



Accelerating and Enhancing Behavioral Health Integration Through Digitally Enabled Care: Opportunities and Challenges

Research collaboration led by

manatt

AMERICAN MEDICAL ASSOCIATION® ACCELERATING AND ENHANCING BEHAVIORAL HEALTH INTEGRATION THROUGH DIGITALLY ENABLED CARE: OPPORTUNITIES AND CHALLENGES

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ABOUT THIS REPORT

The American Medical Association (AMA) and Manatt Health Strategies (Manatt Health) gathered a diverse working group of stakeholders representative of physician practices and health systems, large employers, health plans and patient advocates to meet twice during the fall of 2021 to contribute to and inform the development of this report. This report summarizing the working group's proceedings was jointly developed by the AMA and Manatt Health and builds on the AMA's ongoing efforts to [advance effective and sustainable behavioral health integration \(BHI\)](#), including the [BHI Collaborative](#), and the [AMA Return on Health](#) Framework for measuring the comprehensive value of virtual care. Notably, this report acknowledges yet does not attempt to address broader health care issues that impact the quality of care more generally such as social determinants of health and access to broadband internet, among others.

The goal of this work is threefold:

1. Define the opportunities and limitations to incorporating technology to advance BHI;
2. Define practical solutions that stakeholders—physician practices and systems, health plans and coverage programs (e.g., Medicare and Medicaid), federal and state policymakers, employers and private or publicly-traded behavioral health companies—can pursue to advance digitally enabled BHI; and
3. Demonstrate how to use the Return on Health Framework to measure the value of digitally enabled BHI models.

I. Executive Summary

The United States is in the midst of a decades-long behavioral health crisis that has been exacerbated by the COVID-19 pandemic. The number of American adults reporting symptoms of anxiety and/or depressive disorder grew from one in 10 in 2019 to four in 10 by early 2021.^{1,2} In 2018, deaths due to drug overdose were four times higher than in 1999.³ The prevalence and severity of mental health conditions among children and teens have also increased sharply during this time, with suicide now the second-leading cause of death among individuals between the ages of 10 and 24.⁴ Stakeholders across the health care system have committed to addressing this crisis; however, the long-standing shortage of behavioral health providers has limited timely access to treatment.

Behavioral health integration (BHI), or the integrated delivery of both behavioral and physical health care, is essential to reaching more individuals who need behavioral health treatment and solving the nation's growing behavioral health crisis. Experts agree that behavioral health is a core component of primary care; however, BHI adoption among primary care practices remains low due to persistent workforce, financial, information and cultural barriers.⁵

The current shift within the U.S. health care system toward digitally enabled care models presents a unique opportunity to enhance the overall effectiveness of BHI. Appropriately applied, the incorporation of technology—including digital tools for screening and intake, clinical decision support, and telehealth care delivery—can support current BHI models by helping engage more people in behavioral health treatment and possibly encouraging broader adoption by providers. It is important to note, however, that the adoption of technology-based solutions can augment but cannot replace interactions between providers and their patients. In addition, persistence of disparities in access to technology, such as broadband internet or smartphone-enabled devices, may impede equitable adoption of digitally enabled BHI.

Stakeholders across the health care ecosystem have a role to play in advancing the adoption and sustainability of digitally enabled BHI. This report, which was informed by a diverse working group convened by the AMA and Manatt Health, proposes a set of practical solutions that stakeholders—physician practices and health systems, health plans and coverage programs, federal and state policymakers, employers, and private or publicly-traded behavioral health companies—can pursue in order to accelerate the widespread adoption of sustainable BHI.

The ability to demonstrate the comprehensive value that digitally enabled BHI generates for providers, patients and society at large could further drive adoption among primary care specialists. The value framework described in the AMA's [Return on Health](#) report is a useful tool that can be used to achieve this aim. There are commonly used measures associated with each value stream within the Return on Health Framework—clinical outcomes; quality and safety; access to care; patient, family member and caregiver experience; financial and operational impact; and health equity—that can be standardized to assess the value of digitally enabled BHI models. For example, diagnostic screening and assessment tools, such as Patient Health Questionnaire-2 (PHQ-2)/PHQ-9 and Alcohol Use Disorders Identification Test-Concise

(AUDIT-C), can be used to measure clinical outcomes, quality of care and safety. Referral completion percentages can be used to assess access to care for patients.

There is ample evidence that BHI, specifically the Collaborative Care Model, produces superior patient outcomes, improves patient experience and access to care, and can generate cost savings.^{6,7,8,9} Incorporating technology into BHI models has the potential to accelerate BHI adoption and impact. All stakeholders have a critical role to play in making it easy for primary care specialists and behavioral health providers to adopt BHI in their practices, as doing so will significantly impact the trajectory of our nation’s behavioral health crisis.

SUMMARY OF PRACTICAL SOLUTIONS TO ADVANCE DIGITALLY ENABLED BHI

STAKEHOLDERS	PRACTICAL SOLUTIONS TO ADVANCE DIGITALLY ENABLED BHI
<p>Physician Practices and Health Systems</p>	<ul style="list-style-type: none"> • Increase behavioral health diagnosis and treatment rates by incorporating evidence-based digital health solutions and enabling technology into standard workflows. • Address the siloed delivery of care by primary care specialists and behavioral health providers by implementing technologies that facilitate care coordination and enable highly collaborative care. • Raise provision of evidence-based treatment to best practice standards by adopting and integrating standard measurement tools into provider and patient-facing technologies and by promoting data-driven continuous quality improvement. • Increase BHI training for primary care specialists and behavioral health providers by incorporating digitally enabled BHI into standard curricula.
<p>Health Plans and Coverage Programs</p>	<ul style="list-style-type: none"> • Increase BHI adoption by expanding coverage and fair payment with a margin for all stakeholders utilizing the Collaborative Care Model (CoCM) and other BHI models that facilitate care management and transitions of care for patients with behavioral health conditions. • Encourage the incorporation of telehealth into BHI by implementing payment parity for behavioral health services delivered via video or audio-only telehealth modalities. • Make integrated behavioral health care more affordable for people by evaluating how and when to apply cost-sharing (e.g., co-pays, health savings account deductibles), including its elimination where appropriate, for CoCM codes, as well as integrated behavioral health services delivered in person or via telehealth. • Assist primary care practices in integrating behavioral health by offering technical support, provider training and regional sharing of resources. • Expand provider networks and improve access to BHI by minimizing and/or eliminating prior authorization and other utilization management practices for BHI services.



