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Authors

Clarke, Robin MA
Jeffrey, Jessica
Grossman, Mark
et al.

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By Robin M. A. Clarke, Jessica Jeffrey, Mark Grossman, Thomas Strouse, Michael Gitlin, and Samuel A. Skootsky

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IMPLEMENTATION PROFILE

Delivering On Accountable Care: Lessons From A Behavioral Health Program To Improve Access And Outcomes

ABSTRACT Patients with behavioral health disorders often have worse health outcomes and have higher health care utilization than patients with medical diseases alone. As such, people with behavioral health conditions are important populations for accountable care organizations (ACOs) seeking to improve the efficiency of their delivery systems. However, ACOs have historically faced numerous barriers in implementing behavioral health population-based programs, including acquiring reimbursement, recruiting providers, and integrating new services. We developed an evidence-based, all-payer collaborative care program called Behavioral Health Associates (BHA), operated as part of UCLA Health, an integrated academic medical center. Building BHA required several innovations, which included using our enterprise electronic medical record for behavioral health referrals and documentation; registering BHA providers with insurance plans' mental health carve-out products; and embedding BHA providers in primary care practices throughout the UCLA Health system. Since 2012 BHA has more than tripled the number of patients receiving behavioral health services through UCLA Health. After receiving BHA treatment, patients had a 13 percent reduction in emergency department use. Our efforts can serve as a model for other ACOs seeking to integrate behavioral health care into routine practice.

Robin M. A. Clarke (rclarke@mednet.ucla.edu) is an assistant clinical professor in the Department of Medicine, David Geffen School of Medicine, University of California, Los Angeles (UCLA), and is the medical director for quality for the UCLA Faculty Practice Group, in Los Angeles.

Jessica Jeffrey is a health sciences clinical assistant professor in the Department of Psychiatry, David Geffen School of Medicine, UCLA.

Mark Grossman is a clinical professor in the Departments of Medicine and Pediatrics, David Geffen School of Medicine, UCLA.

Thomas Strouse is a professor in the Department of Psychiatry, David Geffen School of Medicine, and is chief medical officer of the Stewart and Lynda Resnick Neuropsychiatric Hospital, both at UCLA.

Michael Gitlin is a professor in the Department of Psychiatry, David Geffen School of Medicine, and is director of the Adult Division of Psychiatry at the Resnick Neuropsychiatric Hospital, both at UCLA.

Samuel A. Skootsky is a professor in the Department of Medicine, David Geffen School of Medicine, UCLA, and is chief medical officer of the UCLA Faculty Practice Group and Medical Group.

The burden of behavioral health in the United States is substantial: 26.2 percent of adults have a diagnosable behavioral health disorder in a given year, and 20 percent of children suffer from a mental illness.[1] Behavioral health disorders are associated with both personal and societal costs because the disorders lead to morbidity and mortality as well as adverse outcomes of comorbid medical conditions.[2,3] Studies indicate that patients with depression, for example, are less adherent to medical treatment recommendations, have higher rates of premature death from their medical diseases, and use health services at significantly higher rates than patients with medical diseases alone.[4–6]

While moderately effective treatments are well established within the United States, poor outcomes continue to be associated with behavioral health disorders.[2] The failure to deliver these treatments effectively to populations in need

has numerous causes, including the segmentation of mental health and physical health by providers; additional segmentation based on payment arrangements where mental health services are paid separately through "carve-out" payment plans; and stigma surrounding these disorders. For many years primary care providers were encouraged to provide basic mental health services themselves; as a result, primary care became the "de facto" behavioral health services system.[7] Studies demonstrate that without access to specialist consultation and overwhelmed by other demands, primary care providers often do not deliver sufficient dosages or duration of psychotropic medications.[7,8]

The Affordable Care Act (ACA) promotes the expansion of accountable care organization (ACO) models in which provider organizations serve as integrators to promote the Triple Aim of, improved patient experience, improved population health, and reduced costs. It is hoped that delivering optimal population-based care that considers patient needs will attenuate or reduce the total cost of care.[8,9] Better management of behavioral health disorders is of natural interest for ACOs, but these organizations face numerous barriers to implement effective strategies.

