PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

AIMS CENTER

UNIVERSITY of WASHINGTON

Psychiatry & Behavioral Sciences

Rural Mental Health Integration Initiative

REQUEST FOR APPLICATIONS (RFA)

Eligible organizations: Primary care clinics in rural Washington and Alaska
Funding available: Up to $245,000
Timeframe: July 2021 through September 2022
RFA Release date: January 11, 2021
Webinar for Potential Applicants: February 2, 2021 at 12:30 PM Pacific Time
Application due date: Sunday, March 28, 2021 (11:59 PM Pacific Time)
Award notification: May/June 2021
Activities start: July 2021

SECTION 1: OVERVIEW

1.A PURPOSE

Premera Blue Cross is committed to healthy communities by making health care work better. Rural communities and residents of those communities face significant social and health disparities as compared with urban and suburban residents. Rural residents are older,[1] poorer,[1] have lower educational attainment and income,[2] are more likely to be unemployed,[1,2] and are more likely to have experienced adverse childhood events (ACEs), including household mental illness.[3]

Rural residents face similar health disparities. They are more likely to have chronic health conditions, are less likely to receive healthcare of any kind, and are less likely to receive evidence-based treatments when they do access care.[4,5,6] Geographic maldistribution of mental health specialists from all disciplines and education levels (e.g., psychology, social work, psychiatry) creates significant access challenges.[7] Rural areas also experience primary care workforce shortages. Given primary care settings are where most rural mental health treatment occurs, this further exacerbates access barriers.[8,9]

Furthermore, COVID-19 continues to affect Americans' behavioral health. According to a recent survey conducted by the American Psychiatric Association, 37% of respondents said COVID-19 is seriously affecting their mental health, with 75% of the respondents saying they are somewhat or extremely anxious about it. Many respondents (48%) said COVID-19 is disrupting their daily life, with some endorsing worse sleep, difficulty concentrating, and increased substance use.[10] Primary care is likely to see many of these patients.

1.B INTEGRATED CARE

Integrating evidence-based mental health services into primary care settings is particularly important in rural areas where workforce shortages for both primary care and mental health are most acute. The most effective approaches apply the principles underlying effective management of chronic medical illnesses to depression, anxiety, and other behavioral health conditions commonly treated in primary care.[11,12-13] The core principles, which can be achieved in a variety of ways,[14] are:

<u>Population-Based Care</u>
Primary care practices routinely screen for mental health conditions that commonly occur in primary care (e.g., depression, anxiety). The care team (comprised of the primary care provider, a behavioral health care manager, and psychiatric consultant) shares a defined group of patients. The behavioral health care manager enrolls and tracks patients who screen positive in a registry designed to drive measurement-based treatment to target by proactively prompting treatment changes for patients who are not improving or are only partially improving after an adequate treatment trial, typically 10-12 weeks per treatment change. The psychiatric consultant (e.g., psychiatrist, psychiatric nurse practitioner, psychiatric physician's assistant) provides regularly scheduled caseload-focused consultation rather than ad-hoc advice.

<u>Patient-Centered Team Care</u>
Primary care and behavioral health providers collaborate together using a shared care plan that incorporates patient goals. Primary care providers (PCPs) remain the locus of care, prescribing medication if that is part of the treatment plan. The PCP is augmented by a behavioral health care manager, typically a social worker, counselor, or nurse. The behavioral health care manager performs

the initial assessment, completes the treatment plan with input from the PCP and psychiatric consultant, assists with differential diagnosis, routinely measures symptoms, proactively follows up with patients, prompts the treatment team to make a change in the treatment plan if patients are not adequately improved, and delivers evidence-based behavioral interventions and psychotherapy. In rural areas, where workforce shortages can make it difficult to recruit behavioral health providers and nurses, the behavioral health care manager role can be shared by a licensed provider (e.g., nurse, social worker) and non-licensed staff (e.g., medical assistant, community health worker). Non-licensed staff perform key behavioral health care manager functions that do not require a license, e.g., symptom measurement with PHQ-9 or GAD-7, proactive patient check-ins, entering information into the registry, assisting with pleasant events scheduling, and other interventions appropriate to their scope of practice.