STAKEHOLDERS	PRACTICAL SOLUTIONS TO ADVANCE DIGITALLY ENABLED BHI
<p>Federal and State Policymakers</p>	<ul style="list-style-type: none"> • <i>[Federal and States]</i> Help primary care specialists overcome financial barriers to adopting BHI by providing long-term sustainable funding opportunities and fair payment rates with a margin for providers delivering BHI services in federal and state coverage programs. • <i>[Federal and States]</i> Provide funding to achieve universal and affordable access to broadband internet. • <i>[Federal]</i> Pass legislation to remove originating site and geographic restrictions for all telehealth services in Medicare that limit access to care. • <i>[Federal]</i> Grow the behavioral health workforce by increasing federal funding for efforts such as loan forgiveness and new residency and training programs. • <i>[Federal]</i> Advance the BHI evidence base by funding health services research related to digitally enabled BHI, including a focus on health equity. • <i>[States]</i> Increase adoption of telehealth within BHI by requiring private payers and Medicaid programs to cover behavioral health care delivered via video or audio-only visits at parity with in-person care. • <i>[States]</i> Expand access to BHI and reduce coverage-related barriers by prioritizing the adoption of BHI within primary care initiatives, working with health plans and coverage programs to strengthen networks, and enhancing consumer awareness.

STAKEHOLDERS	PRACTICAL SOLUTIONS TO ADVANCE DIGITALLY ENABLED BHI
<p>Employers</p>	<ul style="list-style-type: none"> • Enhance coordination among employers, employees, primary care specialists and behavioral health providers by: <ul style="list-style-type: none"> – Increasing the number of employees with regular (longitudinal) sources of primary care – Adopting technologies that enable coordination among providers – Launching whole-person, employer-based behavioral health programs with care navigation support, with intentional culture-focused work to destigmatize behavioral health – Contracting with primary care specialists that offer BHI in addition to further analysis and standard-setting for private, particularly venture-backed, or publicly-traded behavioral health companies that enable (or are complimentary to) primary care specialists to adopt BHI, to drive delivery of coordinated high-quality behavioral health services through the primary care system. • Reduce out-of-pocket costs for employees seeking care by evaluating how and when to apply cost-sharing (e.g., co-pays, health savings account deductibles), including its elimination where appropriate, for integrated behavioral health services conducted in-person or via telehealth.
<p>Private or Publicly-traded Behavioral Health Companies</p>	<ul style="list-style-type: none"> • Evolve current and develop new businesses to support BHI, address patient and physician needs, complement in-person care, support comprehensive care delivery, and enable asynchronous communication among patients and providers. • Generate robust clinical and economic evidence for digitally enabled BHI by working with BHI stakeholders to develop national standards for BHI technologies and by partnering with practices to test new solutions and develop clinical and economic evidence.



II. The Need to Advance Adoption of Digitally Enabled Behavioral Health Integration

The United States is in the midst of a decades-long behavioral health crisis, which has been exacerbated by the COVID-19 pandemic. Before 2019, one in 10 adults reported symptoms of anxiety and/or depressive disorder,¹⁰ and nearly one in five adults were living with a mental illness.¹¹ In 2018, deaths due to drug overdose were four times higher than in 1999,¹² and more than 48,000 Americans died by suicide.¹³ The onset of the pandemic, and the associated economic recession and implementation of social distancing and isolation measures, deepened the already growing behavioral health crisis and created new barriers to accessing care. By January 2021, four in 10 adults reported symptoms of anxiety and/or depressive disorder.¹⁴ People of color, young adults and women with children have been at particularly high risk for experiencing pandemic-related behavioral health consequences. Suicide is now the second-leading cause of death among those ages 10 to 24.¹⁵ Stakeholders across the health care system have committed to addressing this crisis; however, the long-standing shortage of behavioral health providers has made it particularly challenging to ensure Americans have timely access to necessary behavioral health treatment.

CURRENT STATE OF BHI ADOPTION AND THE USE OF TECHNOLOGY

A person's behavioral health condition(s) can impact other medical conditions and their overall health. Most people with a behavioral health condition are first diagnosed in the primary care setting or an emergency room. Primary care teams are often best positioned to screen for and address common behavioral health conditions, such as depression, anxiety and substance abuse, with as many as 70% of primary care visits stemming from psychosocial issues.^{16, 17} To that end, behavioral health integration (BHI), or the integrated delivery of both behavioral and physical health care, is essential to reaching more individuals in need of behavioral health treatment and solving the nation's growing behavioral health crisis.

BHI models fall on a continuum—from coordinated care, where primary care specialists, behavioral health providers, and other members of the care team are located in separate settings but communicate periodically with one another about shared patients, to co-located care, where providers operate in the same facility, share some systems (e.g., medical records, billing, scheduling) and communicate more regularly regarding shared patients, to fully integrated care, where providers deliver highly collaborative care within the same space using shared systems.¹⁸ Experts agree that behavioral health is a core component of primary care; however, BHI adoption among primary care practices remains low. Studies conducted before the COVID-19 pandemic found that the majority of primary care specialists were not co-located with behavioral health providers.¹⁹ Rates of co-location varied by practice size and geographic location; relative to other providers, solo practice providers and rural practice providers were less likely to be physically co-located with a

behavioral health provider.²⁰ Failure to implement BHI more broadly will perpetuate the nation's growing behavioral health crisis; however, there are several overarching factors limiting the widespread adoption of BHI:

