<table>
<thead>
<tr>
<th>Session</th>
<th>Title</th>
<th>Presenter(s)</th>
<th>Duration</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2a</td>
<td>(25 minutes)</td>
<td>Headache and History Class Under One Roof: PATCH, the Pre-Adolescent to Teen Center for Health (5801382)</td>
<td>Suan Hemingway, Tobi Chaisse, Robert Kelly, John Freeman, George Devito, Andrew Valeras, Aimee Valeras</td>
<td>Portland, Oregon USA</td>
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<tr>
<td>A2b</td>
<td>(25 minutes)</td>
<td>Linking Primary Care, Schools, and Families to Enhance Child and Adolescent Health (5810983)</td>
<td>Cindy Carlson, Courtney Valentine, Elizabeth Minne, Jane Ripperger-Suhler, Celia Neavel, Jacqueline Caemmerer, Annie Hollerman</td>
<td>Portland, Oregon USA</td>
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<tr>
<td>A2c</td>
<td>(25 minutes)</td>
<td>Nurturing the Community as well as each student: Collaborative, Integrated Care in a School/Community Based Health Center (5808216)</td>
<td>Diana McIntosh, Francine Wolgin, Marilyn Crompton, MD</td>
<td>Portland, Oregon USA</td>
</tr>
<tr>
<td>B2a</td>
<td>(25 minutes)</td>
<td>An Interactive, Case-Based Introduction to Quality Improvement Within Integrated Health Care Settings (5810983)</td>
<td>Joe Grasso, Andrew Pomereza</td>
<td>Portland, Oregon USA</td>
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<td>B2b</td>
<td>(25 minutes)</td>
<td>Envisioning the Integration of Behavioral Health in Women's Care: From Funding to Implementation (5753038)</td>
<td>K.C. Lomornaco, Alison Lieberman, Kathryn Wizeman</td>
<td>Portland, Oregon USA</td>
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<tr>
<td>B2c</td>
<td>(25 minutes)</td>
<td>Expanding Integrated Care Across the Lifespan: Knowledge and Skills for Pediatric and Geriatric Practice (5801436)</td>
<td>Colleen Fischer, Christopher Sheldon, Alison Lieberman, Margaret Tomcho, Amy Sarosca, Jill Hersh</td>
<td>Portland, Oregon USA</td>
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<tr>
<td>C2a</td>
<td>(25 minutes)</td>
<td>A Model of Integrated Behavioral Health in a Pediatric Primary Care Setting (5810955)</td>
<td>Carolyn Adams, Kathleen Armstrong, Carol Lilly, MD</td>
<td>Portland, Oregon USA</td>
</tr>
<tr>
<td>C2b</td>
<td>(25 minutes)</td>
<td>An Environmental Scan of Behavioral Health Integration in Oregon (5805870)</td>
<td>Jennifer Hall, Deborah Cohen, Jason Kroening-Roche</td>
<td>Portland, Oregon USA</td>
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<tr>
<td>C2c</td>
<td>(25 minutes)</td>
<td>Coaches at the Helm: Coaching Programs at the Heart of Integrated Care</td>
<td>Jackie Williams, Monica Parikh</td>
<td>Portland, Oregon USA</td>
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<tr>
<td>D2a</td>
<td>(40 minutes)</td>
<td>Financing Behavioral Health Integration: The State of Oregon (5805792)</td>
<td>Jason Kroening-Roche, Deborah Cohen, Jennifer Hall, Ruth Rowland, David Cameron</td>
<td>Portland, Oregon USA</td>
</tr>
<tr>
<td>D2b</td>
<td>(40 minutes)</td>
<td>An Introvert's Guide to Collaboration and Leadership: A Pecha Kucha Experience</td>
<td>Randall Reitz, Polly Kurtz, Kaithin Luckie, Stephen Mitchell, Paul Simmons, Cindy Wilbur, Jackie Williams-Stade</td>
<td>Portland, Oregon USA</td>
</tr>
<tr>
<td>F2a</td>
<td>(40 minutes)</td>
<td>More than Enough Work to go Around: Adding a Health Coaching Program into an Integrated Primary Care Clinic (5773861)</td>
<td>Shandra M. Brown Levey, Corey Lyon, Lacey Clement, Kalle Ross, Kevin S. Masters</td>
<td>Portland, Oregon USA</td>
</tr>
<tr>
<td>F2b</td>
<td>(40 minutes)</td>
<td>Degree of Integration of Behavioral Health: Does It Impact Patient Outcomes? (5809000)</td>
<td>Rachel Vakley, Jenny Burt, Blake Lancaster, Tawnya Meadows, Shelley Hosterman, Monica Parikh</td>
<td>Portland, Oregon USA</td>
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<td>G2</td>
<td>(90 minutes)</td>
<td>Moving from Co-location to Integration: Collaboration between a Health Plan (Managed Care Organization) and a Federally Qualified Health Plan (FQHC)</td>
<td>David Johnson, Sean Benedict</td>
<td>Portland, Oregon USA</td>
</tr>
</tbody>
</table>