Measurement-Based Treatment to Target

Each patient's treatment plan clearly articulates personal goals and clinical targets. The behavioral health care manager measures progress toward achieving these targets by routine use of evidence-based screening and assessment tools, like the PHQ-9 depression scale and GAD-7 anxiety scale. These tools are used in conjunction with clinical assessment and judgment of the treating providers. Symptom severity is measured at treatment initiation and at each subsequent contact, similar to taking blood pressure readings for patients being treated for hypertension, and this information is used to adjust treatment. Treatments are proactively changed if patients are not improving or only partial symptom improvement occurs.

Evidence-Based Care

Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. Treatment may include medications, psychotherapy and other behavioral interventions, or both. Evidence-based psychotherapies proven to work in primary care include Cognitive Behavioral Therapy, Behavioral Activation, and Problem-Solving Treatment.

Accountable Care

Clinics are accountable to their patients, providers, and the communities they serve. This accountability includes increasing access to services as well as the effectiveness of those services.

1.C COLLABORATIVE CARE

Clinics participating in the Rural Mental Health Integration Initiative will receive training and coaching support to implement Collaborative Care (CoCM).

CoCM is a specific type of integrated care developed at the University of Washington that treats common mental health conditions such as depression. Based on the principles of effective chronic illness care, outlined in Section 1.B, CoCM focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained primary care providers and behavioral health professionals provide evidence-based medication or psychosocial treatments supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.[15] Figure 1 on the following page illustrates the CoCM team structure.

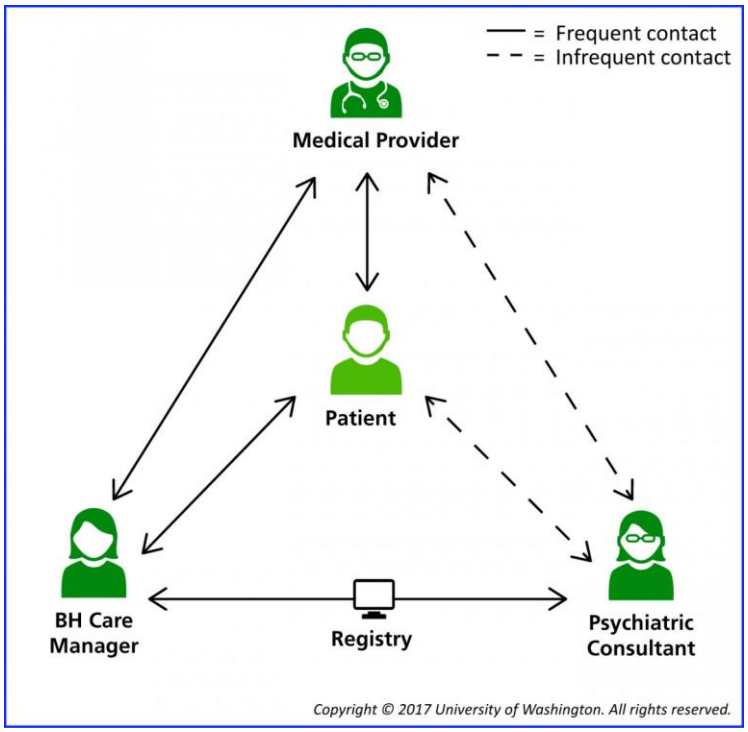

Figure 1: The CoCM team includes the patient, the medical provider (or PCP), the behavioral health care manager, and the psychiatric consultant. The BH care manager utilizes a registry to manage a caseload of patients and prioritize them for review with the psychiatric consultant.[16] Patients' treatment plans may include psychotropic medication prescribed by the PCP and/or evidence-based brief behavioral health interventions from the BH care manager, as appropriate.[17]

CoCM has been tested in more than 90 randomized controlled trials in the US and abroad. These studies make it clear that CoCM consistently improves on care as usual. It leads to better patient clinical outcomes, better patient and provider satisfaction, improved functioning, and reductions in health care costs, achieving the Quadruple Aim.[15] CoCM has also been proven to be effective when delivered via telehealth, either in part or wholly.[18]

SECTION 2: ELIGIBILITY REQUIREMENTS

Eligible organizations must be a primary care clinic or a healthcare organization with at least one primary care clinic located in a rural area of Washington or Alaska that provided primary care services to at least 1,500 unique patients age 18 or older in the most recent reporting year. This minimum patient count applies to each individual applicant clinic and refers to all patients treated in the clinic, regardless of whether they were/are treated for behavioral health issues or have a behavioral health diagnosis. This minimum patient population should **not** include patients who only utilize a clinic's specialty services without also being primary care patients.