Several population-based behavioral health programs have been put into practice; however, many of these have required external support from multipayer networks[10] or statewide collaboratives.[11] Fewer systems have implemented broad-reaching behavioral health programs using only internal resources. Within the ACO framework of UCLA Health, we, as clinical and administrative leaders from primary care and psychiatry at the University of California, Los Angeles, developed such a program, called Behavioral Health Associates (BHA). In this article we describe successes and challenges during BHA's three-year experience to date.

Setting For Behavioral Health Population Intervention

UCLA Health is the integrated, academic medical center affiliated with the David Geffen School of Medicine at UCLA. Its ACO includes the system's four hospitals, 265 primary care physicians practicing in 41 practices, and 1,200 medical and surgical specialists located in 110 practices. UCLA Health has held partial- and full-risk capitation contracts for commercial and Medicare Advantage members for more than thirty years. UCLA Health has entered into a Medicare Shared Savings Program (MSSP) contract and multiple commercial preferred provider organization-based ACO contracts since 2013. Using a primary care provider–based attribution rule, we now count over 250,000 patients in what we refer to as our "primary care population," of whom more than half are now in some form of risk-bearing contract or accountable care contract. As UCLA Health has assumed accountability for an increasingly larger proportion of our primary care population, we have made effectively meeting our patients' behavioral health needs a core part of our strategy.

As an academic medical center, UCLA Health contains the School of Medicine's Department of Psychiatry. Historically, however, the department primarily focused on treating people with severe psychiatric diseases and was not staffed to deliver population-based services across a broad geographic area. BHA was established in November 2012 as a new provider group within UCLA Health dedicated to enhancing access for more common mental health conditions.

Program Description

SELECTING THE RIGHT BEHAVIORAL HEALTH MODEL Collaborative behavioral health care delivery models, in which behavioral health and primary care providers work together closely, are better able to provide care that addresses patients' behavioral health and medical needs than each provider group treating independently.[8,12–15] One model of collaborative care, the Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) program, was recognized by an Agency for Healthcare Research and Quality report as having the strongest results of any intervention[16] and is widely recognized as an evidence-based practice.[17] The IMPACT model was evaluated through a randomized controlled trial and was associated with a 10.3 percent reduction in total health care costs as paid by health plans over four years.[18]

BHA incorporated several core principles of the IMPACT model[19] in establishing its collaborative care program, including providing evidence-based care, patient-centered care, treating to a targeted level of improvement based on standardized symptom assessments, and population-based care (for a graphical depiction of the adapted IMPACT model framework, see the online Appendix).[20]

Among BHA providers are child/adolescent, adult, and geriatric psychiatrists, as well as master's degree–level therapists experienced in treating each of these age groups. Treatment options include cognitive behavioral therapy, supportive therapy or medication consultation by a psychiatrist, or both. After the BHA intake evaluation, psychiatrists and therapists may refer patients to one another, as appropriate to optimize treatment. Intake sessions with a psy-

The large number of referrals to BHA demonstrates the historical burden of untreated behavioral health needs within our system.

chiatrist are scheduled for seventy-five minutes for adult and geriatric patients and ninety minutes for child and adolescent patients. Follow-up medication management appointments are thirty minutes, and therapy intake and follow-up sessions are sixty minutes.

BHA provides short-term (intended to be up to fifteen weeks in length, with a maximum of nine months) behavioral health treatment to children and adults. The short-term care model is discussed with patients during their initial appointments at BHA, so that expectations are set appropriately. Upon completion of BHA treatments, stable patients transition back to primary care provider care for ongoing medication management. Patients with longer-term treatment needs (months to years) are referred for additional behavioral health services at either the Department of Psychiatry or a community therapist or psychiatrist. Additionally, some patients may transition to group therapy treatment for maintenance of treatment gains.

BHA providers use standardized assessment instruments including the Patient Health Questionnaire-9 (PHQ-9) for depression and various other condition-specific questionnaires to define treatment plans and track symptoms during care. Patients complete their assessments using the Internet-based UCLA Behavioral Health Checkup assessment platform at intake and at three- and six-month follow-up appointments. The platform processes patients' protective and risk factors ascertained from the assessments and guides BHA providers' treatment decisions. Additionally, the assessment results inform decisions about whether patients need more advanced care or about others who may be ready for transition back to their primary care providers for care. For instance, a psychiatrist reviews the medical history records of all adult patients in the registry to provide treatment recommendations for patients not reaching certain thresholds of improvement (for example, a 50 percent reduction in PHQ-9 score after twelve weeks of treatment).