CFHA reserves the right to make adjustments to this agenda based on the best interests of the association and the Conference.
CONCURRENT EDUCATION SESSIONS
Period 2: Friday, October 16, 2015 – 1:30 PM to 3 PM

A2a  Friday, October 16, 2015 – Period 2 – 1:30 PM (25 minutes)

Headache and History Class Under One Roof: PATCH, the Pre-Adolescent to Teen Center for Health

Providing access to healthcare within the school system increases students’ health knowledge and access to health-related services, and can potentially reduce risk-taking behaviors and increase academic success. This presentation describes the formation of a collaborative partnership between the Pittsfield, NH Public School System and the family medicine residents and behavioral health clinicians of NH Dartmouth Family Medicine Residency in creating a school-based health clinic to meet the needs of students attending this middle high school, grades 7-12 (ages 11-18). This fruitful collaboration resulted in not only students getting easier access to behavioral health and medical healthcare and referrals, but also in family medicine residents learning about and gaining comfort with an at-risk adolescent population. This presentation will include an experiential activity on multidisciplinary collaboration and communication, as well as concrete steps to create such a unique and worthwhile partnership.

Presented by Suan Hemingway, LCMHC, Behavioral Health Clinician, Concord Hospital Family Health Center; Tobi Chaissie, District Administrator / Co-Project Manager, Building New Models for Systems Change, Pittsfield School District; Robert Kelly, MD, Family Medicine Resident, NH Dartmouth Family Medicine Residency

Primary Track: 2. Redesign of Health Care Services and Structures
Focus Area: A. Pediatrics
Content Level: Basic

Upon completion of this presentation, participants will be able to:
- Describe the compelling factors that support collaboration between health centers, and particularly residencies, and local school systems.
- Describe the opportunities and challenges in meeting students' behavioral health and medical health care concerns and needs in the school-setting.
- List specific steps to implement a collaborative partnership between a health center and local school in participants' home community.
Linking Primary Care, Schools, and Families to Enhance Child and Adolescent Health

Three initiatives that redesign traditional health care services and structures to improve the health outcomes of children and adolescents through unique partnerships between primary care, families, and schools are described, evidence of their effectiveness provided, and lessons learned discussed.

Presented by Cindy Carlson, PhD, Professor, Dept. of Educational Psychology, University of Texas at Austin; Courtney Valentine, PhD, Livingston County Children's Network; Jane Ripperger-Suhler, MD, Seton Hospital System, Seton Mind Institute; Jane Ripperger-Suhler, MD, Seton Hospital System, Seton Mind Institute; Jacqueline Caemmerer, MA, University of Texas at Austin

Primary Track: 2. Redesign of Health Care Services and Structures

Focus Area: F. Patient and Family Approaches to Care

Content Level: All audiences

Upon completion of this presentation, participants will be able to:

- Describe how medical providers and behavioral health specialists serving in child and adolescent-focused integrated primary care settings can advocate for their patients and empower families to advocate for improved school services for their children.
- Describe a rural community model for coordinating and integrating mental health services for children and families across sectors.
- Identify adolescent outcomes, evaluation measures, and program implementation challenges in a school-embedded clinic.
Nurturing the Community as well as each student: Collaborative, Integrated Care in a School/Community Based Health Center

A local federally qualified health center abruptly closed its doors to a community because of management and financial issues, creating a barrier to accessing healthcare for members of the community. This became an opportunity for academia and the community to partner and expand a school based health center to a school/community based health center that offers integrated healthcare. The vision is to improve health outcomes, facilitate prevention and health promotion, and serve as an interdisciplinary clinical training site for advanced practice psychiatric mental health nursing students, family medicine residents and child/adolescent psychiatry fellows to practice integrated physical and mental health care while caring for the underserved population. This presentation will discuss the planning, implementation to date, successes, challenges, and outcomes of this initiative.