See Appendix A for details regarding ineligible geographic areas. Clinics federally designated as rural health clinics (RHCs) are eligible to apply, regardless of zip code.

Applying organizations do **not** need to have patients served by Premera. Organizations that have worked with the AIMS Center in the past are also welcome to apply.

Healthcare organizations with more than one clinic location are eligible to apply for participation of more than one site if those sites are at least 20 miles apart and are both located in a rural area. **Organizations applying on behalf of multiple sites should submit separate applications for each site. Applications can repeat certain sections when they apply to all clinics (e.g., organization overview) but should otherwise reflect the characteristics, personnel, strengths/challenges, and workflows of each separate clinic.** Preference in issuing awards will be given to separate clinics/healthcare organizations. However, depending on the number of applications received, consideration will be given to applications from organizations with multiple sites.

Many primary care clinics have experience of some kind integrating behavioral health services in a variety of different ways. This can look like primary care providers independently providing care, sometimes supported by a clinic nurse, medical assistant, community health worker, or other support staff; co-located behavioral health services; or fully integrated, team-based care. **Regardless of current approaches to behavioral health delivery, including no current provision of any services, all clinics are welcome to apply**. All applicants should clearly articulate what their goals for participation will be in relation to their current level of integration. For clinics with an existing integrated care program, please describe how participation would strengthen and/or expand some aspect of the existing program (e.g., would participation support the clinic in serving more individuals or expanding existing services to another patient population?). Please also articulate how participation in this initiative will make a significant difference in services available in the clinic's community.

SECTION 3: TRAINING, IMPLEMENTATION SUPPORT, AND IMPACT EVALUATION

Premera is partnering with the University of Washington AIMS Center to provide training and practice support for clinics participating in this rural mental health integration initiative. The AIMS Center will lead clinic selection, training, technical assistance, and practice coaching for participating clinics. The AIMS Center has 15 years' experience supporting Collaborative Care (CoCM) implementation, including experience supporting rural and frontier primary care clinics in Texas, Montana, Washington, Alaska, and Wyoming.

Participating clinics will convene the follow teams:

Clinic Implementation Team (CIT)

- Each practice will identify a clinic implementation leader (required). This role is typically filled by a Clinic Manager, CEO, CMO, CNO, Behavioral Health Director, or similar. This person will convene a clinic implementation team (CIT).
- Each practice will identify a Primary Care Provider Champion (required) who will represent the clinic's primary care providers. This person will participate in the CIT, attend the in-person training, and champion practice changes with their peers.
- The CIT leader and PCP Champion are the only required members of the CIT, but clinics may compose a CIT with additional members that fits the unique needs of their setting. Potential other CIT members include clinic leadership, psychiatric consultant, care manager, finance, and/or quality team members.
- The CIT from each organization meets monthly with an AIMS Center implementation coach to tailor implementation of CoCM to their clinic, develop a sustainable financing strategy and processes, and develop/implement a comprehensive, evidence-based suicide prevention protocol. At minimum, CIT leaders and PCP champions are required to attend these calls.
- The CIT participates in the Pre-Launch Training and Virtual Learning Community (VLC) described below. At minimum, CIT leaders and PCP champions are required to attend these calls.

Clinical Team

The clinical team at each healthcare organization is comprised of the primary care providers, behavioral health care manager(s), and psychiatric consultant.

The University of Washington cannot provide psychiatric consultation services for participating clinics. In addition, psychiatric consultation services provided as part of CoCM cannot be ad-hoc. The AIMS Center can provide resources and guidance for clinics who need to identify a psychiatric consultant. Psychiatric nurse practitioners are eligible to serve as psychiatric consultants.

