How Practices Can Advance the Implementation of Integrated Care in the COVID-19 Era

Mary Docherty, Brigitta Spaeth-Rublee, Deborah Scharf, Erin Ferenchik, Jennifer Humensky, Matthew Goldman, Henry Chung, and Harold Alan Pincus

ABSTRACT

ISSUE: Preliminary data predict an increase in mental health needs in the U.S. population because of the COVID-19 pandemic and its socioeconomic consequences. Patients with chronic medical conditions are especially at risk for behavioral health conditions and poorer outcomes. Integrated behavioral health and primary care can improve these patients' clinical outcomes.

GOAL: To describe how practices are successfully implementing and advancing integrated care.

METHODS: A literature review identified 20 primary care practices that deliver high-quality integrated care. Findings from surveys, site visits, and semistructured telephone interviews were then analyzed.

KEY FINDINGS: Financing, health information technology (HIT), and workforce challenges were the top three barriers to advancing integrated care. Practice-level strategies to address barriers included: diversifying revenue streams, prioritizing HIT implementation, and revamping workforce recruitment, training, and retention. To advance and sustain these investments, practices desired greater alignment with state regulators and payers.

CONCLUSION: COVID-19 has magnified how the advancement of HIT, including innovations in digital mental health, could increase access to integrated care and alleviate workforce shortages. While this research was conducted prior to the pandemic, the findings offer insights into how practices have been addressing some of the challenges of providing high-quality, integrated care. State and payer actions could bring successful practice-level integration strategies to scale.

TOPLINES

▸ Barriers to integrated care, which combines primary health care and behavioral health care by using a team-based approach, include challenges in financing, health information technology (HIT), and workforce supply.

▸ The COVID-19 pandemic has magnified how advancement of HIT could increase access to integrated care.

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INTRODUCTION

Behavioral health disorders are highly prevalent among U.S. adults and frequently co-occur with chronic physical health conditions.[1] The COVID-19 pandemic has created multiple psychosocial stressors and socioeconomic impacts that disproportionately affect vulnerable populations including those with comorbid behavioral and physical health conditions.[2] Traditionally, the U.S. health system has treated medical and behavioral health conditions separately, resulting in care that is often fragmented, low-quality, associated with poor outcomes, and extremely costly to deliver.[3] In Medicaid populations, for example, the cost of care is at least double for patients with co-occurring conditions. COVID-19 has both exacerbated and magnified these preexisting challenges.[4]

Integrated care combines primary health care and behavioral health care by using a team-based approach to address the needs of the whole person. Integrated care shows promise for improving health, but uptake has been challenging.[5] At present, states are tasked with leading the design and implementation of integrated care models that improve quality of care and patient outcomes at reduced cost, largely through Medicaid expansion as part of the Affordable Care Act (ACA). State designs create some structure for integrated care programs, but operational details can vary significantly across practices' administrative and community contexts.

The report *Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework* provides a roadmap for integrating care.[6] It describes 14 components of integration organized into eight broad domains, described in Exhibit 1.

Using the framework as a guiding structure, the study aimed to identify key strategies practices are using to successfully address operational and structural challenges to integration. As envisioned, states could then adopt and support broader implementation strategies and bring these to scale. We performed a literature review, preliminary survey, and screening interviews to identify a diverse cohort

Exhibit 1. Key Components of Primary Care and Behavioral Health Integration

Domain	Key components
Case finding, screening, and referral to care	• Screening, initial assessment, and follow-up • Referral facilitation and tracking
Multidisciplinary care team (including patients)	• Care team • Systematic team-based caseload review and consultation • Availability for interpersonal contact between PCP and BH specialist/psychiatrist
Ongoing care management	• Coordination, communication, and longitudinal assessment
Systematic quality improvement	• Use of quality metrics for program improvement
Decision support for measurement-based, stepped care	• Evidence-based guidelines or treatment protocols • Use of pharmacotherapy • Access to evidence-based psychotherapy treatment with behavioral health specialist
Culturally adapted self-management support	• Tools utilized to promote patient activation and recovery
Information tracking and exchange among providers	• Clinical registries for tracking and coordination • Sharing of treatment information
Linkages with community/social services	• Linkages to housing, entitlement, and other social support services

of primary care clinics that had implemented integrated care practices at an intermediate or advanced level. We then conducted semistructured interviews and site visits to describe the practice's approach, as well as barriers they ran into and the strategies they used to overcome those barriers (see "How We Conducted This Study").