OPERATIONALIZING BHA WITHIN A COMPLEX HEALTH SYSTEM We aimed to establish and expand BHA swiftly to deliver effective services for as broad a segment of our population as possible, by using infrastructure and workflow processes that integrated behavioral health services as if they were just another clinical specialty. BHA providers are co-located in primary care practices. To promote accessibility, BHA offers evening and weekend hours. BHA encounters and documentation are available to all providers through UCLA Health's enterprise electronic medical record (EMR) system (EpicCare) and scheduling system; however, because of the sensitivity of mental health information, an extra "breaking the glass" step is required to access these records. Referrals are electronically ordered using the EMR, and there are strong expectations that BHA providers and primary care providers will create shared care plans.

To provide the full spectrum of mental health services, BHA and the more specialized Department of Psychiatry are integrated. In processing a referral, BHA staff (advised by a psychiatrist) review the acuity of the mental health disorder. Patients with a history of psychiatric hospitalizations or who appear likely to need longer-term care are triaged to the Department of Psychiatry or community providers. Additionally, a psychiatrist reviews all urgent referrals to determine whether the patient needs to be evaluated that same day. The aim is to avoid patient harm and a potentially preventable emergency department (ED) visit or hospitalization. UCLA has also cultivated relationships with existing community resources to maintain an active registry of agencies that provide specialized care for eating disorders, substance abuse, and other specific conditions.

HELPING BHA PATIENTS NAVIGATE THEIR HEALTH PLANS Historically, patients have found it extremely challenging to have their health insurance cover expenses for behavioral health care. Typically, a primary care provider who feels a patient needs ambulatory psychiatric management or therapy has been able only to direct the patient to a toll-free number on an insurance card. To make our process accessible and effective, we decided to provide active rather than passive support to our patients.

The first step was to ensure that all BHA providers were credentialed and on the provider panels of the mental health carve-out plans used by UCLA Health patients' insurers. Anticipating large pent-up demand, we also arranged with the

carve-out plans not to market our internal providers publicly, thus allowing those providers to focus on the populations UCLA Health served. Beyond making it possible for patients to use their mental health carve-out insurance to cover BHA services, we set up additional workflows to ease the process for patients. For example, we added a BHA referral choice to the enterprise EMR and routed all such referrals to a centralized staff, which verifies insurance coverage, calculates the patient's cost-sharing information for the entire BHA treatment, and conveys this by telephone to the patient within one week of the referral. The staff also identifies the most appropriate UCLA provider for that patient based on the primary condition and, where possible, age and language concordance.

RECRUITING BEHAVIORAL HEALTH PROVIDERS Traditionally, behavioral health providers have been in solo practice, so we used different tactics to recruit qualified psychiatrists and other therapists to join the BHA group practice as employees. Recruitment of psychiatrists was done jointly with the Department of Psychiatry. All BHA psychiatrists work part time within the program, which allows them to pursue other private practice, research, or inpatient activities. Therapists with experience in group therapy and team-based treatment were targeted for recruitment and were often hired to work more than half time; such therapists received employment benefits, including health insurance and retirement plans. Because of the flexibility of these positions, we have received approximately sixty applicants for every therapist vacancy and five applicants for each psychiatrist position.

Study Data And Methods

DATA To evaluate the performance of the BHA initiative, we first identified patients as having a behavioral health condition if they had one or more clinical encounters during the two years prior to the data report with an *International Classification of Diseases, Ninth Revision* (ICD-9), code that the BHA team placed into one of five behavioral health categories: depression, anxiety, attention deficit hyperactivity disorder, psychosis, or other behavioral health condition. We applied this schema to our full primary care population and patients seen within BHA. For BHA patients, we tabulated descriptive statistics including age, sex, insurance payer mix, and behavioral health category at intake visit.

METHODS We tracked the total number of BHA patients seen and the monthly rate of new intakes since the program's inception in November 2012 through January 2016. We calculated the caseload by provider type (marriage and family therapist, licensed clinical social worker, or psychiatrist) using the number of new completed intake appointments divided by the number of clinical full-time-equivalent staff for each provider type. We calculated the wait time, by behavioral health service. We delineated how long patients stay in the program by the percentage of referred patients reaching certain thresholds for number of BHA visits: one to two, three to six, seven to twelve, or more than twelve.