- A national shortage of both behavioral health providers and primary care specialists
 - Forecasts indicate that by 2034, the demand for physicians will exceed supply by between 37,800 and 124,000 full-time equivalent (FTE) physicians, and there will be a shortfall of 17,800 to 48,000 primary care physicians.²¹
 - It is estimated that by 2025, the United States will have a shortage of approximately 250,510 FTEs across six major behavioral health provider types, including psychiatrists; clinical, counseling and school psychologists; substance use and behavioral disorder counselors; mental health and substance use social workers; mental health counselors; and school counselors.²²
- Payment to providers that is inadequate to cover the costs associated with implementing and delivering BHI
- Siloed nature and inherent cultural differences between behavioral health and non-behavioral health providers (e.g., length of visit time, communication style)
- Federal and state regulations that make it challenging to share patient information across care team members²³

While not a panacea, the incorporation of technology into BHI care models (i.e., digitally enabled BHI), such as

telehealth and other digital tools, could enhance the effectiveness and accelerate the adoption of BHI. Evidence suggests that most patients, providers, employers and health plans recognize the benefits of delivering select behavioral health services via telehealth, including improved access to care that is of equal or greater quality compared to in-person care, enhanced patient and provider satisfaction, and increased patient convenience.^{24,25,26,27} Some people, however, continue to prefer to receive services in-person. A recent national poll conducted during the pandemic found that while 82% of respondents who had a telehealth visit were satisfied, nearly two-thirds (64%) would have preferred an in-person visit.²⁸ Another study conducted during the pandemic found that older people, Asian Americans, and non-English-speaking individuals were less likely to use telehealth to receive primary and specialty ambulatory care.²⁹ Medicare, Medicaid programs and commercial payers are actively expanding coverage for virtually-delivered behavioral health services on a permanent basis following the pandemic. There are opportunities for stakeholders across the health care system to address the nation's growing behavioral health crisis and increase access to treatment by advancing the adoption of digitally enabled BHI.

DEFINITIONS

Behavioral Health Integration (BHI)

The integrated delivery of comprehensive physical and behavioral health services within the primary care practice setting.

Collaborative Care Model (CoCM)

The Collaborative Care team is led by a primary care provider (PCP) and includes behavioral health care managers, psychiatrists and frequently other mental health professionals all empowered to work at the top of their license. The team implements a measurement-guided care plan based on evidence-based practice guidelines and focuses particular attention on patients not meeting their clinical goals. (Source: [American Psychiatric Association](#))

Digitally Enabled BHI

Fully integrated in-person and virtual BHI care models that hybridize care delivery and incorporate technology to enhance care management and treatment of behavioral health conditions based on clinical appropriateness and other factors such as convenience and cost.

Virtual Care

Health care delivered remotely—synonymous with “telehealth.”

Note: Unless otherwise noted, definitions developed by the AMA.

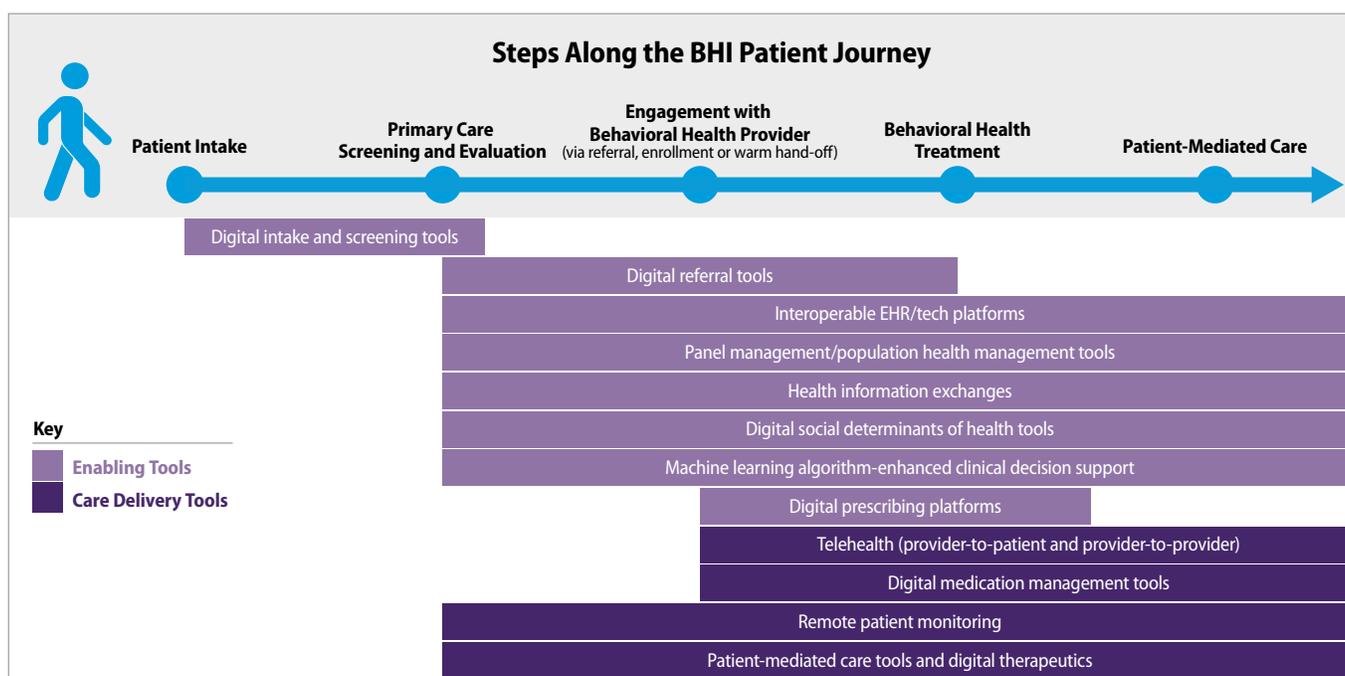


III. Use of Technology to Support BHI: Opportunities and Limitations

The health care system is in a decades-long shift from in-person care delivery to digitally enabled care models that blend the best features of in-person care delivery with those of virtual care.³⁰ Adoption of virtual care and other digital tools lagged before 2020. The COVID-19 pandemic spurred a dramatic increase in the adoption of digital tools, namely telehealth.³¹