PRACTICE-SPECIFIC BARRIERS TO INTEGRATED CARE

Most practices rated themselves as having fully or nearly fully implemented four of the key components for integration: patient screenings and case findings, referral facilitation, information sharing, and using a multidisciplinary care team. Other components of integrated care such as information tracking and sharing, quality improvement through measurement-informed care, and self-management support were less developed. The capacity to connect patients to social service organizations was underdeveloped, but all practices reported that plans to improve these components were under way.

Practice interviewees described external and internal barriers to advancing integrated care (Exhibit 2). All the internal barriers related to three issues: inadequate and unsustainable funding, technology gaps, and shortages of trained behavioral health specialists.

Exhibit 2. Barriers to Integrated Care Identified by Providers

External factors	
Regulatory and policy-related barriers	- State regulations related to primary and behavioral health care providers impede integrated care delivery - Privacy laws (for example, CFR-42) limit health information sharing - Health information technology (HIT) infrastructure and data are insufficient to support regional or state Health Information Exchanges and community needs assessments - Local workforce lacks appropriately trained behavioral health specialists - Sustainable financing is limited by: - lack of reimbursement for core care processes - time-limited grants
Internal factors	
Barriers related to organizational structures and processes	- Establishing and maintaining integrated teams is limited by: - low buy-in from primary care practitioners - misaligned primary care and behavioral health provider cultures - misaligned workflows and appointment schedules - Building capacity to deliver team-based care is limited by: - insufficient physical space for colocation and staff expansion - fluctuations in patient flow - HIT and electronic health records that support integrated care - Sustainable financing limited by: - insufficient infrastructure to deliver care processes efficiently, including ability to bill for integrated services - administrative burden of CPT billing codes, including alignment with billing and accounting workflow

PRACTICES' STRATEGIES FOR ADDRESSING BARRIERS TO INTEGRATED CARE

Improve Integrated Care Financing and Build Sustainable Services

Our findings confirmed that adequate financing for integrated care remains challenging and impedes taking integration to scale. The majority of practices we interviewed were primarily supported through fee-for-service billing, which is limited by a lack of billing codes to support team-based activities, care management, and non-face-to-face clinical activities.

Other challenges with fee-for-service included payer or state restrictions on same-day billing for more than one service per day, or billing a primary care and behavioral health visit on the same day. Such restrictions place limits on the ability to provide timely, interdisciplinary, team-based, and patient-centered care. Respondents also pointed to variations in payer and state policies on which licensed providers (for example, clinical social workers or licensed professional counselors) are allowed to bill for elements of integrated care as having a significant impact on practices' ability to sustain integrated services.

New billing codes. The Centers for Medicare and Medicaid Services (CMS) recently introduced two billing options to support integration: 1) time-based billing codes for the cumulative time providers spend managing patients in the context of a particular integrated care model (collaborative care model) over the course of a calendar month, and 2) general behavioral health integration billing codes. Practices' reactions to the time-based billing codes were mixed and overall were not widely used. Several providers reported that administration was complex, and their billing systems were not equipped to handle the requirements. There was also evidence of variation and confusion in how the codes could be applied to overcome profession-specific restrictions in who could bill for integrated services.

Of those providers that had successfully implemented these billing codes, the majority felt the related payments had partially but not fully compensated for all integrated care activities. Providers in smaller practices reported needing more HIT capacity and technical assistance to take advantage of these codes.

Grants. Use of federal, state, and foundation grants was extremely common. All respondents identified that grant funding had played a role in some aspect of their integrated services. Grant-related challenges included the resources needed to secure grants and the time-limited nature of the funding. Successful strategies focused on how to use grants to support sustainability. One exemplar practice created a grant development department to ensure program sustainability and growth. Another practice received additional funds from a hospital system to fund integrated care program leadership and promote ongoing growth.

Combination of funding streams. Practices reported sustaining integrated care through multiple funding streams, typically including fee-for-service payments and grants and, less frequently, value-based income streams. In one practice, this included reinvestment of productivity savings generated from contracts into additional needed services, such as resources to address social needs. The Federally Qualified Health Centers in our sample reported that prospective payment system rates — which are typically tied to overall practice costs and not CPT or time-based billing — were critical to the feasibility of delivering integrated care.