Training and implementation support for these teams will include:

Pre- and Post-Program Launch Reading and Online Didactic Training

Pre-launch reading assignments will come from *Integrated Care: Creating Effective Mental and Primary Health Care Teams*. Two copies of this book will be provided to participating clinics free of charge.

All online trainings utilize existing AIMS Center training content delivered through a Learning Management System (LMS) and/or the American Psychiatric Association (APA)'s online training

offerings. The purpose of this initial online training is to focus on knowledge transfer so the in-person training can focus on applying knowledge and skill development.

In addition to the required training outlined below, the AIMS Center will offer comprehensive suicide prevention training free of charge, dependent upon a provider's licensure/credentials and their prior completion of similar training.

- ***Primary Care Provider Champion:*** The PCP champion will complete approximately five hours of combined reading and online training prior to program launch. Core content focuses on the importance of the PCP role and key components of CoCM. Additional content will focus on workflow development and implementation. The PCP Champion will also complete three hours of suicide prevention training, if similar training has not already been completed.

- ***Other Primary Care Providers Participating in CoCM:*** These providers will complete approximately five hours of combined reading and online training prior to program launch. Core content focuses on the importance of the PCP role and key components of CoCM.

- ***Behavioral Health Care Manager(s):*** BH care managers will complete approximately 10 hours of combined reading and online training prior to program launch. Core content focuses on key activities associated with the behavioral health care manager role and training in evidence-based behavioral interventions appropriate for primary care (e.g., Behavioral Activation skills).

- ***Psychiatric Consultant:*** Psychiatric consultants will participate in approximately five hours of combined reading and online training through the American Psychiatric Association prior to program launch, with an additional two hours of APA online training post program launch. The APA training will be required unless the clinician serving in this role has already completed it or attended an in-person workshop hosted by the APA. Core content focuses on the consultant role, especially regular caseload consultation with the behavioral health care manager.

- ***Clinic Leadership and Staff:*** CIT Leaders will complete approximately two hours of combined reading and online training prior to program launch. Core content will include an overview of CoCM principles and key components as well as the caseload registry, workflow development, and implementation. CIT Leaders and other staff are welcome to participate in any of the aforementioned training as desired.

<u>Live Skills Training</u>

The AIMS Center will provide a series of live skills training sessions, either virtually or in Seattle. This training will build upon the online training and will emphasize adapting and applying the principles to each clinic's local context. Clinicians will also practice skills relevant to integrated behavioral health. The training will include caseload management using a registry.

Live skills training attendees must include the Clinic Implementation Leader, PCP Champion, all behavioral health care managers, and the psychiatric consultant. Other staff are welcome to attend the live skills training upon mutual agreement of the clinic and AIMS Center.

Virtual Learning Communities (VLC):

- ***Clinic Implementation Teams (CIT):*** Project ECHO serves as the model for these videoconference-based virtual learning communities. The CIT leader and PCP champion from each clinic participate. The PCP Champion will represent all PCPs in the clinic and will be responsible for bringing content back to other PCPs in their clinic via in-service or similar venues, according to the culture of each clinic. Video conferences will occur monthly. During the planning and pre-training phase, topics will include creating a program vision, preparing workflows, identifying staff to fill roles or hiring new staff, developing a financing plan, etc. After launch, the conferences will focus on quality metrics and problem-solving implementation challenges. Participants learn from each other as they continue to make adaptations to maintain core components of CoCM and hit quality targets. This is in addition to the monthly organization-specific meetings each CIT participates in with an AIMS Center coach (described on page 4 under CIT description).

- ***Behavioral Health Care Managers:*** Prior to program launch, training for behavioral health care managers focuses on knowledge and skills necessary to fulfill their role immediately following the in-person training. Thereafter, behavioral health care managers will participate in a monthly VLC designed to expand and hone their skills. This training will focus on specific behavioral health topics, including relapse prevention, working with patients with challenging or complex conditions, and using a registry to drive clinical decisions with the care team.

