Connecting Body and Mind: A Resource Guide to Integrated Health Care in Texas and the United States

Hogg Foundation for Mental Health

SERVICES, RESEARCH, POLICY & EDUCATION

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Hogg Foundation for Mental Health

The Hogg Foundation for Mental Health was founded in 1940 to promote improved mental health for the people of Texas. The foundation originally was funded through a bequest by Will C. Hogg, son of former Texas Governor James Stephen Hogg, and for many years was guided by his sister, Miss Ima Hogg.

Today the foundation provides grants to support mental health consumer services, research, policy analysis and public education projects in Texas. Current priority areas include integrating physical and behavioral health care, developing the state's mental health workforce, and promoting the use of evidence-based practices to deliver culturally and linguistically appropriate mental health services to the many populations of Texas.

The foundation operates programs to support its priority areas and to promote mental health education and awareness. The foundation also awards scholarships and fellowships to promote timely, innovative and beneficial advancements in mental health education and research in Texas.

The foundation is part of the Division of Diversity and Community Engagement at The University of Texas at Austin. For more information, visit www.hogg.utexas.edu.

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Executive summary

Background

There is a call across the country and in Texas to improve health care systems through integrated care. Integrated health care is the systematic coordination of physical and behavioral health services. The idea is that physical and behavioral health problems often occur at the same time and that integrating services will provide the best results and be the most acceptable to individuals receiving services.

However, the health, mental health and substance abuse treatment systems developed independently, are physically separate and typically are financed separately. Shifting to integrated care requires substantial changes to existing service systems and is a challenging endeavor.

This report summarizes various approaches to integration and what is known about their effectiveness. It also describes integrated health care programs in Texas and nationally and identifies resources to assist with developing and implementing integrated care systems.

Behavioral health problems in primary care settings

Most people seek help for mental health and substance abuse problems from their primary care physician. This is especially true for people of color. In fact, primary care providers have been shown to provide the majority of behavioral health treatment. In addition, primary care patients with chronic medical problems such as diabetes, heart disease and asthma have high rates of behavioral health disorders. When behavioral health problems go untreated in individuals with chronic illnesses, they have poorer outcomes, higher morbidity and higher medical costs.

People who are referred to specialty behavioral health providers frequently do not follow through. Lack of insurance, high co-pays, distance, lack of transportation and stigma are among the many reasons individuals fail to get help from specialty clinics. Many physicians report limited referral resources for behavioral health services in their communities. So if most individuals with mental health or substance abuse problems do not receive care from a specialist, what care do they receive?

In primary care, behavioral health problems frequently go undetected and untreated. When difficulties are recognized, individuals usually do not receive the quality of care recommended in practice guidelines. The primary care setting is designed to manage acute medical problems, and providers rarely have time for adequate assessment, patient education and collaboration with other providers.

Health problems in behavioral health settings

Individuals with behavioral health problems are at an increased risk for comorbid medical conditions. Chronic conditions such as diabetes, heart disease and high blood pressure are common. In fact, individuals with severe and persistent mental illness die 25 years earlier than individuals without these disorders.

Despite these comorbidities, people with mental illnesses are less likely to receive primary medical services

than those without, and have poorer quality of medical care when they do receive it. Most psychiatrists do not conduct physical examinations of their patients and fail to recognize more than half of the existing medical conditions. Evidence also suggests that behavioral health providers frequently fail to obtain and monitor vital signs and laboratory tests recommended for prescribed medications.

Inadequate training of behavioral health specialists, time demands on psychiatrists and inadequate space and equipment can all serve as barriers to the provision of integrated primary care within behavioral health settings.

Improving behavioral health treatment in primary care settings

Several approaches to improving care for individuals with behavioral health problems have been created. In the primary care setting, studies have addressed strategies to increase the recognition of behavioral health problems through standardized screening. Although these strategies can increase identification of common behavioral health problems, screening has not been found to improve the quality of care that patients receive.

Efforts to enhance the skills of primary care providers through training on behavioral health issues and the use of practice guidelines have produced little change in providers' behaviors. Programs that sought to increase primary care providers' referrals to specialty behavioral health clinicians also found little effect on patient outcomes, likely due in part to the low rates at which patients follow through on these referrals. It is likely that all of these strategies are necessary – but not sufficient – to improve the outcomes of individuals with behavioral health disorders.

Several models for integrating behavioral health treatment into primary care have been developed and tested across the country.

Several models for integrating behavioral health treatment into primary care have been developed and tested across the country. One strategy is to co-locate behavioral health specialists within the primary care setting. The co-location model can help make referrals easier, improve the likelihood that patients will follow through and increase communication between the primary care provider and behavioral health specialist. However, without an infrastructure that promotes collaboration and shared treatment, the effectiveness of co-location is limited.