Presented by Diana McIntosh, PhD., APRN, PMHCNS-BC Associate Professor College of Nursing University of Cincinnati; Francine Wolgin, CPC, MSN Senior Project Officer, Protecting the Healthcare Safety Net Interact For Health; Marilyn Crumpton, MD, MPH Medical Director Division of School & Adolescent Health Cincinnati Health Department

Primary Track: 2. Redesign of Health Care Services and Structures
Focus Area: D. The Role & Impact of Physical Health/Mental Providers on Integrated Care Practice
Content Level: Basic

Upon completion of this presentation, participants will be able to:

- Describe an initiative that redesigned a health structure and resulted in an integrated physical and mental health care in a school/community based health center.
- Discuss the challenges and successes with planning and implementing an academic/community partnership that engages the community in planning for the health center that serves as an interdisciplinary practice training site.
- Examine outcomes, including health outcomes, satisfaction and redesigned model.
An Interactive, Case-Based Introduction to Quality Improvement Within Integrated Health Care Settings

Quality improvement (QI) processes can yield key benefits for patients, providers, and health care systems and is especially important for assessing and optimizing outcomes in new models of integrated care. However, many integrated care clinicians and administrators have not received formal training in QI methods, and questions about how QI differs from traditional research continue to persist. This introductory presentation is designed for attendees who want a clearer, more practical understanding of 1) what QI is, 2) how QI differs from research, 3) how QI could be applied to their health care setting, and 2) what tools and processes are important for conducting a QI project. Interactive exercises will encourage attendees to apply QI concepts to real-life problems, and case-based examples will illustrate how QI can lead to exciting innovations for integrated and collaborative care settings.

Presented by Joe Grasso, PhD, Psychology VA Quality Scholar Postdoctoral Fellow, San Francisco VA Medical Center; Andrew Pomerantz, MD, Psychiatry National Mental Health Director for Integrated Care, Veterans Administration Associate Professor, Dartmouth Medical School

Primary Track: 6. Training in Research and Evaluation

Focus Area: B. Primary Care Behavioral Health Model of Service Delivery

Content Level: Basic

Upon completion of this presentation, participants will be able to:
- Describe what quality improvement is, how it differs from research, and what tools are especially integral to QI processes.
- Discuss practical knowledge about how quality improvement processes (specifically the plan-do-study-act model of QI) can apply to problems affecting integrated care settings.
- Develop an aim/purpose statement and a basic, step-by-step plan for QI project development and facilitation within their own integrated care setting or health care system.
C2a Friday, October 16, 2015 – Period 2 – 1:30 PM (25 minutes)

**A Model of Integrated Behavioral Health in a Pediatric Primary Care Setting**

A model of integrated health in a pediatric primary care setting utilizing doctoral level school psychologists alongside pediatricians to address the behavioral health concerns of youth will be discussed. Data collected regarding services provided, practitioner satisfaction utilizing this model, and families’ experiences receiving behavioral health care will be shared. Presenters will highlight success experienced over the past three years of implementation, as well as challenges to overcome.

*Presented by Carolyn Adams, PhD, School Psychologist/Director of HOT DOCS Parent Behavioral Intervention Program, University of South Florida, College of Medicine, Department of Pediatrics; Kathleen Armstrong, PhD, Director, Pediatric Psychology Program, University of South Florida, College of Medicine, Department of Pediatrics; Carol Lilly, MD, MPH, Division Chief, College Of Medicine Pediatrics, University of South Florida, College of Medicine, Department of Pediatrics*

**Primary Track:** 2. Redesign of Health Care Services and Structures

**Focus Area:** B. Primary Care Behavioral Health Model of Service Delivery

**Content Level:** All audiences

Upon completion of this presentation, participants will be able to:
- Explain the rationale for integrating behavioral health care and pediatric health care.
- Discuss advantages and challenges related to integrating behavioral health care in pediatric primary care.
- Describe the advantages for integrating psychologists with knowledge of the educational setting into pediatric primary care settings.