We tracked BHA patients' use of acute facilities—specifically, all-cause emergency department (ED) visits. We tabulated a population rate of ED visits by measuring the rate of BHA patients' ED visits in the period before and after their first BHA visit. This was standardized into a population rate per thousand patient-years that adjusted for the length of time each patient was in each period.

LIMITATIONS This evaluation was subject to two limitations. The IMPACT model is an evidence-based practice, so we did not design the ED utilization tracking (which does not control for regression to the mean or secular changes) as a summative evaluation. In addition, this program was delivered within a single delivery system, which is also an academic medical center, so the findings might not be generalizable to other systems.

Meeting the behavioral health needs of our patients while maintaining cost-effectiveness presents exciting but substantial ongoing challenges.

Study Results

At the time of BHA's launch in late 2012, 21 percent (nearly 44,000 patients) of UCLA Health's primary care population had been diagnosed with a behavioral health disease. But our own system's behavioral health providers were treating only 4 percent (approximately 1,700) at that time; as for the other patients, even their primary

care providers almost always lacked information about whether or not they were receiving treatment.

Thirty-two months after BHA's launch, the program has grown rapidly. BHA providers have treated nearly 13 percent of the approximately 44,000 patients with a behavioral health condition in our population (approximately 5,720), more than tripling the number of patients receiving our system's services. As of January 2016 BHA had twenty-four behavioral health providers (thirteen psychiatrists, six licensed clinical social workers, and five marriage and family therapists) embedded within seven primary care practice locations throughout our region. The social workers and therapists work close to full time, with 9.53 FTEs among 11 providers; in contrast, the psychiatrists work mostly part time, with 4.875 FTE among 13 providers. The psychiatrists average forty-nine new visits per month per clinical FTE, while the therapists average twenty-nine per month and the social workers average twenty-three. Current wait times for an intake appointment are prolonged across all provider types, ranging from the shortest of two to three weeks for a pediatric therapist to eight to twelve weeks for a geriatric therapist (Exhibit 1).

The demand for services has been robust, with approximately 190 new patient referrals to BHA weekly (10 percent of these are child and adolescent patient referrals). From November 2012 until January 2016, BHA providers saw 5,569 new patients—an average of 166 per month. About half of the patients are working age (ages 21–64), with the other half split between pediatric and senior age groups. Forty-five percent of BHA patients have commercial insurance, 21 percent have Medicare, and 29 percent have UCLA Health's health maintenance organization (HMO) product (both commercial and senior). Relative to the broader UCLA Health population, the BHA population had similar payer and gender breakdowns but had a greater proportion of pediatric and elderly patients. Based on billing data from initial BHA visits, patients fit the following behavioral health categories: 41 percent depression, 33 percent anxiety, 7 percent AHDH, 1 percent psychosis, and 18 percent other. The length of treatment had a broad distribution: One-third had only one to two visits, nearly 40 percent had three to twelve visits, and nearly 20 percent had more than twelve visits (Exhibit 2).

BHA patients used the ED at a rate of 260 visits per thousand patient-years before BHA and 226 visits per thousand patient-years after receiving treatment (a 13 percent reduction, $p < 0.01$). This confirms that BHA was reaching higher-utilizing patients because the ED visit rate for the general population was 135 visits per thousand patient-years. For the patients treated by BHA, this reduction amounts to approximately 204 averted ED visits. At an average health plan payment of $2,000 per visit, this amounts to approximately $408,000 in reduced total cost of care for UCLA Health's ACO population.

Discussion

By integrating behavioral health services into patients' usual source of care using the ACO model, BHA has expanded from being a pilot program to a sustainable service that has cared for more than 2 percent of UCLA Health's primary care patients. BHA's multifaceted team serves a diverse patient population having different insurance types, ages, and behavioral health needs. The internal evaluation of UCLA Health's implementation of the adapted IMPACT model demonstrates an effect size on health care use similar to that of the initial randomized controlled trial: BHA's 13 percent reduction in ED visits compared to the IMPACT trial's 10 percent reduction in costs.[18] This provides validation that a single delivery system—within the ACO framework—can implement population-level behavioral health services and achieve similar levels of outcome improvement without participating in an external collaborative.