Among those few practices with value-based payment arrangements, challenges to their successful implementation included a lack of administrative infrastructure and availability of appropriate performance measures tied to integration. Another hurdle was the significant negotiating leverage needed to contract with managed care organizations (MCOs). As the Institute for Community Living's chief medical officer noted:

> Size matters here. The administrative structure required to transform . . . to value-based payment, to be big enough to contract with the managed care plans, have them give us our data and get their attention . . . we're not like the hospitals; it takes more effort on our part.

The practices that had successfully implemented value-based payment arrangements identified a close working partnership with the health plan as essential. Health plans need to be flexible and allow practices to incrementally implement these models while also supporting and assisting practices in building the necessary administrative infrastructure.

In summary, no single financial solution nor payment model appeared to satisfy practices' varying financial contexts and needs, although a range of helpful strategies were identified (Exhibit 3). Ultimately, organizational financial acumen, resourcefulness, and a real commitment at the leadership level to delivering integrated care were deemed necessary to sustain these programs.

HIT Advances Practices Along the Integration Continuum

Implementation of HIT was described by many respondents as critical to delivering integrated care. They said it reduced the reliance on otherwise human-resource-intensive care processes and facilitated core clinical and administrative functions, including clinical information sharing and billing.

Preliminary and intermediate implementation of some of the key components of integration, such as patient screening, care referrals, and follow-up, could be achieved with manual processes or basic IT systems. However, more advanced activities, such as the use of clinical registries and population health analysis, required more robust technological infrastructure. Smaller practices that had made progress in this area reported that it had been a strategic priority for investment. "We must find ways to lower the IT barrier to entry in order to foster uptake of collaborative care," a physician executive with Philadelphia's Penn Primary Care told us.

Exhibit 3. Strategies Used to Support Financial Sustainability

- Prioritize investment in core infrastructure (for example, health information technology)
- Subsidize integrated care through other revenue-generating activities
- Pursue broad-based funding approaches, including grants
- Provide technical support for new billing codes
- Repeal same-day and profession-specific billing requirements
- Introduce value-based payment incrementally
- Provide technical assistance to improve use of billing codes and value-based payments
- Reinvest savings into infrastructure to address social needs

Use of HIT to target specific implementation challenges. Across our sample of practice sites, HIT had been applied to advance integrated care in many different ways (Exhibit 4). Respondents highlighted that it was helpful to view HIT as a problem-solving tool for a range of different challenges.

Embed HIT in clinical quality improvement teams. Respondents highlighted that *how* IT was implemented was as critical as the infrastructure itself. IT implementation needs to be seen as an iterative quality improvement process that evolves alongside integrated workflows. Marana Health Care included IT technicians and operations staff as core members of the clinical team to optimize the design, interoperability, and user-friendliness of the system.

Build partnerships with vendors and Health Information Exchanges (HIEs). Clinical information sharing in integrated care has been difficult because of strict privacy laws (that is, HIPPA CFR Part 42) and the lack of systems to share information across different providers. The practices that we interviewed identified state-level initiatives as important facilitators of information exchange.

Exhibit 4. How Technology Advances Practices Along the Integrated Care Continuum

Integrated care domain	Application of technology to improve integrated care process
Case finding, screening, and referral to care	• Identify and target at-risk or priority groups • Increase efficiency of screening processes • Referral tracking • Secure, real-time messaging to increase warm handoffs
Multidisciplinary care team (including patients)	• Telepsychiatry to increase access to behavioral health specialists • Remote consultation services to support primary care practitioners • Efficient systems to conduct caseload review • Web-based staff training programs • Virtual collaborative care teams
Ongoing care management	• Built-in tracking systems to monitor patients' attendance and progress • Built-in templates supporting multidisciplinary approach
Systematic quality improvement	• Dashboards and quality reports to engage providers • Implementation of CPT billing codes • Automated billing and administrative functions • Population planning and workforce needs modelling
Decision support for measurement-based, stepped care	• Decision-support tools embedded in the electronic health record • Automated tracking of patient symptoms • Access to web-based psychotherapy and telepsychotherapy
Culturally adapted self-management support	• Remote translating services • Apps for self-management
Information tracking and exchange among providers	• Health information exchanges • Interoperable health records across settings
Linkages with community/social services	• Use of electronic platforms to link patients to services

For example, Washtenaw County Community Mental Health described how the state of Michigan's mandated use of a standardized consent form greatly accelerated the practice's efforts to build efficient systems for clinical information sharing. The practice partnered with its EHR vendor, PCE Systems, and Great Lakes Health Connect, one of the largest HIEs in Michigan, to build a novel e-consent system with a seamless single sign-on. This ensured that behavioral health providers could view their patients' medical records and medical providers could access their patients' behavioral health information. Grant funding and a positive working partnership with the EHR vendor, which was built on a mutual desire to innovate, were key to facilitating this relatively low-cost initiative. "The financing wasn't hard on this piece, because they saw the benefit on this," said the practice's deputy director. "We were one of the first to do this, so it's also proof of concept for them."