C2b Friday, October 16, 2015 – Period 2 – 2:00 PM (25 minutes)

**Envisioning the Integration of Behavioral Health in Women’s Care: From Funding to Implementation**

This education session will look at the process of a newly integrated Women’s Care Clinic serving an urban, underserved, under/uninsured population in a safety net hospital. It will also investigate and discuss the rationale behind why women’s care IS primary care. This presentation will reflect on the first year of integration, the reach of services, patients served, and the opportunities for future services and expansion to other sites within the larger health system.

*Presented by K.C. Lomonaco, PsyD, Clinical Psychologist, Denver Health Medical Center; Alison Lieberman, PsyD, Clinical Psychologist, Denver Health Medical Center*

**Primary Track:** 1. Focus on a Patient and Family Centered Approach to Care

**Focus Area:** B. Primary Care Behavioral Health Model of Service Delivery

**Content Level:** All audiences

Upon completion of this presentation, participants will be able to:
- Define the steps necessary for implementing IPC in women's care.
- Describe the role of IPC in women’s care clinics.
- Discuss why IPC is a perfect fit for women’s care clinics.
Expanding Integrated Care Across the Lifespan: Knowledge and Skills for Pediatric and Geriatric Practice

The behavioral health issues for children and elderly patients are complex and challenging for primary care providers and caregivers. These populations tend to have developmental changes, cognitive fluctuations, caregiver considerations, and more multifaceted social stressors. This presentation will describe a grant-supported initiative to efficiently provide integrated behavioral health for high-need, high-cost primary care clinics. The session will highlight the unique assessment and treatment techniques, as well as the clinic structure and flow, in these medical clinics.

Presented by Colleen Fischer, PhD, Psychologist, Denver Health Medical Center; Christopher Sheldon, PhD, Psychologist, Denver Health Medical Center; Alison Lieberman, PsyD, Psychologist, Denver Health Medical Center; Margaret Tomcho, MD, Attending Physician in Pediatrics, Denver Health Medical Center; Amy Starosta, MA, Doctoral Psychology Intern, Denver Health Medical Center; Jill Hersh, MA, Doctoral Psychology Intern, Denver Health Medical Center

Primary Track: 1. Focus on a Patient and Family Centered Approach to Care
Focus Area: B. Primary Care Behavioral Health Model of Service Delivery
Content Level: All audiences

Upon completion of this presentation, participants will be able to:
- Describe the way in which behavioral health can be integrated into pediatric and geriatric primary care.
- Identify specific evidence-based assessment and intervention strategies useful with these populations.
- Discuss some of the challenges and opportunities for growth with these specialized populations.

Financing Behavioral Health Integration: The State of Oregon

The benefits of behavioral health integration have been well studied and described in the literature. Despite this, sustainable financing models to support integration are lacking. This presentation will discuss how Coordinated Care Organizations (CCOs) across Oregon are tackling this issue. CCOs are Oregon's version of Accountable Care Organizations for the Medicaid population. We will discuss the structure of Oregon CCOs, the barriers they face to financing integration, as well as potential solutions at both the State and CCO levels to address these complexities. We will also discuss the role licensure and credentialing play in sustainable models.