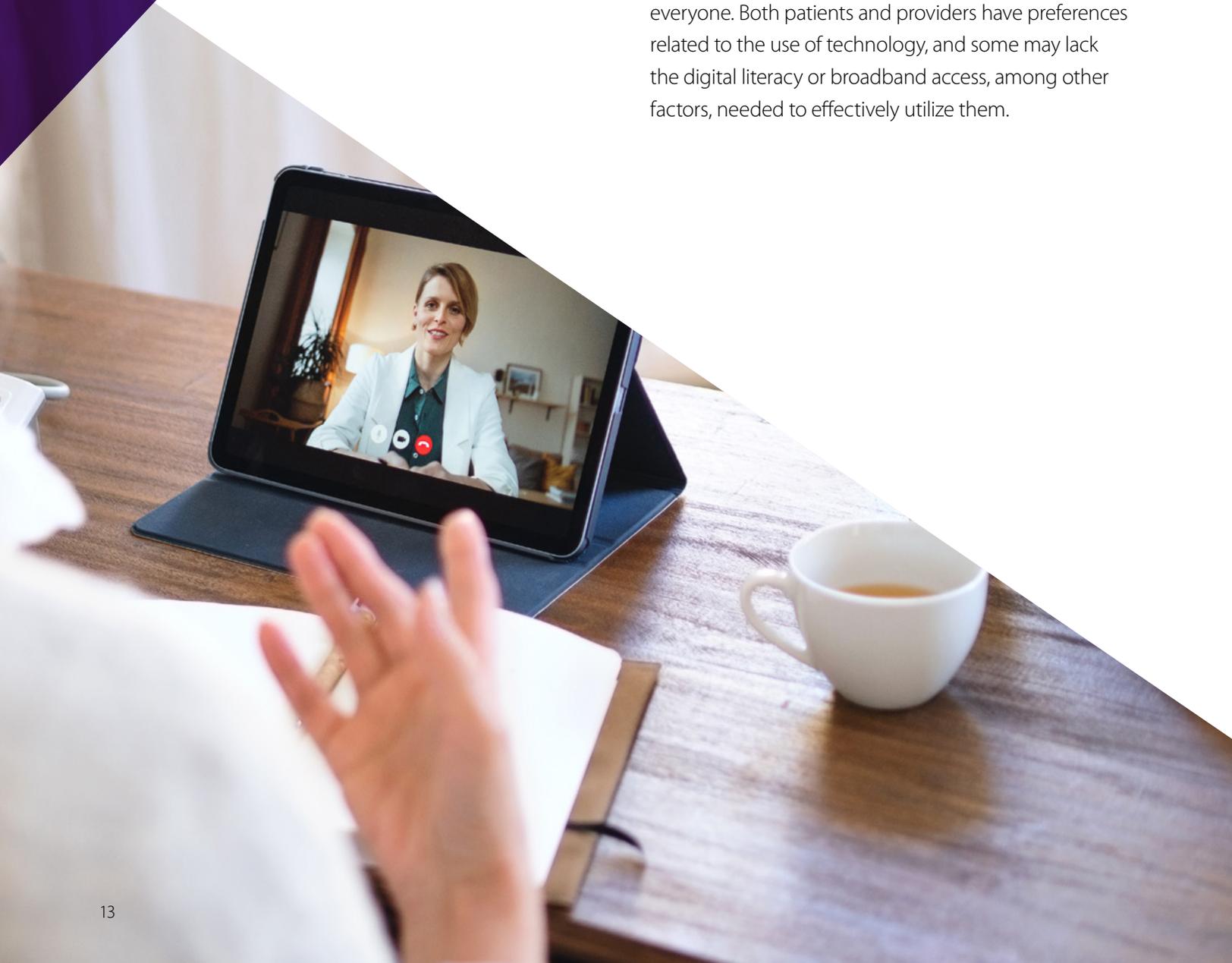
As depicted in Figure 1, there are several opportunities along the BHI patient journey within primary care to incorporate technology that can enhance patient management and treatment, support integration, limit fragmentation of care, and ultimately generate value for both patients and providers.

FIGURE 1: TECHNOLOGIES THAT CAN SUPPORT AND ADD VALUE TO BHI



There are notable limitations to the use of technology within BHI that must be weighed when considering these opportunities:

- Technology will not completely replace the need for in-person interactions or patient assessments, or the longitudinal provider-patient relationship.^{32,33,34}
- Lack of robust clinical or economic evidence regarding the impact of technology solutions within BHI models to support major regulatory and coverage decisions.
- The use of technology within BHI is not clinically appropriate for or available to all people.
- The use of technology within BHI will not work for everyone. Both patients and providers have preferences related to the use of technology, and some may lack the digital literacy or broadband access, among other factors, needed to effectively utilize them.



IV. Solutions to Address Gaps Hindering Widespread Adoption of BHI

All stakeholders have a role to play in ensuring that as the health care system adopts digitally enabled BHI, it does so in a way that is patient-centered and expands access to safe, equitable, high-quality behavioral health care. This section proposes practical solutions that different stakeholders—physician practices and health systems, health plans and coverage programs, federal and state policymakers, employers, and private or publicly-traded behavioral health companies—can pursue in order to address specific gaps that currently hinder the widespread adoption of BHI.

PHYSICIAN PRACTICES AND HEALTH SYSTEMS

The following are practical solutions that physician practices and health systems can pursue that would encourage the integration of physical and behavioral health services, increase rates of behavioral health diagnosis and treatment, and better enable primary care specialists—regardless of their practice setting, size, sub-specialty or geographic location—to adopt and deliver effective BHI:

CURRENT GAPS	PRACTICAL SOLUTIONS
Behavioral health conditions often go undiagnosed and untreated.	<ul style="list-style-type: none">• Adopt standardized digital intake and screening tools within the patient portal (or other patient intake technology) to increase rates of behavioral health screenings and identification of people with behavioral health needs.• Develop virtual regional “pools” of behavioral health specialists to remotely consult and treat patients identified by primary care practices in areas with provider shortages.
Siloed delivery of care by primary care specialists and behavioral health providers.	<ul style="list-style-type: none">• Leverage technology to integrate behavioral health screening, diagnosis and treatment into primary care workflows, using proven integration models such as CoCM.• Increase adoption of established and emerging technologies and approaches such as virtual interprofessional consultations and Project ECHO (Extension for Community Healthcare Outcomes) to empower primary care specialists to collaborate with psychiatrists and other behavioral health providers to provide behavioral health treatment in a primary care setting.



CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Lack of consistent use of evidence-based treatments according to industry best practice standards.</p>	<ul style="list-style-type: none"> • Use measurement-based standardized instruments [e.g., PHQ-9, General Anxiety Disorder-7 (GAD-7) and Patient-Reported Outcomes Measurement Information System (PROMIS) tools] to measure, assess and track patient symptoms and outcomes over a period of time and tailor patient treatment accordingly (i.e., “treat to target”). • Incorporate clinical decision support tools into electronic health records (EHRs) and clinical workflows to make it easier to provide evidence-based care. • Collaborate with medical and behavioral health societies and others to develop evidence-based guidelines and consensus statements regarding best practices for digitally enabled BHI care delivery, similar to the Best Practices in Videoconferencing-Based Telemental Health developed by the American Psychiatric Association and the American Telemedicine Association.
<p>Lack of BHI training for primary care specialists and behavioral health providers.</p>	<ul style="list-style-type: none"> • Standardize teaching and training of digitally enabled BHI through: <ul style="list-style-type: none"> – Continued medical education; – Conferences; – Medical society initiatives; – BHI training programs for future behavioral health providers; and – Residency programs, including creating and increasing the number of combined med-psych residency programs that focus on the bi-directional impact of behavioral and physical health conditions and prepare physicians to deliver both internal medicine and psychiatric care in a comprehensive and integrated manner.

HEALTH PLANS AND COVERAGE PROGRAMS

The following are practical solutions that health plans and coverage programs can pursue to ensure sufficient payment for BHI services, support for practices seeking to adopt BHI and reduce financial barriers experienced by patients:

CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Lack of coverage and payment for providers utilizing CoCM and other BHI models to provide BHI services.</p>	<ul style="list-style-type: none"> • To assist providers utilizing the Collaborative Care Model (CoCM): <ul style="list-style-type: none"> – <i>[All Payers]</i> Ensure fair payment for providers delivering CoCM services in fee-for-service and value-based-payment models that not only covers the direct cost of care delivery but also provides a margin to cover start-up expenses that practices incur when adopting CoCM (e.g., staffing, training, technology and infrastructure expenses). – <i>[Medicaid]</i> Ensure that all Medicaid programs cover and provide fair payment for CoCM codes; as of May 2021, only 19 state Medicaid programs were covering these codes.³⁵ • To assist providers utilizing other BHI models who are often uncompensated for integration-related activities: <ul style="list-style-type: none"> – <i>[All Payers]</i> Cover and pay for care coordination and care management activities conducted by physical and behavioral health care team members. – <i>[All Payers]</i> Offer coverage and payment for virtual interprofessional consults between primary care specialists and behavioral health providers, including psychiatrists who offer medication management consultative support.
<p>Primary care specialists often lack funding and other resources to adopt BHI.</p>	<ul style="list-style-type: none"> • <i>[All Payers]</i> Offer provider training, and support regional sharing of resources, including consulting psychiatrist coverage, to help practices surmount the upfront costs, resources and training needed to adopt digitally enabled BHI.
<p>The uncertain future of telehealth coverage and reimbursement makes it challenging for providers to invest in deploying technology solutions.</p>	<ul style="list-style-type: none"> • <i>[All Payers]</i> Ensure equal coverage and payment for behavioral health services delivered in-person or via telehealth by implementing permanent payment parity for behavioral health services delivered via video or audio-only, as is clinically appropriate. • <i>[All Payers]</i> Implement a new audio-only modifier designated by the AMA CPT® Editorial Panel to ensure aligned billing practices across health plans/coverage programs and enable tracking and analysis of behavioral health services delivered via audio-only modality.
<p>Out-of-pocket patient costs serve as a barrier to patient access.</p>	<ul style="list-style-type: none"> • <i>[All Payers]</i> Evaluate how and when to apply cost-sharing (e.g., co-pays, health savings account deductibles), including its elimination where appropriate, for (1) CoCM codes and (2) integrated behavioral health services delivered in person or via telehealth.

CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Health plan requirements and narrow networks impede patient access to care.</p>	<ul style="list-style-type: none"> • <i>[All Payers]</i> Minimize, and where appropriate, eliminate prior authorization and other utilization management practices for BHI services. • <i>[All Payers]</i> Expand provider networks to offer adequate coverage of behavioral health and primary care specialists, particularly in areas with marginalized populations. • <i>[All Payers]</i> Offer standard allowance for visits with both a primary care and a behavioral health provider on the same day to enable same-day BHI screenings and consultations.

FEDERAL AND STATE POLICYMAKERS

The following are practical solutions that federal and state policymakers can pursue to support the widespread adoption of BHI:

CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Primary care specialists often lack upfront funding and other resources to adopt BHI within their practices.</p>	<ul style="list-style-type: none"> • <i>[Federal + States]</i> Provide long-term sustainable funding opportunities for primary care practices (similar to funding provided for Meaningful Use and patient-centered medical home [PCMH] adoption) to support training and education on implementation of digitally enabled BHI services among primary care specialists. • <i>[Federal + States]</i> Make payment for BHI services sustainable for practices on an ongoing basis by providing fair payment rates with a margin for all stakeholders in federal and state coverage programs for collaborative care, care management/coordination, psychotherapy, and other relevant in-person and telehealth services utilized by primary care practices that have adopted BHI.
<p>The uncertain future of telehealth coverage and reimbursement makes it challenging for providers to adopt and deploy long-term sustainable digital tools.</p>	<ul style="list-style-type: none"> • <i>[Federal]</i> Pass legislation that removes the originating site and geographic restrictions for all telehealth services in Medicare. • <i>[States]</i> Require private payers and Medicaid programs to cover and reimburse for behavioral health care delivered via video or audio-only visits at parity with in-person care and add coverage for asynchronous forms of telehealth that support BHI.
<p>Lack of federal funding directed at efforts to address the national shortage of behavioral health providers.</p>	<ul style="list-style-type: none"> • <i>[Federal]</i> Increase federal funding to support growing the behavioral health workforce, especially psychiatrists and other behavioral health specialists who practice in underserved areas (e.g., through loan forgiveness programs, new and expanded residency and training programs).

CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Lack of funding and resources directed at efforts to expand access to BHI and reduce coverage-related barriers.</p>	<ul style="list-style-type: none"> • <i>[Federal and States]</i> Provide funding to achieve universal broadband availability and affordable access to the internet. • <i>[States]</i> Incorporate and prioritize the adoption of BHI within statewide primary care initiatives. • <i>[States]</i> Analyze and address network deficiencies in public coverage programs. • <i>[States]</i> Work with health plans and coverage programs to limit the use of utilization management review practices, enforce behavioral health parity laws, and strengthen network adequacy regulations. • <i>[States]</i> Enhance consumer literacy and awareness of BHI care models through ombudsman programs and other outreach efforts.
<p>Limited evidence base regarding the most impactful interventions to advance BHI nationally.</p>	<ul style="list-style-type: none"> • <i>[Federal]</i> Fund health services research efforts to study the most effective, high-quality and sustainable interventions that promote integration, health equity, and the positive impact of digitally enabled BHI.

EMPLOYERS

The following are practical solutions that employers can pursue to ensure employees receive timely access to comprehensive primary care services that integrate behavioral health:

CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Lack of coordination among employers, employees, primary care specialists and behavioral health providers.</p>	<ul style="list-style-type: none"> • Increase the number of employees with a regular (longitudinal) source of primary care by incentivizing employees to attend annual wellness visits. • Adopt technologies that can enable coordination between primary care specialists and behavioral health providers. • Design, pilot and launch whole-person, employer-based behavioral health programs that provide employees with immediate and direct access to behavioral health resources and providers, including care navigation support, with intentional culture-focused work to destigmatize behavioral health. • Contract with primary care specialists that offer BHI in addition to further analysis and standard-setting for private, particularly venture-backed, or publicly-traded behavioral health companies that enable (or are complimentary to) primary care specialists to adopt BHI, as opposed to stand-alone behavioral health solutions, to drive delivery of coordinated, high-quality behavioral health services through the primary care system.

CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Out-of-pocket costs deter some employees from seeking primary and behavioral health services.</p>	<ul style="list-style-type: none"> • Evaluate how and when to apply cost-sharing (e.g., co-pays, health savings account deductibles), including its elimination where appropriate, for integrated behavioral health visits conducted in-person or via telehealth.

PRIVATE OR PUBLICLY-TRADED BEHAVIORAL HEALTH COMPANIES

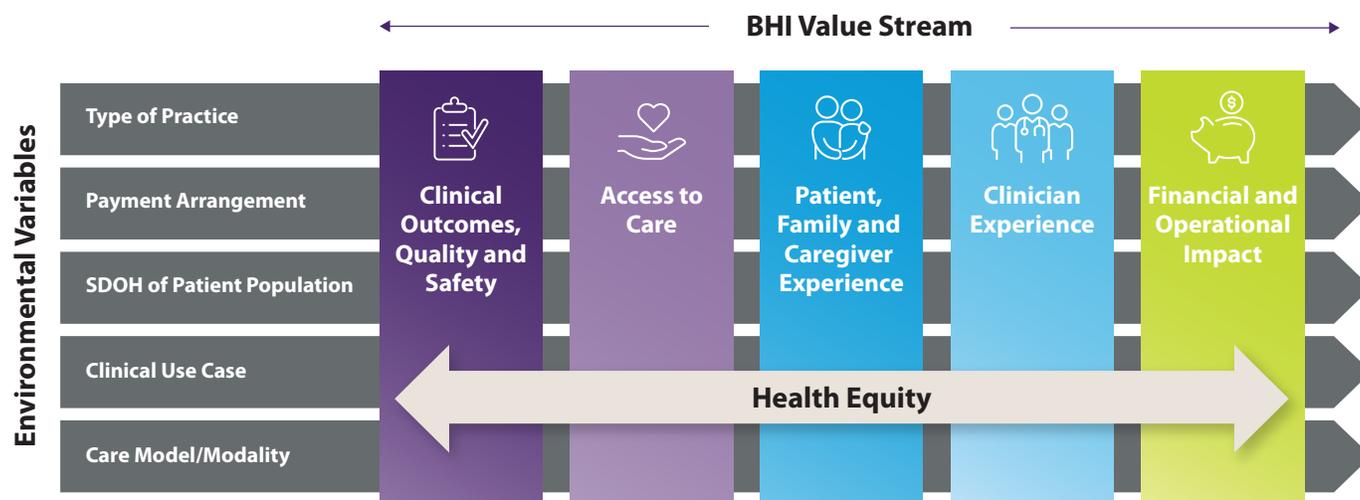
The following are practical solutions that private, particularly venture-backed, or publicly-traded behavioral health companies can pursue to ensure that the solutions they design are evidence-based and support comprehensive digitally enabled BHI:

CURRENT GAPS	PRACTICAL SOLUTIONS
<p>Existing businesses frequently operate in a manner that is disconnected from the existing primary care system.</p>	<ul style="list-style-type: none"> • Evolve current and develop new businesses to: <ul style="list-style-type: none"> – More consistently support digitally enabled BHI and linkages to primary care; – Complement in-person care delivery; – Easily integrate into existing care model workflow; – Be flexible and customizable based on the unique nature of a given physician practice or patient population; and – Enable asynchronous communication between provider and patient or among providers to streamline care coordination and better engage patients in their care.
<p>Lack of national standards or robust clinical and economic evidence for emerging digitally enabled BHI models and solutions.</p>	<ul style="list-style-type: none"> • Work with BHI stakeholders to develop national definitions and standards for developers and users of technologies that support BHI to ensure appropriate, equitable and consistent use of such tools across the United States. • Partner with practices that have successfully implemented BHI to test new technology solutions and develop clinical and economic evidence that is sufficiently rigorous to support employer and payer coverage decisions, including evaluation/clinical trials for digital health and therapeutic solutions.