Build practice networks to bridge HIT gaps. Bridging solutions could be developed in the absence of comprehensive interoperable records and HIEs. Several respondents described how building networks with other practices and including patient-tracking responsibilities into clinical roles helped them improve quality of care and clinical information sharing.

Partners in Recovery in Gilbert, Arizona, for example, employed a collaborative approach to develop a network of specialist medical providers for patients with serious mental illnesses. The practice created enhanced referral processes and shared care agreements, including written agreements detailing mutual expectations around clinical communication between general medical providers and behavioral health services. The efficacy of this strategy was enhanced through quality improvement work; the practice

adjusted referral processes to complement the existing provider culture. For example, the in-house primary care clinician handled referrals to external medical partners.

Building an Adequate Behavioral Health Workforce to Deliver Integrated Care

Behavioral health workforce shortages and inadequate reimbursement in the public sector often disincentivizes practitioners from pursuing employment with integrated care teams, aggravating the lack of appropriately trained clinical staff. To address these issues, the practices we interviewed focused on increasing the supply of appropriately trained clinical behavioral health staff, optimizing the existing supply, and prioritizing retention strategies of those already in the system.

CREATING FELLOWSHIPS TO BUILD A SKILLED AND SUSTAINABLE WORKFORCE

Fellowships address two distinct problems: They attract high-caliber candidates to a geographic area, increasing the workforce supply. Fellowships also help staff develop the appropriate skills and competencies necessary to deliver integrated care. Cherokee, Intermountain, Salud, and Community Health Network had all invested in and created specific postqualification or postdoctoral fellowships and were achieving high retention rates.

Smaller providers also were adopting this approach. Community Health Alliance in Reno, Nevada, had innovated by partnering with the University of Nevada, Reno, to create extern opportunities. They reported dual benefits of giving psychology students exposure to primary care settings and integrated care models while providing the service with needed capacity and resources to carry out several core clinical functions.

The ability to develop, fund, and benefit from fellowship schemes was influenced both by provider resourcefulness in forging arrangements with local universities and by their geographical position or proximity to academic organizations.

Increase workforce supply. A common strategy to increase workforce supply focused on the creation of internships and fellowships.

Other approaches (in states without profession-specific reimbursement restrictions) included applying flexibility to staffing models and recruiting behavioral health professionals — psychologists, registered nurses, licensed clinical social workers, or other licensed therapists — according to local availability. Several advanced practices had developed recruitment processes to assess candidates "fit" with the organization. Flexibility, competency in diagnostic skills, and comfort with both behavioral and general medical conditions were felt to predict whether a candidate would adjust, work effectively, and remain with the organization. A small group of providers broadened their definition of "workforce" to include peer specialists and peer patient educators.

Optimize existing supply. Strategies to optimize existing workforce capacity were varied. These included intensive staff development techniques, adjustments to integrated care processes, and redefining staff roles to streamline activities with existing workflows. Stepped care approaches, often guided by treatment algorithms, were commonly used to preserve scarcer behavioral health expertise for more complex cases and to ensure that primary care clinicians and other providers with diagnostic expertise (psychologists) work to the top of their skill level. Telepsychiatry also was employed by many of our respondents both to increase patient access to behavioral health expertise and to provide supervision and support to primary care providers delivering behavioral health care (Exhibit 5).

Two innovations addressed workforce issues with technology: Montefiore Medical Center in The Bronx, New York, was testing the impact of a virtual collaborative care model for small primary care practices with limited access to psychiatrists. In addition, Intermountain Healthcare in Salt Lake City, Utah, had prioritized workforce planning and was working through its mental health integration service, Alluceo, to use patient population data and predictive modeling to plan and tailor staffing models directly to patient need.

