Have trouble

NICHQ-VVanderbilt ADHD Assessment (PDF)

NICHQ Vanderbilt Assessment Scale—PARENT Informant

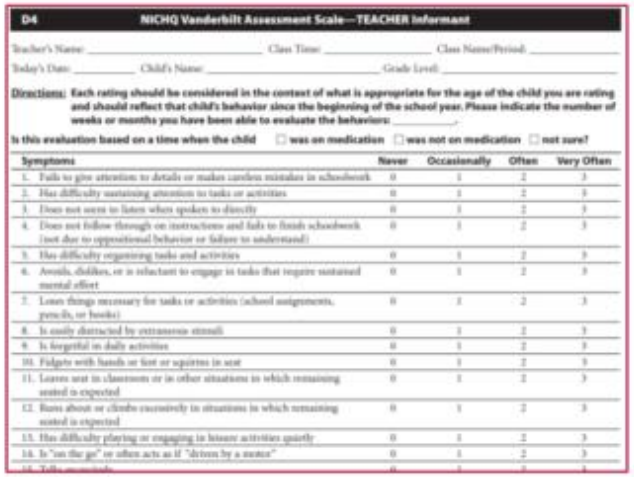
Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1		
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1		
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1		
8. Is easily distracted by noises or other stimuli	0	1		
9. Is forgetful in daily activities	0	1		
10. Fidgets with hands or feet or squirms in seat	0	1		
11. Leaves seat when remaining seated is expected	0	1		
12. Runs about or climbs too much when remaining seated is expected	0	1		
13. Has difficulty playing or beginning quiet play activities	0	1		



Integrated Case Management

- Increase points of contact to manage complex behavioral and medical needs of patients
- Utilize population and patient-level tracking
- Decreases outpatient utilization
- Address obstacles and barriers to treatment
- Improve self-management skills
- Maintain patient engagement
- Provision through NYS Medicaid (Case Management Policy)

Approaches

Wholistic integration includes patient-centered techniques that address Whole Person Health.

The Most Effective Approaches for Integration

All about the quality of the patient-provider relationship

Aligned with a person's readiness level

Addresses the emotional issues related to health management

Mobilizes helpful social supports

Addresses lifestyle changes

Explores the use of medication combined with counseling and psychological therapies

Focuses on the person's felt needs for change and high priority goals

Respects the person's cultural, religious and personally meaningful values

Considers the person's day-to-day realities (what's realistic)

Includes a way of monitoring improvements

Involves peers where possible

Sources: Primary Care Mental Health Integration

Summary

- Integration creates agility and flexibility to address gaps in care and shifting workforce dynamics in Primary Care and Behavioral Health
- Data sharing agreements and protocols enable integration across separate practices and specialties on behalf of the patient

Conclusion

- Integration improves health outcomes and yields cost savings
- There is an upfront cost to integration, including Provider Education across specialties, physical space changes, and secure, data systems for medical records and correspondence

Screening & Early Intervention Tools

- BEARS Pilot Study
- Depression Scale for Children (CES-DC) (PDF)
- NICHQ-VVanderbilt ADHD Assessment (PDF)
- PHQ-9 for Teens (PDF)
- Severity Measure for Generalized Anxiety Disorder (PDF)
- SPENCE Child Anxiety Scale

Resources/References

- AACP Pediatric Health Home Integration (PDF)
- Adverse childhood experiences and health outcomes: a 20-year real-world study - PubMed
- Andrew Philip, PhD: Primary Care Development Corporation
- Anthony Salerno, PhD: NYU McSilver Institute for Poverty Policy and Research
- A Novel Approach for Mental Health Disease Management: The Air Force Medical Service's Interdisciplinary Model | Disease Management Center of Excellence Resources
- Behavioral Health Integration and Guidance Initiative - MMHPI - Meadows Mental Health Policy Institute
- Center for Disease Control

Resources/References

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- Chronic Health Conditions and Mental Health | Mental Health America
- Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence | American Journal of Psychiatry
- Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report | ASPE
- Exploring the Promise of Population Health Management Programs to Improve Health. Washington, DC: Mathematica Policy Research (PDF)

Resources/References

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- From Volume to Value: Progress, Rationale, and Guiding Principles | AAFP
- Health2 Resources
- Home | Integrated Care Resource Center
- High prevalence of mental disorders in primary care – ScienceDirect
- How integrated behavioral health is bringing pediatric psychologists into the pediatrician's office | Children's Wisconsin (January 2019)
- HRFK JULY 2025 INFOGRAPHICS
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Resources/References