- ***Psychiatric Consultants:*** Training for psychiatric consultants focuses on how their role differs from traditional consultative models, including best practices for the weekly caseload review. An experienced psychiatric consultant from the AIMS Center will join a caseload review between the psychiatric consultant and care manager(s) within about 10 weeks of the in-person training. This expert will give verbal feedback at the end of the review as well as a written summary for the psychiatric consultant and CIT. Over the following 11 months, this caseload review consultation with an AIMS Center expert will occur once or twice more. In addition, psychiatric consultants from all participating clinics will meet together for a one-hour conference call with an experienced psychiatric consultant from the AIMS Center every two months. These calls will focus on the consultant role, monitoring quality measures, and strategies the psychiatric consultant can use to reinforce the training topics covered with the behavioral health care managers.

Onsite Technical Assistance
When needed and as appropriate given public health guidelines, AIMS Center CoCM experts will provide onsite coaching and assistance to diagnose implementation challenges and develop strategies for overcoming them.

Caseload Tracker/Registry
The AIMS Center will provide a simple caseload tracker to each participating clinic. The care team uses this simple yet powerful registry tool in conjunction with the electronic health record to drive measurement-based treatment to target. It tracks all patients engaged in treatment, identifies patients not improving as expected or ready for discharge from active treatment, and prompts providers to act upon this information.

Use of the caseload tracker is required unless the clinic is already using the Mental Health Integrated Tracking System (MHITS) through the Washington State Mental Health Integration Program (MHIP) OR another version of the Care Management Tracking System (CMTS). You will be required to sign a software use agreement for this registry tool, and this agreement cannot be modified.

Impact Evaluation

The AIMS Center will conduct an impact evaluation for this initiative. The Clinic Implementation Team leader will complete surveys prior to the planning phase and after implementation about the clinic's experiences with practice change. Clinical staff (primary care providers, behavioral health providers, and psychiatric consultants) will also complete surveys about their experience implementing CoCM.

Clinics will also be asked to submit a one-time report of diagnosis code data extracted from their electronic health records. This data will help illustrate the prevalence of different behavioral health conditions at each clinic; no identifying information about individual patients will be requested.

SECTION 4: AWARD INFORMATION

4.A. Amount

Clinics are eligible to receive up to $245,000 for participation in this initiative. The award will be made in two payments directly from Premera. The first payment will be $160,000, and the second payment will be $85,000. Receipt of the second payment will be contingent upon meeting participation requirements.

4.B. Award Notification

The AIMS Center will notify clinics about the outcome of the application process by **early June 2021**. If a healthcare organization applied for participation of more than one clinic site, it is possible some but not all sites will be selected to receive funding.

4.C. Award Start

Grants will be awarded in **June or July 2021** and work with the AIMS Center will start in **July 2021**. Each organization's participation in the initiative will last 15 months.

4.D. Allowable Use of Funds

Funding is intended to offset the cost of clinic staff time to participate in planning, training, and coaching activities described in Section 3. Clinics may use funds to pay "locum" providers to cover for providers to participate in these activities, so long as these providers treat patients in the same manner (i.e., the clinic will bill the patient and their payer in the exact same way as they would if the provider who is participating in this initiative was seeing the patient).

Funds are also intended to pay for clinic staff to travel to Seattle to participate in the live skills training, in the event that the training is held in-person.

Grant funds MAY NOT be used for

- Clinical care delivery (i.e., clinics must bill patients and payers for services rendered as they normally would)
- Hiring new staff (with the exception of locum providers to cover clinical responsibilities for providers participating in training)
- Medications, lab tests, imaging, or similar costs related to clinical care delivery
- Technology infrastructure (EHR costs, computers, etc.)
- Fundraising
- Facility acquisition or renovation
- Deficit reduction or debt payment
- Lobbying activities
- Displacement of existing funding sources

Neither the AIMS Center nor Premera will require any budgets or financial reporting from participating clinics over the course of the initiative. However, participating clinics should keep records that would support their correct use of the funds in the event of an audit from Premera.

SECTION 5: APPLICATION PROCESS

5.A. Web Address for Information, including application materials

https://aims.uw.edu/premera-rural-mental-health-initiative
If you have questions about completing the application, please email ruralmh@uw.edu.

5.B. Applicant Webinar

The AIMS Center will host a webinar for potential applicants on **February 2, 2021 at 12:30 PM Pacific**. Connection information is provided below. This webinar will summarize this opportunity and applicant questions received to date as well as offer the opportunity for live questions.