Exhibit 5. Strategies to Optimize Existing Integrated Care Capacity

- Shorten screening tools or use two-stage screening to ensure patients with complex needs undergo more comprehensive assessments
- Prioritize at-risk or priority groups
- Redefine staff roles to preserve scarcer behavioral health resources (for example, train medical assistants to conduct screening and introduce bachelor's-level care coordinators
- Use technology for self-screening in the waiting room
- Create a centralized assessment and referral center optimizing computerized decision support for screening, referral facilitation, and follow-up
- Use telepsychiatry for primary care consultation, learning, and delivering care
- Use medical risk stratification to allocate resource differentially according to clinical need

PROMISING INNOVATIONS IN DELIVERING SELF-MANAGEMENT SUPPORT

Montefiore Medical Center was using a portfolio of patient engagement and self-management tools, including a secure online application and messaging system that allowed for longitudinal clinical monitoring, engagement, and follow-up with patients. Interactions with patients were conducted via HIPAA-compliant text messages. Patients were offered support, screening, condition monitoring, and prompts/recommendations around behavior modification, mindfulness exercises, and physical exercise.

The Institute for Community Living, New York City, and the Lowell Community Health Center, Lowell, Mass., had developed expertise in introducing peer specialists into clinical teams. Interviewees described extremely positive patient response and improvements in patient engagement. The practices were successfully using trained peers to deliver interventions in smoking cessation and exercise as well as chronic disease management support.

DISCUSSION

We identified a cohort of practice sites across the United States using innovative approaches to advance integrated care. All of our respondents reported that, while this work was technically difficult and financially challenging, it was critical to their organization's mission, culture, and belief in whole-person care. They emphasized that significant policy changes are needed to enable large-scale uptake and sustainability of integrated care.

Policy Implications for States, MCOs, and Practices

States. States wishing to promote integrated care could assist by resolving regulatory barriers that hinder, rather than protect, patient safety. One example is to create integrated licenses and single standardized consent processes. States, in collaboration with the federal government, also could establish stronger incentives for implementing integrated care models and target financial and technical support to develop health information exchanges and HIT capabilities. In addition, there is a need for more robust metrics for integrated care, including valid measures of quality that share accountability across the behavioral health and primary care interface and appropriately incentivize and reward clinics for good service. To do this, states must ensure clinician, patient, and caregiver involvement in the development of measure sets.

Managed care organizations. Health plans and other MCOs can help practices develop the administrative systems for integrated care, including those needed to report quality metrics and bill for collaborative care. Providers did not identify a single solution to alleviate financing challenges, and the lack of current progress in adopting value-based payment suggests this is not an immediate panacea to funding shortfalls. Efforts might focus on MCOs working collaboratively with each other to ensure consistency in requirements placed on practices. They also should work collaboratively with primary care practices to develop VBPs, roll out payment plans incrementally, and help practices to build the necessary systems and processes to diversify funding sources and ensure available payment options are being used to their fullest (for example, CPT billing codes).

Practice sites. Primary care practices and clinics can adopt various strategies to advance integrated care even within the current landscapes of funding constraints and workforce shortages. Prioritizing the implementation of HIT and optimizing the existing workforce can generate increased capacity to deliver integrated care more efficiently. Choosing leadership that embraces integrated care, using the whole organization's expertise to address challenges, and looking externally to build partnerships, networks, and influence with states, MCOs, and other practices also helped practices advance.

CONCLUSION

We identified three cross-cutting issues as critical to advancing implementation of integrated care, which should be priorities for policy targets: financing, HIT capabilities, and workforce. Even prior to the COVID-19 epidemic, the expansion of HIT was considered an important driver of advancing integrated behavioral health services and a tool to alleviate some workforce shortages. Our study showed that, although challenging, practices are managing to address some of these barriers and that there are ways for states and MCOs to support their efforts. Adoption of these strategies could directly help practices and inform policymakers seeking to support their efforts. The evolving impact of COVID-19 on the behavioral and physical health of our population serves to further highlight the need to accelerate adoption of these practices.

HOW WE CONDUCTED THIS STUDY

We performed a cross-sectional study using a series of sampling methods including literature review, surveys, and screening interviews to identify intermediate or advanced implementers across different types of primary care settings. We conducted semistructured interviews and site visits to structure our enquiry into how practices were implementing key components of the continuum-based framework, what barriers they had encountered, and the methods they had used to overcome them.

We completed interviews with clinicians and lead administrative and finance staff from 20 practices delivering integrated behavioral health and primary care. We also visited six clinical practice sites belonging to four different organizations in two states. Practice-site respondents included integrated program leads and frontline staff: primary care physicians, psychiatrists, nurse specialists, licensed clinical social workers, and psychologists. Practice-site characteristics were balanced by region and setting, provider type, insurance type, and size of population served.