We have learned important lessons about im-

EXHIBIT 1

Operational characteristics of Behavioral Health Associates (BHA), October 2012–January 2016

Characteristic	Value
Number of new patients seen, mean	166 per month
PROGRAM PROVIDER COMPOSITION	
Number of part-time clinical providers	
Marriage and family therapists (5 individuals)	3.8 FTEs[a]
Licensed clinical social workers (6 individuals)	5.7 FTEs
Psychiatrists (13 individuals)	4.9 FTEs
PATIENT VOLUME PER PROVIDER	
Number of new patients per clinical FTE, mean[b]	
Marriage and family therapist	29 per month
Licensed clinical social worker	23 per month
Psychiatrist	47 per month
WAIT TIME FOR INTAKE APPOINTMENT BY PROVIDER TYPE	
Adult psychiatrist	6–8 weeks
Adult therapist	6–8 weeks
Geriatric psychiatrist	8–10 weeks
Geriatric therapist	8–12 weeks
Pediatric psychiatrist	4 weeks
Pediatric therapist	2–3 weeks

SOURCE Authors' analyses of staffing and appointment schedule data. [a]FTE is full-time equivalent. [b]The capacity of each provider type to see new patients was calculated based on mean new patients per month by type.

EXHIBIT 2

Demographic characteristics of patients served by Behavioral Health Associates, October 2012–January 2016

Characteristic	Value
Unique number of patients seen	5,569
Age (years)	
0–21	24%
22–64	49
>65	27
Female	59
Payer type	
Commercial	45
Medicare	21
UCLA HMO[a]	29
Other	5
Behavioral health category	
Depression	41
Anxiety	33
ADHD	7
Psychosis	1
Other	18
Number of visits per patient	
1–2	32
3–6	27
7–12	18
>12	23

SOURCE Authors' analyses of patient medical record data and billing data from UCLA Health. **NOTE** ADHD is attention deficit hyperactivity disorder. [a]Health maintenance organization patients with the University of California, Los Angeles, Medical Group as their provider.

plementing a behavioral health population health program. First, despite the perception that, as a large physician organization, we would encounter a large hurdle in enrolling our providers with mental health insurance carve-out plans, we had no difficulty. Second, we found that many behavioral health providers were eager to leave (or supplement) private practice and relished the collaborative, team-based model of care. Third, our primary care providers viewed the active navigation of patients from referral to intake appointment as vital for the patient experience and for adherence to the care plan. Lastly, the co-location of behavioral health care services in primary care settings promoted visibility among our clinicians and ease of access for our patients.

The large number of referrals to BHA demonstrates the historical burden of untreated behavioral health needs within our system, which are likely similar to those in many settings around the United States. Through the rapid expansion of BHA, we have been able to nearly quadruple the number of patients to whom we provide behavioral health services. While the services generate revenue through reimbursements from the health plan carve-outs, BHA is possible only through investments made by UCLA Health. These investments are made anticipating future shared savings in ACO contracts with the Centers for Medicare and Medicaid Services and other commercial payers. This approach allowed us to implement BHA without the support of grants or other external resources. With costs stabilizing as the program matures, we project that BHA revenue and attributed shared savings will cover the majority to nearly all of the program's costs in coming years.

Meeting the behavioral health needs of our patients while maintaining cost-effectiveness presents exciting but substantial ongoing challenges. The long wait times for intake appointments is a result of the large number of patients who desire behavioral health services—and who likely would never have received such services prior to BHA. The psychiatrist review of each referral ensures safety; nevertheless, providing better access means that we must explore additional ways to optimize our system's capacity and allow our model to evolve. To ensure that our services remain focused on short-term treatment, we are reinforcing our policies for referring patients to longer-term treatment or step-down care, as appropriate. This is often difficult, as our patients (and occasionally our providers) reasonably desire to continue a therapeutic relationship.

To extend the reach of our current BHA providers, we are testing cost-effective treatment modalities, including electronic consults to help primary care providers manage their patients' behavioral health needs without a BHA visit and the adoption of innovative web-based preventive and behavioral health treatment resources. Additionally, we are building a Behavioral Health Network by establishing referral relationships with community-based behavioral health professionals in which UCLA assesses their quality and maintains primary care of the patients.

