Behavioral Health Integration Meeting

OCTOBER 21ST, 2025 | 2:00 – 4:00 PM ET

PARTICIPATING ORGANIZATIONS

American Academy of Family Physicians, American Academy of Child and Adolescent Psychiatry, American Psychological Association, EvolvedMD, Mental Health America, National Committee for Quality Assurance, Pediatric Innovation Center, Society of General Internal Medicine, UPMC Health Plan

Thank you to Our Speakers:

- Co-Chairs: Mary Giliberti, Mental Health America & Alin Severance, UPMC Health Plan
- Helen Jack, MD, University of Washington
- David Kraus, Outcome Referral, Inc
- Mike Thompson, Formerly National Alliance of Healthcare Purchaser Coalitions
- Brenda Reiss-Brennan, APRN, PhD, Intermountain Healthcare

MEETING SUMMARY

Welcome

Larry McNeely, PCC's Director of Policy, opened the meeting welcoming participants and outlining the objectives for the session, emphasizing behavioral health integration as a cornerstone of PCC's whole-person care strategy.

Larry reviewed the agenda highlighting:

- PCC Press Release: PCC Encourages Swift, Collaborative Action to Protect Access to Primary Care Services
- On October 16, the PCC joined more than 150 organizations on a Families USA-led sign-on letter urging Congress to "extend the enhancements to the premium tax credit without delay and without any changes that could place health coverage out of reach for millions of vulnerable Americans."
- The upcoming release of PCC's 2025 Evidence Report – *Closing the Distance in Rural Primary Care: Evidence, Stories and Solutions*

Lastly, he shared ARHQ's Behavioral Health Resources

- AHRQ's Investments in Primary Care Research for 2023 and 2024
- Behavioral Health Integration Ecosystem Directory
- Medications for Opioid Use Disorder Playbook

Co-Chair Remarks

Mary Giliberti of Mental Health America reflected the current political environment, and the uncertainties impacting our work and Americans access to healthcare. She spoke about work being done at MHA to find ways for people to continue to have access to behavioral health services and encouraged attendees to reach out if their organizations were working through exemptions in the new Medicaid rules. In addition, Mary highlighted the victory of the Physician Fee Scheule Proposed Rule and the work that this group did to champion it forward. In closing Mary highlighted opportunities in the behavioral health space, the opportunity to rethink health and her desire to have behavioral health no longer be an add-on but rather a core.

Alin Severance of UPMC Health Plan echoed Mary's remarks and added some of the challenges ahead of use has to do with choice of language and messaging. He suggested that we tell the same story in a language that the new administration will resonate with.

AUD/SUD Treatment in Primary Care

Dr. Helen Jack of the University of Washington presented on integrating peer support into alcohol and substance use disorder treatment within primary care practices.

Helen opened her presentation by sharing national context on the peer workforce, noting that there are approximately 65,100 lay health workers in the United States. She then provided an overview of her research study, *"Addressing Substance Use Disorder in Primary Care: The Role, Integration, and Impact of Recovery Coaches."* Findings from the study indicated that peers were most helpful to patients in the areas of system navigation, supporting behavior change, harm reduction, and relationship building.

Helen suggested that framing the question as "Are peers helpful?" may be the wrong approach. Instead, she encouraged a shift away from focusing narrowly on outcomes such as reduced substance use and toward relational and engagement-based measures, including patient retention and whether peers encourage patients to consistently engage with their primary care clinicians. She emphasized the importance of considering whether the role of peers is to drive specific clinical outcomes or to support patients in the ways they need most.

Helen also referenced two additional research articles, highlighting that successful peer models depend on thoughtful consideration of program structure, intensity, and clarity around desired outcomes. She underscored that peers bring unique expertise through lived experience, and that the health system must consider how best to incorporate this growing workforce. She noted that peer programs vary widely, that some demonstrate improvements in clinical outcomes, and that additional research is needed to determine which outcomes matter most. She further emphasized the importance of understanding how peers fit into the broader primary care team.

Alin commented that he agreed with the points Helen highlights and the challenges she raised up are the same as the challenges around sustainable funding for outcomes research more broadly. Alin also highlights that doctors do not get any training on how to work with peers and there is not a good communication system set up between them. Pennsylvania has required all Medicaid plans to cover peer and it has been pretty successful and Alin would like it to be broader in coverage.