Join Zoom Meeting
https://uw-phi.zoom.us/j/526912592?pwd=TTJtYmFiTmNPOS9PQzZYK3FEK3hNQT09
Dial by your location
+1 669 900 6833 US (San Jose)
Meeting ID: 526 912 592
Passcode: 1959

5.C. Application Submission

Applications must be received by the due date and time below. The AIMS Center will not consider late submissions.
Due Date/Time: **Sunday, March 28, 2021 11:59pm Pacific**
Submit applications by email to: ruralmh@uw.edu

5.D. Written Application Review

Two CoCM experts from the AIMS Center will review and score written applications. Finalists will be invited to participate in a selection site visit (see below). Applicants not selected for a site visit will receive feedback about their application. Applicants will receive a determination about the outcome of the written application review in **April 2021**.

5.E. Selection Site Visits

At least one member of the AIMS Center will travel to the finalist clinics; **if circumstances require it, site visits will be conducted virtually instead of in-person**. A representative from Premera may participate in some site visits. The purpose of this visit will be to address questions that arose from review of the written application and to give applicants the opportunity to expand on their written application, if necessary. Applicants will receive an agenda for the visit and questions to address at least one week prior to the visit to ensure they have time to prepare their answers. If questions arise during the selection site visit that cannot be answered at the time of the visit, clinics will be given one week to submit a brief written response to ruralmh@uw.edu. If a healthcare organization applied for more than one clinical site, it is possible some sites but not others will be selected to participate in a selection site visit. **Selection site visits will occur within May and June 2021**. Key members of clinic leadership (e.g., CMO, clinic manager) and clinical providers already on staff (e.g., primary care provider champion, BH care manager if hired) must be available to participate in the visit.

SECTION 6. APPLICATION

6.A Application Format

Applications must be submitted in pdf format. Font must be Calibri point 11. Tables may use Calibri point 10. Margins must be 1 inch. Header must include clinic name. The application narrative is limited to five (5) single-spaced pages and a required one-page appendix. **We will not consider any materials beyond the required components and five (5)-page narrative application.**

6.B Application Components

- Cover Page
    - This must be completed, signed, and dated by an authorized representative as well as key stakeholders.
- Behavioral Health – Primary Care Integration Assessment
- Clinic Implementation Team (CIT) Appendix
    - Applicants will submit a one-page appendix describing the leadership, providers, and other staff members who will comprise the CIT. This description will include these individuals' roles within the CIT, their credentials, length of tenure at the organization, and any other information that will illustrate your plan for the CIT.
- Application Narrative
    - The narrative should be clear, concise and address each of the items below. Applicants will provide the narrative and all required attachments as a combined pdf: 1) Cover Sheet, 2) Application Narrative, 3) Integrated Care Assessment, 4) CIT Appendix

6.C Application Narrative Components

1) Organization overview: Applicant should describe their organization, including a brief history, mission, organizational and governance structure, payer mix, and the number of unique adult (18+) patients served in primary care in the last reporting year.

2) Goals: Applicant should describe their interest in this integrated care initiative and what they hope to achieve through participation.

3) Organizational strengths, challenges: Applicant should describe organization strengths and anticipated challenges associated with integrating behavioral health services into primary care according to the principles described in Section 1.B. When describing challenges, applicants should describe potential solutions or mitigating factors and/or why previous attempts at overcoming challenges have not succeeded.

4) Screening for behavioral health conditions: Applicant should describe current screening practices for common behavioral health conditions including depression, anxiety, and substance use. Applicants must report the proportion of the clinic population screened for each condition as well as the source and timeframe for that data, or clearly address why such information is unavailable.

5) Current behavioral health services: Applicant should describe current behavioral health services, if applicable. Please describe: a) the physical location of these services in relation to primary care service area, b) the types of psychotherapy available and number of providers trained to deliver each, and c) the range of behavioral health services provided. Applicants should base these descriptions on services offered in the clinic applying to participate, rather than the health care organization as a whole.