Conclusion

In January 2016 the U.S. Preventive Services Task Force updated its recommendation on depression screening. This update takes an important step toward addressing undertreated mental health needs by recommending screening for all adults.[21] However, the increased identification of patients will further strain health systems as they attempt to deliver population-based behavioral health services. As in the BHA program, using collaborative care approaches that integrate these services with primary care and addressing the common barriers of recruiting providers, reimbursing behavioral health services, and providing patient navigation support can be an effective solution. ■

NOTES

1 Strine TW, Mokdad AH, Balluz LS, Gonzalez O, Crider R, Berry JT, Kroenke K. Depression and anxiety in the United States: findings from the 2006 Behavioral Risk Factor Surveillance System. Psychiatr Serv. 2008;59(12):1383–90.

2 Rush AJ, Trivedi M, Carmody TJ, Biggs MM, Shorew-Wilson K, Ibrahim H, et al. One-year clinical outcomes of depressed public sector outpatients: a benchmark for subsequent studies. Biol Psychiatry. 2004;56(1):46–53.

3 de Oliveira C, Cheng J, Vigod S, Rehm J, Kurdyak P. Patients with high mental health costs incur over 30 percent more costs than other high-cost patients. Health Aff (Millwood). 2016;35(1):36–43.

4 Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: impact of depressive symptoms on adherence, function, and costs. Arch Intern Med. 2000;160(21):3278–85.

5 Cuijpers P, Vogelzangs N, Twisk J, Kleiboer A, Li J, Penninx BW. Differential mortality rates in major and subthreshold depression: meta-analysis of studies that measured both. Br J Psychiatry. 2013;202(1):22–7.

6 Katon WJ. Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. Biol Psychiatry. 2003;54(3):216–26.

7 Regier DA, Narrow WE, Rae DR, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorder service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. Arch Gen Psychiatry. 1993;50(2):85–94.

8 Unutzer J, Katon W, Callahan CM, Williams JW Jr., Hunkeler E, Harpole L, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002;288(22):2836–45.

9 Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Aff (Millwood). 2008;27(3):759–69.

10 McClellan M, McKethan AN, Lewis JL, Roski J, Fisher ES. A national strategy to put accountable care into practice. Health Aff (Millwood). 2010;29(5):982–90.

11 A new direction in depression treatment in Minnesota: DIAMOND program, Institute for Clinical Systems Improvement, Bloomington, Minnesota. Psychiatr Serv. 2010;61(10):1042–4.

12 Unützer J, Harbin H, Schoenbaum M, Druss B. The Collaborative Care Model: an approach for integrating physical and mental health care in Medicaid health homes [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2013 May [cited 2016 Jun 30]. (Health Home Information Resource Center Brief). Available from: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf

13 Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012;10: CD006525.

14 Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med. 2006;166(21): 2314–21.

15 Simon G. Collaborative care for mood disorders. Curr Opin Psychiatry. 2009;22(1): 37–41.

16 Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, Hagedorn H, et al. (Minnesota Evidence-based Practice Center, Minneapolis, MN). Integration of mental health/substance abuse and primary care [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; 2008 Nov [cited 2016 Jun 30]. (Evidence Report/Technology Assessment No. 173). Available from: http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf Accessed May 14 2016.

17 Unützer J, Ratzliff A. Evidence base and core principles. In: Raney L, editor. Integrated care: working at the interface of primary care and behavioral health. Arlington (VA): American Psychiatric Publishing; 2015.

18 Unutzer J, Katon W, Fan MY, Schoenbaum MC, Line EH, Della Penna RD, et al. Long-term cost effects of collaborative care for late-life depression. Am J Manag Care. 2008;14(2):95–100.

19 AIMS Center. Principles of collaborative care [Internet]. Seattle (WA): AIMS Center, Advancing Integrated Mental Health Solutions; c 2016 [cited 2016 Jun 30]. Available from: http://aims.uw.edu/collaborative-care/principles-collaborative-care

20 To access the Appendix, click on the Appendix link in the box to the right of the article online.

21 U.S. Preventive Services Task Force. Depression in adults: screening [Internet]. Rockville (MD): The Task Force; 2016 Jan [cited 2016 Jun 30]. Available from: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1?ds=1&s=depression