NOTES

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ABOUT THE AUTHORS

Mary Docherty, B.A. (Hons), M.A., M.B.B.S. (Hons), MRCP, MRCPsych, is a consultant liaison psychiatrist with the South London and Maudsley NHS Foundation Trust. She was a 2018–19 Harkness Fellow in Health Care Policy and Practice, based at New York State Psychiatric Institute at Columbia University. Dr. Docherty has policy, research, and clinical expertise in integrated care and has held policy roles with the U.K.'s Department of Health, NHS England, the National Institute of Health and Care Excellence (NICE), and London's Healthy London Partnership. She is a member of both the Royal College of Physicians and Royal College of Psychiatrists.

Brigitta Spaeth-Rublee, M.A., is a research associate at New York State Psychiatric Institute. Her research interests focus on behavioral health integration (general medical and serious illness care), behavioral health quality measurement (U.S. and internationally) and improvement of access to care for underserved populations. She is also the program manager of the Health and Aging Policy Fellows Program at NYSPI.

Deborah Scharf, Ph.D., CPsych, is a clinical and health psychologist and an assistant professor of Psychology and Health Sciences at Lakehead University. She is a practicing clinician and researcher whose work aims to improve health care systems for high-need, high-cost and underserved populations, particularly adults with serious mental illness and cooccurring chronic disease.

Erin K. Ferenchick, M.D., is a medical anthropologist and family physician. She is an assistant clinical professor of Medicine in the Center for Family and Community Medicine and an adjunct assistant professor in the Department of Health Policy and Management at the Mailman School of Public Health at Columbia University Irving Medical Center. Dr. Ferenchick has been involved with global initiatives focused on strengthening primary health care throughout her career. She has worked for the International Rescue Committee, Gavi, World Health Organization, and most recently The Global Fund.

Jennifer Humensky, Ph.D., is an assistant professor of Clinical Health Policy and Management (in Psychiatry) at the Columbia University Department of Psychiatry and New York State Psychiatric Institute. Her research areas are in mental health services research and mental health economics. Her work focuses on the role of social determinants of health, notably work and school participation, in improving functioning and well-being for adolescents and young adults. Dr. Humensky's work comes from an economic and policy perspective and uses quantitative, qualitative, and mixed methods in the process of developing policy-relevant research.

Matthew L. Goldman, M.D., M.S., is the medical director for Comprehensive Crisis Services in the San Francisco Department of Public Health, and he is a volunteer clinical assistant professor in the UCSF Department of Psychiatry and Behavioral Sciences. Dr. Goldman is an early career psychiatrist board member of the American Association of Community Psychiatry, a member of the American Psychiatric Association's Council on Advocacy and Government Relations, and sits on the National Council for Behavioral Health's Medical Director Institute. He is coeditor of the Editor's Choice Collections for the journal Psychiatric Services and coleads the Psychiatric Services Policy Advisory Group.

Henry Chung, M.D., is senior medical director of Behavioral Health Integration Strategy at Montefiore Care Management Organization and professor of Psychiatry at the Albert Einstein College of Medicine. He also has conducted community-based services research and published scholarly articles in the integration of behavioral health and primary care particularly for racial and ethnic minorities. Dr. Chung is the project executive director of the Centers for Medicare and Medicaid Services–funded Integrated Care for Kids project, which is partnering with the New York State Department of Health and community-based providers to improve the quality of care for children and families in Bronx County of New York City.

Harold Alan Pincus, M.D., is professor and vice chair of the Department of Psychiatry and codirector of the Irving Institute for Clinical and Translational Research at Columbia University and the New York State Psychiatric Institute. Dr. Pincus also serves as a senior scientist at the RAND Corporation. He is the national director of the Health and Aging Policy Fellowship (funded by The John A. Hartford Foundation, West Health Institute, and Atlantic Philanthropies), and previously directed national programs for the Robert Wood Johnson Foundation and the MacArthur Foundation. Dr. Pincus has been appointed to the editorial boards of twelve scientific journals and has published more than 500 scientific publications on health and mental health policy and practice. He has been cochair of the national committee that reviews all U.S. health care quality measures under the Affordable Care Act, the World Health Organization's ICD-11 Committee on Quality and Patient Safety, and also was vice chair of the Task Force on DSM-IV, among multiple other national/international committee appointments.

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For more information about this brief, please contact:
Harold Alan Pincus, M.D.
Professor and Vice Chair
Department of Psychiatry
Columbia University College of Physicians and Surgeons
harold.pincus@nyspi.columbia.edu