V. Applying the AMA's Return on Health Framework to Digitally Enabled BHI

Demonstration of the comprehensive value that digitally enabled BHI generates for providers, patients and society at large could further drive adoption among primary care specialists. The value framework presented in the [Return on Health](#) report (see Figure 2) is a useful tool that can be used to achieve this aim.

FIGURE 2: FRAMEWORK FOR MEASURING THE VALUE OF BHI



Several measures can be used to assess the value generated by each value stream. Variations in quality and performance measures utilized by different health plans and coverage programs make it challenging for stakeholders to identify the most impactful actions.

The following is a list of high-priority measures identified by participating members of the working group that may be used to assess the value of digitally enabled BHI programs across the six Return on Health value streams. More work is needed to further refine this list and achieve alignment and relevance in BHI quality and performance measurement approaches nationally. Members of the working group emphasized that the measurement approach applied within BHI models should be meaningful, avoid unnecessary burden, and support a healing environment for all patient populations.

Clinical Outcomes, Quality and Safety	<ul style="list-style-type: none"> • Diagnostic assessment tools (PHQ-9, AUDIT-C, etc.) • Patient assessment scores (PHQ-2, PHQ-9, Columbia-Suicide Severity Rating Scale (C-SSRS), GAD-7, MHQoL - (Mental Health Quality of Life) Questionnaire) • National Committee for Quality Assurance (NCQA)/Healthcare Effectiveness Data and Information Set (HEDIS) Measures • Emergency Department (ED) visits • Hospital admissions • Medication adherence
Access to Care	<ul style="list-style-type: none"> • Risk-adjusted time to next available appointment • Referral completion percentage • Median travel time to care • Out-of-pocket costs as a percentage of household income
Patient, Family and Caregiver Experience	<ul style="list-style-type: none"> • Net promoter score • Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) • Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)
Clinician Experience	<ul style="list-style-type: none"> • Ease of use of technology • Engagement and satisfaction with work • Burnout (e.g., Mini-Z) • Care team turnover rates
Financial and Operational Impact	<ul style="list-style-type: none"> • Appointment adherence • Professional fee revenue • Claims approvals or denials rate • Savings under Value-Based Payment arrangements • Patient retention rate • Clinician panel size
Health Equity	<ul style="list-style-type: none"> • Disparities in clinical outcomes, quality, and safety • Disparities in access to care • Disparities in patient, family, and caregiver experience • Disparities in clinician experience • Disparities in financial and operational impact



VI. Conclusion

There is ample evidence that BHI, specifically the Collaborative Care Model, produces superior patient outcomes, improves patient experience and access to care, and can generate cost savings.^{36,37,38,39} The evolution toward digitally enabled BHI models that incorporate the use of technology has the potential to accelerate BHI adoption and impact; however, technology is only one part of the solution needed to meaningfully drive adoption of sustainable BHI.

All stakeholders have a critical role to play in making accessible and equitable treatment that addresses peoples' behavioral and physical health needs a more standard practice within primary care. It is essential that all stakeholders act now to ensure that primary care specialists receive dedicated support to operationalize digitally enabled BHI, and that BHI is paid for with a margin in both fee-for-service and value-based payment models in order to achieve widespread adoption.

VII. Appendix

RETURN ON HEALTH DIGITALLY ENABLED BHI—CASE STUDIES FROM PENN MEDICINE AND THE U.S. DEPARTMENT OF VETERANS AFFAIRS

PENN MEDICINE

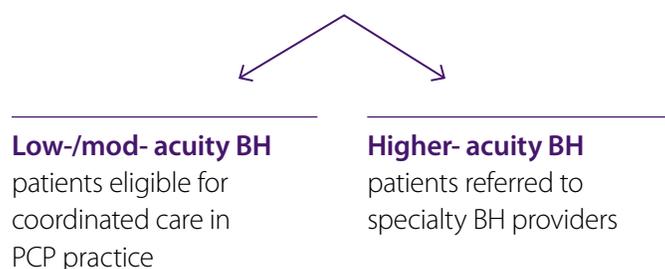
Description

Penn Medicine’s BHI model is an adaptation of the traditional Collaborative Care Model; it utilizes a centralized resource center that conducts patient intake, enables panel management, and facilitates outbound referrals. The program is supported by collaborative care billing codes and has grown substantially since launching in 2018.

High-Level Process

Intake: Trained intake coordinator from the centralized resource center conducts a phone call with patients referred by their PCP to complete standard assessments

Referrals and Warm Hand-Offs: Intake coordinator uses decision support tools to determine appropriate care plan for patients in need of BH care:



Coordinated BH Care: Patients directed into the BHI program receive 3–5 months of coordinated PCP/BH care from a care team consisting of: care manager, PCP, consulting psychiatrist. Care management is currently mostly digital (phone or video)

Digital Components

- Video and phone visits for care management
- *[Planned, in Pilot Phase]* Digital tool to manage:
 - Patient intake/screening
 - Panel management for care managers