6) Staffing: All information below should refer to the applicant clinic rather than the healthcare organization as a whole.
    - Applicant should describe total FTE primary care providers, total FTE behavioral health staff, and total FTE leadership.
    - Please provide information about the length of tenure of personnel in key organizational leadership roles (e.g., CEO, CMO, CNO, Behavioral Health Director).
    - Please provide the FTE of primary care providers who are non-permanent (e.g., locum tenens).
    - Applicants should describe in detail how they plan to fill the behavioral health care manager and psychiatric consultant roles. Specifically, will applicant redeploy existing staff or hire new staff? If the former, how will existing responsibilities be managed? If the latter, applicant should describe available workforce in their area, whether the psychiatric consultant will work onsite or remotely, and prior experience recruiting behavioral health workforce if applicable. Applicants should describe their previous experience recruiting behavioral health providers, if any.
    - Applicant should describe their planned approach to the behavioral health care manager role. For example, will only licensed behavioral health staff serve in this role, or do applicants intend to share care management duties with non-licensed staff? If the latter, please describe the type of non-licensed staff to be used, whether staff will be hired or redeployed and, if redeployed, how existing responsibilities will be managed.

7) Implementation leadership plan: Applicant should describe their plan for designating an implementation leader and that person's experience with prior quality improvement initiatives.

8) Financing: Applicant should describe their current financing strategies for behavioral health services, if applicable, and current or anticipated challenges associated with financing. Applicants using CMS (Centers for Medicare and Medicaid Services) Psychiatric Collaborative Care (CoCM) billing codes should describe how they are using the codes.

9) Applicants should describe their plan to sustain the Collaborative Care program after completing participation in the initiative.

6.D Required CIT Appendix

Applicants must submit a one-page appendix describing the leadership, providers, and other staff members who will comprise the Clinic Implementation Team (CIT). This description should include these

individuals' roles within the CIT, their credentials, length of tenure at the organization, and any other information that will illustrate your plan for the CIT. See section 6.A for formatting specifications. **Any materials beyond this one-page appendix will not be considered during the application review.**

REFERENCES

1. American Community Survey: 2015. United States Census. http://www.census.gov
2. United States Department of Agriculture Economic Research Service. State data website. https://data.ers.usda.gov/reports.aspx?ID=17854.
3. Crouch E, Radcliff E, Probst JC, Bennett KJ, McKinney SH. Rural-Urban Difference in Adverse Childhood Experiences Across a National Sample of Children. 2019; J Rural Health, Apr 2. doi: 10.1111/jrh.12366.
4. Preventing Chronic Diseases and Promoting Health in Rural Communities. National Center for Chronic Disease Prevention and Health Promotion. Centers for Disease Control and Prevention. https://www.cdc.gov/chronicdisease/pdf/factsheets/Rural-Health-Overview-H.pdf
5. Matthews KA, Croft JB, Liu Y, et al. Health-related behaviors by urban-rural county classification - United States, 2013. MMWR Surveill Summ. 2017;66(5):1-8
6. Moy E, Garcia M, Bastian B, et al. Leading causes of death in nonmetropolitan and metropolitan areas—United States, 1999-2014. MMWR Surveill Summ. 2017;66:1-8
7. Ellis AR, Konrad TR, Thomas KC, Morrissey JP. County-level estimates of mental health professional supply in the United States. Psychiatr Serv. 2009;60(10):1315-1322. doi:10.1176/ps.2009.60.10.1315
8. Douthit N, Kiv S, Dwolatzky T, et al. Exposing some important barriers to health care access in the rural USA. Public Health. 2015;129(6):611-620.
9. National Quality Forum. Performance Measurement for Rural Low-Volume Providers. Washington, DC: National Quality Forum; 2015. http://www.qualityforum.org/ Publications/2015/09/Rural_Health_Final_Report.aspx.
10. American Psychiatric Association. New APA Poll Shows Surge in Anxiety Among Americans Top Causes Are Safety, COVID-19, Health, Gun Violence, and the Upcoming Election. American Psychiatric Association. October 2020. https://www.psychiatry.org/newsroom/news-releases/anxiety-poll-2020
11. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane database of systematic reviews (Online). 2012;10:CD006525. doi:10.1002/14651858.CD006525.pub2
12. Thota AB, Sipe TA, Byard GJ, et al. Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis. *American Journal of Preventive Medicine*. 2012;42(5):525-538. doi:10.1016/j.amepre.2012.01.019
13. Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. *The British Journal of Psychiatry* 2006;189:484-493. doi:10.1192/bjp.bp.106.023655
14. Advancing the Integration of Behavioral Health in Primary Care. Institute for Clinical Systems Improvement. May 2019. https://www.icsi.org/wp-content/uploads/2019/05/IBH-Call-to-Action-1.pdf
15. Collaborative Care. University of Washington AIMS Center. http://aims.uw.edu/collaborative-care
16. Collaborative Care: Team Structure. University of Washington AIMS Center. http://aims.uw.edu/collaborative-care/team-structure