Presented by Jason Kroening-Roche, MD MPH, 3rd Year Family Medicine Resident, Oregon Health Science University; Deborah Cohen, PhD, Associate Professor in the Department of Family Medicine, Oregon Health Science University; Jennifer Hall, MPH, Research Associate in the Department of Family Medicine, Oregon Health Science University; Ruth Rowland, MA, Research Associate in the Department of Family Medicine, Oregon Health Science University; David Cameron, Bachelors, Research Assistant in the Department of Family Medicine, Oregon Health Science University

Primary Track: 4. Financial Sustainability and Cost Control
Focus Area: E. Policy
Content Level: All audiences

Upon completion of this presentation, participants will be able to:
- Discuss how legacy organizational structures may affect behavioral health integration financing.
- List 3 financing barriers to integration commonly encountered by states and organizations.
- Identify 3 potential solutions to financing integration that address these identified barriers.
An Environmental Scan of Behavioral Health Integration in Oregon

Integration is a cornerstone of Oregon's vision for Coordinated Care Organizations (CCOs), an Accountable Care model for Medicaid beneficiaries. This is because evidence shows patient experiences and outcomes improve and costs are contained when behavioral and medical issues are addressed together. In this presentation we describe how CCOs are integrating primary care and behavioral health within the current fragmented health system. We share the varied approaches to integration observed across the state and the contextual factors that impacted their efforts.

Presented by Jennifer Hall, MPH, Research Associate, Department of Family Medicine, Oregon Health & Science University; Deborah Cohen, PhD, Associate Professor, Departments of Family Medicine and Medical Informatics and Clinical Epidemiology, Oregon Health & Science University; Jason Kroening-Roche, MD, Resident, Department of Family Medicine, Oregon Health & Science University

Primary Track: 2. Redesign of Health Care Services and Structures

Focus Area: B. Primary Care Behavioral Health Model of Service Delivery

Content Level: All audiences

Upon completion of this presentation, participants will be able to:

- Describe common contracting and organizational approaches to integrating behavioral health and primary care.
- Identify common challenges to statewide implementation of integrated care.
- Identify and discuss opportunities for policies that would support behavioral health and primary care integration.

Family and Community Collaborative Care for Older Adults and Their Family Caregivers

As our country rapidly ages, the future of American healthcare depends in large part on how well we serve the needs of seniors in patient- and family-centered, evidence-based, cost-effective ways. In this workshop, we will present a family and community systems model for conceptualizing collaborative care for older adults and their family caregivers, as well as introduce 3 types of integrated geriatric care: psychotherapy for family caregivers, a primary care-based care transitions program, and a super-utilizer program for frail elderly patients. Specific knowledge and skills for competent geriatric care will be identified.

Presented by Barry J. Jacobs, PsyD, Director of Behavioral Sciences, Crozer-Keystone Family Medicine Residency Program; John Rolland, MD, MPH, Co-Executive Director, Chicago Center for Family Health University of Chicago; Lauren DeCaporale-Ryan, PhD Senior Instructor University of Rochester Medical Center; Janelle Jensen, MS, LMFTA Northwest Family Therapy, Seattle

Primary Track: 1. Focus on a Patient and Family Centered Approach to Care

Focus Area: F. Patient and Family Approaches to Care

Content Level: Basic

Upon completion of this presentation, participants will be able to:

- Describe a family and community systemic model for conceptualizing the medical, psychological and existential needs of older adults.
- Identify basic knowledge and skills for providing competent, interprofessional team-based care for older adults and their family caregivers.
- Define key components of integrated care for removing barriers to care and reducing hospital re-admissions and high healthcare utilization among seniors.
Engaging Important Stakeholders to Assess Gaps in Primary Care for Dementia: Considering the Forest as well as the Trees

Dementia is a significant public health concern, and though recent national policies (such as the Medicare Annual Wellness Visit and the National Plan to Address Alzheimer's Disease) are drawing attention to the need for effective and efficient clinical pathways to diagnose and treat dementia, rates of detection of dementia in primary care (PC) remain low. Failure to adequately address dementia in PC can result in poor outcomes such as higher health care utilization and decreased quality of life for patients and families. PC systems transformation and innovation, such as those being implemented in the Veterans Health Administration (VHA), are needed in order to provide high quality, whole-person care for patients with dementia and their families. In order to understand this implementation environment, focus groups and individual interviews were conducted with key stakeholders who work within and use the VHA health care system at two sites. This presentation will employ interactive exercises to engage participants in developing strategies to identify and collaborate with their important stakeholders in quality improvement; presenters will also discuss themes addressing barriers and facilitators to high quality dementia care identified through qualitative content analysis and discuss how PC quality for patients with dementia can be improved through stakeholder engagement.