Scale

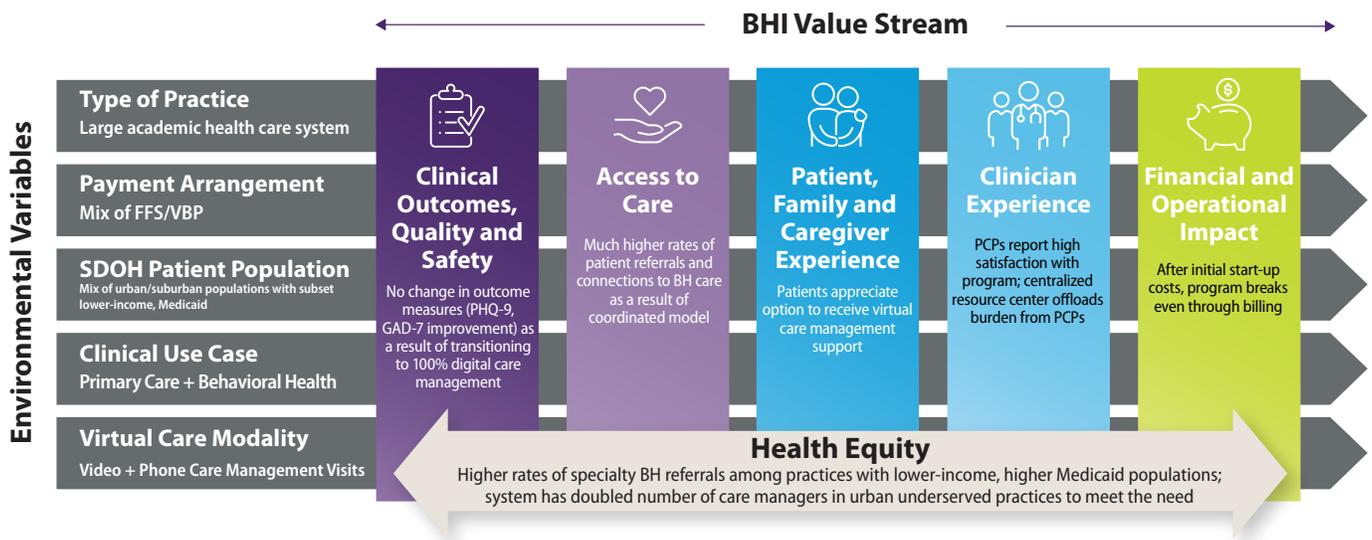
Growth:

- Started in eight practices in 2018, grew to 15 as a result of significant demand.
- Added 10 new practices in 2021 with ~10 more in 2022.
- Over 20,000 patients referred into program in three years.

Resources:

- Most care managers and psychiatrists are not trained in Collaborative Care, so the program has invested resources in training and onboarding new collaborative care staff.

Return on Health Framework



U.S. DEPARTMENT OF VETERANS AFFAIRS

Description

The U.S. Department of Veterans Affairs has a mental health integration program that screens veterans for behavioral health conditions and coordinates warm hand-offs to designated team members for those veterans with lower-acuity behavioral health needs. Digital support options were in place pre-COVID, but now the majority of care management and behavioral health visits within the program are conducted virtually.

High-Level Process

Intake: Nearly 95% of veterans are screened on a regular basis for depression (annually), PTSD (annually for five years, then once per five years thereafter), alcohol use disorder (annually), and suicidality (annually). Screens are generally conducted by a medical assistant (MA)/licensed practical nurse (LPN) during patient check-in.

PCP Intervention: When a positive screen is identified, PCPs can use counseling dialogues for some conditions (e.g., alcohol use) and conduct brief interventions before alerting mental health clinicians of positive screens (if desired by the patient).

Warm Hand-Offs: Based on patient acuity and needs, PCPs provide patients with a warm hand-off to either the mental health integration team or referral to specialty mental health.



Mental Health Integration Team

Lower-acuity behavioral health (BH) patients with depression, anxiety or PTSD referred to mental health integration team. Team consists primarily of psychologists and licensed clinical social workers (LCSWs) as well as registered nurses (RNs), psychiatric physician assistants (PAs)/nurse practitioners (NPs), peers and mental health techs.

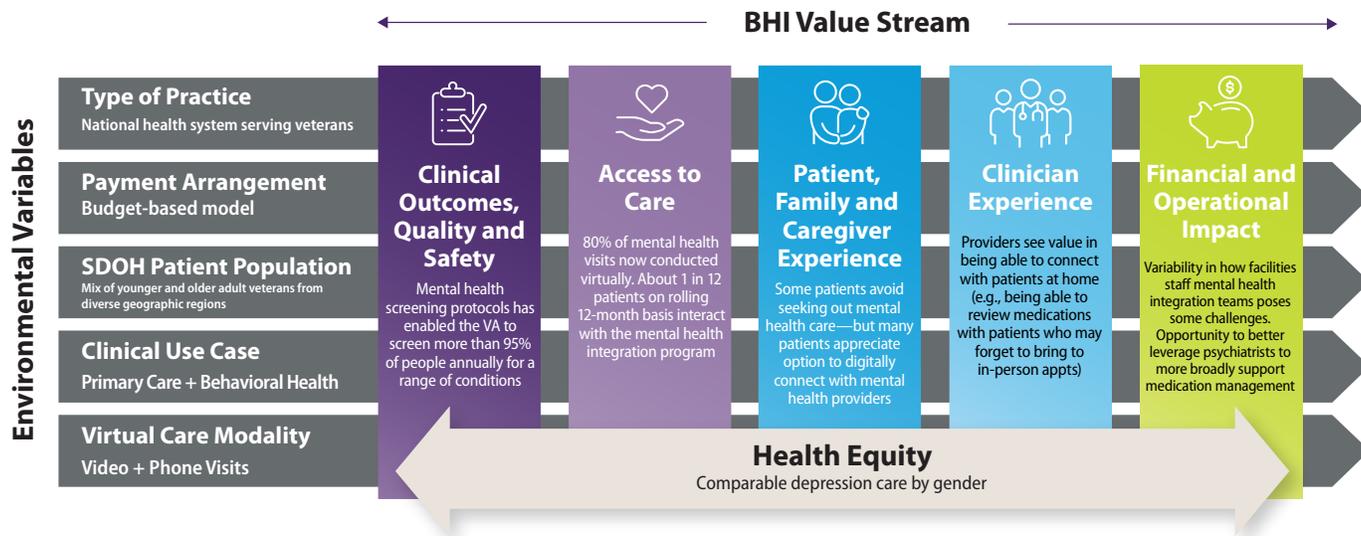
Specialty Mental Health

Higher-acuity BH patients referred to specialty mental health clinics, which provide psychological, psychiatric and group supports.

Digital Components

- Integrated electronic medical records (EMRs) across all areas
- Digital clinical decision support
- Patient-reported outcome measures (PROM) support (staff entry)
- Video and phone visits
- Back-end data syndicated from EMR
- *[Planned]* Warm hand-offs via video
- *[Planned]* Patient-facing PROM entry
- *[Planned]* Registries integral to EMR

Return on Health Framework



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