Alin commented that he agreed with the points Helen raised and noted that the challenges she described mirror broader issues related to sustainable funding for outcomes research. He added that clinicians receive little to no training on how to work effectively with peers and that communication systems between clinicians and peers are often inadequate. He highlighted Pennsylvania's requirement that all Medicaid plans cover peer services, noting that the policy has been successful and expressing interest in broader adoption. Alin also emphasized that one of the most promising aspects of peer integration is the collaborative relationship between clinicians and peers in supporting patients.

Helen echoed Alin's comments regarding the importance of incorporating peer integration into clinician training.

Shahla Baharlou of SGIM asked whether there is research on the impact of peers on clinician burnout in primary care settings.

Helen responded that she has not found specific data addressing clinician burnout in relation to peer integration.

Larry McNeely thanked Helen for her presentation and participation.

PC–BH Referrals: Leveraging Outcomes-Based Matching

Mike Thompson of the National Alliance of Healthcare Purchaser Coalitions and David Kraus of Outcome Referral, Inc. presented on innovations in outcome-based referral matching between primary care and behavioral health clinicians.

David explained that many poor outcomes in behavioral health are not the result of inadequate treatment, but rather of mismatches in care - specifically, patients being referred to clinicians who are not the best fit for their needs. He noted that their solution does not focus on retraining clinicians, but instead on creating a platform that more effectively matches patients to clinicians based on outcomes data.

David described how algorithmic matching tools use patient outcome data to optimize referrals, assigning patients to clinicians with demonstrated expertise in addressing specific behavioral health conditions. He reviewed the science behind the approach and shared evidence indicating that this matching process leads to improved patient outcomes.

Mary asked whether the platform is able to work with Medicaid MCOs and Medicare Advantage plans.

David responded that one of their earliest partners was a managed Medicaid plan in Massachusetts, demonstrating the platform's ability to work with Medicaid populations. Mike added that Outcome Referral is contracted with provider networks, which enables referrals across patient populations.

Alin asked whether the evaluation of behavioral health clinicians is based on the same patient metrics collected during the initial assessment.

David confirmed that clinicians are assessed based on patient outcomes, noting that the data are risk-adjusted to ensure that performance reflects patient progress rather than patient complexity or baseline health status.

Alin then asked whether behavioral health clinicians are receptive to being evaluated in this way.

David responded that there has been strong buy-in from clinical partners interested in integrating the platform into their practice settings. He also shared that clinicians who participated in the pilot reported increased provider satisfaction, as the model allowed them to focus on areas where they are particularly effective in delivering care.

Scott Barstow of the American Psychological Association asked how patient data are captured and tracked, and whether this occurs through electronic health records.

David responded that the platform primarily uses EHR data, which are uploaded into their system to allow both primary care and behavioral health clinicians to access shared patient information.

Behavioral Health and Whole Person Care

Brenda Reiss-Brennan of Intermountain Healthcare presented on Intermountain's Whole Person Care model, which integrates behavioral health, primary care, and social supports.

Brenda began by providing a brief history of mental health integration at Intermountain Health and described three foundational insights that informed the development of a culture centered on collaboration, mutual gain, and shared responsibility.

- Trusting Relationships are the most healing and underleveraged deficient natural human resources in health systems and institutions.
- Relational Reciprocity is the way we relate and connect to each other - the biological relational operating system built on mutual exchanges, cooperation and obligation where everyone contributes to a collective purpose that produces trust and shared benefits.
- Complexity is not a math problem, human problem It is an adaptive asset and determining quality of natural and human ecosystems that creates the conditions to harness ingenuity

Brenda then discussed the implementation process and explained that Intermountain conducted research to assess key results and outcomes from its team-based care journey. She highlighted the following patient outcomes:

- Emergency department visits were reduced by 23%
- Hospital admissions were reduced by 10.6%
- Rates of depression screening increased
- Adherence to diabetes care protocols increased

Steve Biljan of evolvedMD asked what Intermountain has learned over the past decade as the organization has experienced significant community and geographic expansion.

Brenda responded that despite changes in scale and structure, the core mindset at Intermountain has remained consistent, noting that no clinic wants to operate without integrated mental health or collaborative care.

Dominique Quincy of the Primary Care Collaborative thanked Brenda for her presentation and asked how Intermountain pays for and sustains its whole person care model.

Brenda explained that Intermountain intentionally incorporated economics into the model, including paying clinicians for coordinated care. She also noted that the organization reorganized care teams and more fully leveraged existing resources that were already funded but underutilized, such as mental health professionals and nurse care managers.

Larry thanked all speakers and attendees for their active participation.