17. Collaborative Care: Principles of Collaborative Care. University of Washington AIMS Center. https://aims.uw.edu/collaborative-care/principles-collaborative-care
18. Fortney JC, Pyne JM, Mouden SB, et al. Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial. American Journal of Psychiatry. 2013;170(4):414-425. doi: 10.1176/appi.ajp.2012.12050696

Appendix A – *Ineligible* Zip Codes

To determine if your clinic is eligible to apply for this initiative, please locate the zip code for your clinical service delivery location, which may be different from your business office location. If you have multiple clinic locations, some may be eligible and others may not.

Washington zip codes continue onto a second page.

Clinics in the zip codes listed below are NOT eligible unless they are federally designated rural health clinics (RHCs).

Alaska

99501	99505	99509	99514	99518	99522	99530	99703	99708	99716
99502	99506	99510	99515	99519	99523	99599	99705	99709	
99503	99507	99511	99516	99520	99524	99695	99706	99710	
99504	99508	99513	99517	99521	99529	99701	99707	99711	

Washington

98001	98027	98055	98102	98126	98168	98225	98329	98378	98409
98002	98028	98056	98103	98127	98170	98226	98332	98383	98411
98003	98029	98057	98104	98129	98174	98227	98333	98384	98412
98004	98030	98058	98105	98131	98175	98228	98335	98385	98413
98005	98031	98059	98106	98133	98177	98229	98337	98386	98415
98006	98032	98061	98107	98134	98178	98233	98338	98387	98416
98007	98033	98062	98108	98136	98181	98235	98345	98388	98417
98008	98034	98063	98109	98138	98185	98248	98349	98390	98418
98009	98035	98064	98110	98139	98188	98272	98352	98391	98419
98010	98036	98071	98111	98141	98190	98273	98353	98392	98421
98011	98037	98072	98112	98144	98191	98274	98354	98393	98422
98012	98038	98073	98113	98145	98194	98275	98359	98394	98424
98014	98039	98074	98114	98146	98195	98296	98360	98395	98430
98015	98040	98075	98115	98148	98198	98310	98364	98396	98431
98019	98041	98077	98116	98154	98199	98311	98366	98401	98433
98020	98042	98082	98117	98155	98201	98312	98367	98402	98438
98021	98043	98083	98118	98158	98203	98314	98370	98403	98439
98022	98046	98087	98119	98160	98204	98315	98371	98404	98443
98023	98047	98089	98121	98161	98206	98321	98372	98405	98444
98024	98050	98092	98122	98164	98207	98322	98373	98406	98445
98025	98052	98093	98124	98165	98208	98323	98374	98407	98446
98026	98053	98101	98125	98166	98213	98327	98375	98408	98447

98448	98499	98513	98662	98687	98942	99202	99214	99258	99354
98464	98501	98516	98663	98801	99001	99203	99215	99301	99362
98465	98502	98540	98664	98802	99005	99204	99216	99302	99363
98466	98503	98556	98665	98807	99011	99205	99217	99323	99401
98467	98504	98599	98666	98850	99014	99206	99218	99324	99402
98471	98505	98604	98668	98901	99016	99207	99219	99330	99403
98481	98506	98607	98671	98902	99019	99208	99220	99336	
98490	98507	98622	98682	98903	99020	99209	99223	99337	
98493	98508	98626	98683	98904	99021	99210	99224	99338	
98496	98509	98632	98684	98907	99027	99211	99228	99348	
98497	98511	98660	98685	98908	99037	99212	99251	99352	
98498	98512	98661	98686	98909	99201	99213	99252	99353	