Presented by Christina L. Vair, PhD, Clinical Research Psychologist VA VISN 2 Center for Integrated Healthcare; Laura O. Wray, PhD, Interim Executive Director and Associate Director for the Education and Clinical Core, VA VISN 2 Center for Integrated Healthcare Assistant Professor of Clinical Medicine, Division of Geriatrics/Gerontology, Department of Medicine, Sc; Gregory P. Beehler, PhD, MA Research Psychologist, VA VISN 2 Center for Integrated Healthcare Research Assistant Professor, Department of Community Health and Health Behavior Adjunct Assistant Professor, School of Nursing Adjunct Assistant Professor, Coun; John Riley McCarten, MD Medical Director, Geriatrics Research Education and Clinical Center, Minneapolis Veterans Affairs Medical Center

Primary Track: 2. Redesign of Health Care Services and Structures

Focus Area: B. Primary Care Behavioral Health Model of Service Delivery

Content Level: All audiences

Upon completion of this presentation, participants will be able to:

- Identify important stakeholders within their local setting, including ways to conduct a stakeholder analysis and how to engage stakeholders in addressing program evaluation questions.
- Describe the VHA's interdisciplinary, team-based approach for whole-person care (Patient Aligned Care Teams and Primary Care-Mental Health Integration) and ways that these partnerships could be utilized in support of integrated care, system transformation.
- Discuss notable barriers and facilitators to the provision of high quality dementia care within primary care behavioral health models of service delivery and ways to improve quality of PC healthcare services for patients with dementia through engagement.
More than Enough Work to go Around: Adding a Health Coaching Program into an Integrated Primary Care Clinic

Every clinic is challenged to help patients who struggle to make needed behavioral health changes. Even in a level 3 PCMH with behavioral health integration, our reach was limited. In this presentation, we will describe the implementation and early findings related to a health coaching program which provides an extra layer of support to both patients and clinic staff. Understanding and addressing these complexities can help medical homes manage and treat patients in a more holistic manner.

Presented by Shandra M. Brown Levey, PhD, Director of Behavioral Health Integration, A.F. Williams Family Medicine Department of Family Medicine, University of Colorado School of Medicine; Corey Lyon, DO, FAAFP, Associate Program Director, Medical Director, A.F Williams Family Medicine University of Colorado School of Medicine; Lacey Clement, Doctoral Student, Clinical Health Psychology University of Colorado Denver; Kaile Ross, Doctoral Student, Clinical Health Psychology University of Colorado Denver; Kevin S. Masters, PhD Professor and Program Director Clinical Health Psychology Department of Psychology University of Colorado Denver

Primary Track: 3. Population and Public Health
Focus Area: B. Primary Care Behavioral Health Model of Service Delivery
Content Level: All audiences

Upon completion of this presentation, participants will be able to:

- Describe the complexities of integrating health coaches into an existing clinical team.
- Discuss the importance of a targeted intervention to assist patients who want to make health changes but lack the traditional support and resources to do so.
- Develop ideas for better integrating this form of support into other clinical settings.

Degree of Integration of Behavioral Health: Does It Impact Patient Outcomes?

The purpose of the study is to examine patient outcomes across different, naturally-occurring levels of behavioral health integration into primary care settings across three organizations. Data of pediatric behavioral health patients were gathered using chart review. Variables include demographics (patient age, gender, diagnosis, etc), clinically documented symptom severity, symptom improvement, adherence to treatment recommendations, and treatment completion data.

Presented by Rachel Valleley, PhD, Munroe-Meyer Institute; Jenny Burt, PhD \, Munroe-Meyer Institute; Blake Lancaster, PhD, CS Mott Children’s Hospital; Tawnya Meadows, PhD, Geisinger Health System; Shelley Hosterman, PhD, Geisinger Health System; Monika Parikh, PhD, Geisinger Health System

Primary Track: 3. Population and Public Health
Focus Area: B. Primary Care Behavioral Health Model of Service Delivery
Content Level: All audiences

Upon completion of this presentation, participants will be able to:

- Identify simple data collection procedures to measure patient outcomes.
- Compare patient outcomes based upon degree of integration.
- Discuss implications of degree of integration on patient outcomes.
An Introvert’s Guide to Collaboration and Leadership: A Pecha Kucha Experience

Is integrated care a discipline best suited for extroverts? Or, is there a place at the collaborative table for people who find highly social interaction taxing? Furthermore, are introverts vital contributors if integrated care is to thrive? Perhaps for the first time, these questions will be answered by 6 introverts who will share current science and personal narratives in the evocative Pecha Kucha format. Introverts unite!