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- Integrated Primary Care: Organizing the Evidence
- Integrated Primary and Behavioral Care: Role in Medical Homes and Chronic Disease Management | SpringerLink Impact of Integrated Medical and BH
- IBH (Innovation in Behavioral Health) Model | CMS
- Johns Hopkins PICC Toolkit (PDF)
- Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus National Center for Healthy Safe Children | American Institutes for Research

Resources/References

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- Primary Care Behavioral Health Model: Perspectives of Outcome, Cl...: Ingenta Connect
- Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action - PubMed
- Primary Care Workforce
- Population Management in Community Mental Health Center-Based Health Homes (PDF)
- Health Care Payment Learning & Action Network
- Integration | Agency for Healthcare Research and Quality

Resources/References

- Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare (PDF)
- Resources - AIMS Center
- SAMHSA_Business_Case_for_Behavioral_Health_Care_Monograph.pdf (PDF)
- SAMSHA Clinical Practices
- The Triple Aim: Care, Health, And Cost | Health Affairs
- What is primary care mental health? WHO and Wonca Working Party on Mental Health – PMC

Section Header

Main sentence point 1

- Supporting point 1
  - Third-level point
- Supporting point 2
- Supporting point 3

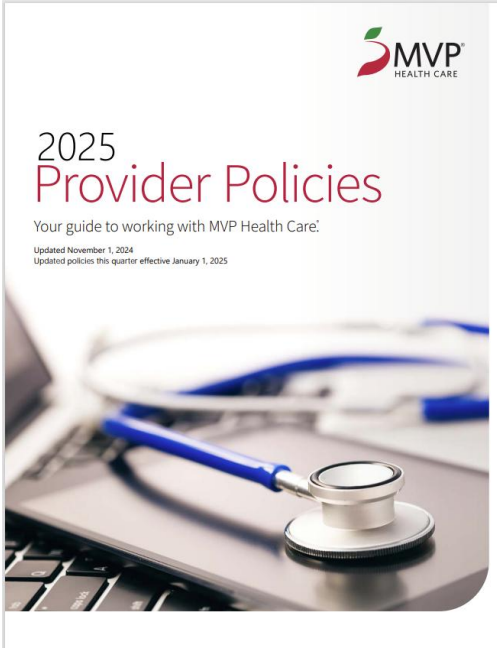
Main sentence point 2

- Supporting point 1
- Supporting point 2
- Supporting point 3

Replacement Claims

- Replacement claims (sometimes referred to as corrected claims or recall claims) submitted electronically will help MVP process the claim promptly and accurately. A replacement claim is any claim that has a change to the original claim (e.g., changes or corrections to charges, procedure or diagnostic codes, dates of service, Member name). Corrected claims may be submitted immediately. **When a replacement claim is being submitted, Providers may submit the correction electronically with a "7" as the frequency code.**

Question	Definition	Examples	How to Submit Claims
What is a replacement (or corrected or recall) claim? (Type of bill ending in 7)	A replacement claim is sent when data on the claim was either missed or needs to be corrected.	• Incorrect date of service (DOS) • Incorrect units • Procedure code missing • Diagnosis code change or addition • Revenue code changes • Line being added • Change to injury date • Change to related cause code • Change to place of service • Change to rendering provider with no billing provider change	If claim was previously processed on Facets and was billed via paper, send in CARF. If claim was previously processed on Facets and billed electronically, follow EDI/MVP replacement claim submission guidelines. Claims that require timely filing review or additional documentation needs to be submitted via CARF.
What is a voided claim? (Type of bill ending in 8)	When identifying elements change, a void submission is required to eliminate the previously submitted claim.	• Payer information change • Subscriber information change • Billing provider change • Patient information change • Statement covers period • Patient did not want insurance billed • Bill type changes from IP to OP or OP to IP	Whether original claim was submitted by paper or electronically, the void may be sent electronically. The void should be sent along with the new original claim. Follow EDI/MVP submission guidelines.



Visit: **mvphealthcare.com/policies**

- Callout point 1
  - Supporting point 1
  - Supporting point 2
  - Supporting point 3

- Callout point 2
  - Supporting point 1
  - Supporting point 2
  - Supporting point 3

Callout point 1

- Supporting point 1
- Supporting point 2
- Supporting point 3

Callout point 2

- Supporting point 1
- Supporting point 2
- Supporting point 3

Callout point 3

- Supporting point 1
- Supporting point 2
- Supporting point 3