

Practices implementing the TEAM UP model focus on a series of priorities aimed at establishing a multidisciplinary integrated care team, developing clinical workflows and processes to enable delivery of integrated behavioral health care, and optimizing the operational environment to support successful uptake and sustainability. The table below outlines major commitments and expectations for participation in the initiative along with implementation activities that further operationalize what practices will be accountable for in each area.

Practice Commitments and Expectations	Summary of Implementation Activities
Executive leadership and organizational structure of the practice support the goals of fully integrated behavioral health (IBH) care that ensures equitable access for all children and adolescents receiving care within the practice	• A member of the executive leadership team is identified to serve as Executive Sponsor and participate in select TEAM UP activities to promote successful implementation and sustainability • Executive Sponsor attests to the organization's commitment to sustaining pediatric IBH as a standard of care and codifying IBH model within organizational chart and strategic plans
Clinical and administrative champions are empowered to lead transformational change within the practice	• Individuals in leadership positions are identified to serve as Clinical Champions from both the medical and behavioral health sides of the practice; individuals with demonstrated commitment to IBH are strongly advised, experience with public health, population health, and quality improvement is recommended • An individual with strong administrative skills is identified to serve as the practice's Project Manager (PM); experience with public health, population health, and quality improvement is recommended • Clinical Champions and PMs lead TEAM UP model implementation efforts within the practice and participate in activities as defined
All members of the integrated team have adequate physical space within primary care	• PCPs, BHCs, and CHWs sit together within primary care enabling full collaboration • Each role has space necessary within primary care to carry out core tasks within their scope
Primary care staffing is augmented in accordance with established staffing ratios for BHCs and CHWs	• 1 FTE BHC is hired for every 3,000 patients • 1 FTE CHW is hired for every 3,000 patients • Job descriptions for each role align with established TEAM UP role definitions
All members of the integrated care team, along with others as defined, participate in TEAM UP trainings	• PCPs, BHCs, and CHWs complete activities as defined in the TEAM UP Learning Community Syllabus • Additional roles, e.g., supervisors, etc. participate in activities as defined
EHR systems are modified to support IBH documentation and data collection for TEAM UP evaluation	• Methods to support data extraction and reporting are established in partnership with the TEAM UP Center • An individual(s) with skills in EHR development and data extraction is identified to serve as an IT/Data representative for the practice and partner with the TEAM UP Center on data collection, reporting, and EHR optimization • All necessary Institutional Review Board (IRB) documentation is completed • TEAM UP Behavioral Health (BH) Plan templates and screeners are built within the practice's EHR with attention to ensuring all data fields are extractable and each is integrated into the appropriate template(s) • EHR templates are optimized and/or developed for PCPs, BHCs, and CHWs such that all roles have access to the same patient data

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The revenue cycle and associated clinical and operational workflows are optimized to ensure sustainability of IBH	- An individual with experience in billing and revenue cycle management is identified to serve as a Billing representative for the practice and participate in activities as defined - Processes are developed to consistently monitor coding, billing, and denials with mechanisms for feedback to the IBH team - IBH schedules, productivity standards, and supervision structures are established and maintained within the practice
Patients and families are proactively engaged in the transformation process	Practices collaborate with the TEAM UP Center to identify opportunities to proactively engage patients and families as they implement components of the TEAM UP Model
Patients birth to 18 years old are screened universally at all well-child visits (WCVs) for social, developmental, and behavioral health concerns	- All patients birth-18 years receive annual screening for health-related social needs utilizing a screener selected by the practice - All patients birth-4 years receive screening at each WCV utilizing the Survey of Wellbeing of Young Children (SWYC) - All patients 5-18 years receive screening at each WCV utilizing the Pediatric Symptom Checklist (PSC) - Patients 12-18 years who screen positive on the internalizing subscale of the PSC receive supplemental screening with the Patient Health Questionnaire (PHQ-9)
Established workflows and communication pathways enable collaboration and handoff between members of the integrated team (PCPs, BHCs, CHWs)	- Workflows are established and documented for initiating a warm handoff from the PCP to both the BHC and CHW - Workflows are established and documented for initiating a cold handoff or referral from the PCP to both the BHC and CHW - Consistent processes for bi-directional communication between members of the integrated team are established and documented
Members of the integrated team (PCPs, BHCs, CHWs) deliver evidence-informed IBH care	- PCPs screen for social, developmental, behavioral health needs at WCV, collaborate on establishment of plan of care for identified issues, and prescribe and manage first line medications for common diagnoses, e.g., ADHD, depression, anxiety - BHCs provide an array of short-term, bridge, and ongoing services to engage, assess, and treat behavioral health issues with evidence-informed transdiagnostic interventions - CHWs provide care coordination and navigation services to engage, educate, and advocate for patients and families identified with social, developmental, and behavioral health concerns
Members of the integrated team (PCPs, BHCs, CHWs) document the plan of care for behavioral health concerns utilizing a standardized IBH template	PCPs, BHCs, and CHWs utilize role-focused TEAM UP BH Plans to document behavioral health assessments, actions taken to address concerns identified, and follow up plans of care as a standard part of all visits documentation in the EHR
Patients receive a universal touchpoint from the integrated team during the newborn period to promote strength-based parenting strategies and support engagement in care	A universal newborn touchpoint with a BHC and/or CHW is delivered to all families with an infant during the first two months of life
Population health strategies, including defined clinical pathways to care, are developed for special populations of focus determined by the practice (e.g., families at-risk during the perinatal period, early childhood developmental concerns, children and adolescents with common diagnoses including ASD, ADHD, depression, anxiety)	- Documented strategies, clinical pathways, and/or workflows are established for a minimum of two special populations of focus determined by the practice - Strategies, clinical pathways, and/or workflows will include at minimum: - An established process for closed loop tracking for common referrals to community and specialty services - A defined scope of work for each member of the integrated team that enhances the IBH services already available within primary care for the unique needs of the identified special populations of focus