Presented by Randall Reitz, PhD, LMFT Director of Behavioral Sciences St Mary’s Family Medicine Residency; Polly Kurtz, MBA, Executive Director, Collaborative Family Healthcare Association; Kaitlin Leckie, PhD, LMFT Director of Behavioral Health Education, Southern Colorado Family Medicine Residency; Stephen Mitchell, Mdiv, LPC Medical Family Therapy Fellow St Mary's Family Medicine Residency; Paul Simmons, MD, Faculty Physician, St Mary's Family Medicine Residency; Cindy Wilbur, RN, Clinical Operations Manager, St Mary’s Family Medicine Residency; Jackie Williams-Reade, PhD, LMFT Professor of Medical Family Therapy, Loma Linda University

Primary Track: 5. Workforce Education and Development
Focus Area: D. The Role & Impact of Physical Health/Mental Providers on Integrated Care Practice
Content Level: Basic

Upon completion of this presentation, participants will be able to:
- Identify unique strengths that introverts bring to leadership and collaboration.
- Practice self-care to sustain introverts across a career in leadership and collaboration.
- Share their own narratives of living in harmony with introversion in environments that value extroversion.

Moving from Co-location to Integration: Collaboration between a Health Plan (Managed Care Organization) and a Federal Qualified Health Plan (FQHC)

Building collaborative relationships between payers and provider organizations is essential to evolve models of care that changes business as usual and is sustainable. This presentation describes lessons learned from collaboration between a payer organization and an FQHC to implement an integrated program modeled after the evidence-based IMPACT program. Challenges and opportunities from both entities are described; preliminary outcome findings are reported, as well as strategies to evolve integrated models of care.

Presented by David Johnson, MSW, ACSW, Director of Health Services, Anthem; Sean Benedict, PhD, Clinical Supervisor, WellSpace

Primary Track: 2. Redesign of Health Care Services and Structures
Focus Area: B. Primary Care Behavioral Health Model of Service Delivery
Content Level: All audiences

Upon completion of this presentation, participants will be able to:
- Define three components in building collaboration between a payer and a provider.
- Identify two or more strategies to move from co-located to integrated health services.
- List three outcomes of collaborative integrated health program.
What's With All the Numbers?: Quality Indicators within Integrated Behavioral Health Programs

The presenters will provide an overview of the quality and clinical metrics utilized for the management and design of primary care behavioral health (PCBH) programs to meet the triple aim of Patient Centered Medical Homes (PCMH). Identification and review of PCBH dashboards, benchmarks, and clinical indicators that shape quality and performance assurance in primary care will be discussed. Additionally, the presenters will discuss specific challenges and barriers with regards to metrics that assist in the development and sustainability of PCBH programs.

Presented by Lesley Manson, PsyD, Director of Integrated Training Initiatives Arizona State University, Doctor of Behavioral Health; David Bauman, PsyD, Behavioral Health Faculty Central Washington Family Medicine Residency; Bridget Beachy, PsyD, Behavioral Health Faculty Central Washington Family Medicine Residency; Melissa Baker, PhD, Behavioral Health Consultant HealthPoint Community Health Center; Stacy Ogbeide, PsyD, MS, Behavioral Health Consultant Licensed Psychologist Healthcare for the Homeless Houston, Instructor, Department of Family and Community Medicine Baylor College of Medicine

Primary Track: 2. Redesign of Health Care Services and Structures

Focus Area: B. Primary Care Behavioral Health Model of Service Delivery

Content Level: All audiences

Upon completion of this presentation, participants will be able to:

- Identify clinical metrics and benchmarks for PCBH programs.
- Describe and discuss data mining options for collecting metrics to demonstrate quality improvement related to PCBH.
- Discuss unique barriers in collecting and assessing metrics for developing and sustaining PCBH programs.