The collaborative care approach borrows from the chronic care model developed for the management of conditions such as diabetes and asthma. Collaborative care incorporates a mental health care manager and psychiatrist into the primary care setting. The care manager, with supervision from a psychiatrist, is responsible for tracking patient progress with standard measures, providing follow-up to increase adherence and educating patients on tools for self-management. The primary care physician utilizes evidence-based algorithms to guide treatment. This model has been shown to improve behavioral health outcomes for a variety of patient populations and conditions.

In the primary care behavioral health model, the behavioral health specialist primarily serves as a consultant to the primary care provider. Much of the behavioral health specialist's work targets behavioral issues related to medical diagnoses, instead of traditional behavioral health problems like depression and anxiety. The primary care behavioral health model has been adopted by numerous organizations which have found it beneficial, but it has not yet been systematically evaluated.

Improving physical health treatment in behavioral health settings

Fewer approaches to improving medical care in behavioral health settings have been tested. Screening tools are available to assist behavioral health providers in detecting medical conditions and health risk indicators, but while important, these also are unlikely to lead to quality medical care. Having psychiatrists serve as primary care physicians, sometimes after formal dual training programs, has also been suggested. However, it is unclear if barriers, such as a lack of psychiatrists and limited training, can be overcome. A nurse also may be used to provide "enhanced referral," in which the nurse assists the individual in accessing medical care and facilitates communication between providers.

Less research has been conducted on models for integrating medical care into behavioral health settings. Models in which primary care providers are co-located within behavioral health clinics have shown to improve access to medical care, improve communication between providers, and reduce the use of emergency rooms and urgent care services.

Barriers to integrated care

Integrating different systems to provide coordinated care has proven to be a challenging task and a number of barriers have been identified. Clinical barriers to integration include insufficient training for providers, lack of provider interest in providing unfamiliar treatment, and a lack of access within communities to evidence-based behavioral health services.

Barriers within the organizational structure include the traditional acute care focus of primary care, insufficient provider time for taking on new duties, and the lack of infrastructure to facilitate communication and collaboration between providers.

Policy and law obstacles to integrating care stem from laws and regulations on how physical and behavioral health care organizations can provide services and share information.

Some of the most critical barriers are financial, such as the lack of reimbursement for components of evidence-based integrated care, including care management and psychiatric consultation. Overcoming these barriers is critical to creating a sustainable, effective integrated program.

Integration efforts in Texas

Integrated health care efforts are underway in Texas. To learn more about the extent of these efforts, the Hogg Foundation for Mental Health surveyed providers across the state. Responses reflected national trends. Much of the integrated health care efforts in Texas are focused on integrating behavioral health care into primary care settings. The major barriers Texas providers experience in trying to integrate care relate to paying for it.

Some innovative integrated programs in Texas are highlighted, including foundation initiatives and local collaborations between behavioral health and primary care providers.

National integrated care programs

Around the country, a number of programs have been developed that attempt to implement proven models of integrated care, adapt models to meet local system needs, and explore methods to finance integration. Integrated programs have been created at the national, state and local levels. Some programs focus on the real-world implementation of evidence-based models such as collaborative care, while others test innovative financing strategies. Examples are offered of the integration of primary care services in behavioral health settings, as well as the provision of behavioral health services in primary care. There is much to learn from the experience of these innovators in integrated health care.

Conclusions

There is no single way to integrate behavioral and primary care services, and different solutions are needed depending upon the unique characteristics of the health system. Nowhere is this truer than Texas, with its diverse geography, diverse cultural communities and varied models for financing health care. However, the lessons learned by the numerous research and evaluation efforts as well as the state and national implementation projects offer some keys for success.

In many ways, Texas is poised to take on the challenge of expanding access to integrated care. The reorganization of state agencies to integrate public health, mental health and substance abuse sets the stage for addressing some of the barriers to integrated treatment. But Texas also has significant challenges, including shortages of primary care and mental health providers, high rates of uninsured and low reimbursement rates for mental health services.

With the growing recognition of the need to implement integrated health care systems for individuals with comorbid behavioral health and physical health problems, Texas is poised to become a leader in this national movement. However, the barriers to integration are abundant. Success will require the collaborative efforts of state leaders, health insurers, employers, state agencies, primary care providers, behavioral health providers, advocacy groups, consumers and universities.

KEY POINTS

- Medically ill populations are at increased risk for behavioral health problems, just as individuals with behavioral health problems are at higher risk for medical comorbidities. Failing to treat medical or psychiatric comorbidities decreases an individual's chances for successful recovery and overall health.

- Screening for behavioral health problems in primary care or medical problems in behavioral health settings is crucial for detection of health concerns, but is not sufficient to improve the outcomes of individuals with comorbid conditions.

- Many primary care providers need training on identifying and treating behavioral health disorders, but this training is most effective when delivered through on-going communication and collaboration with behavioral health providers.

- Although several models for integrated care exist, the most effective models impact the treatment system in comprehensive, multi-faceted ways.

- The cost benefit of providing integrated care for depression, and probably other common mental health disorders, is similar to the benefit achieved in managing other chronic health conditions.

- Successful integration efforts require dynamic, committed leadership.

- A growing number of resources such as clinical and implementation manuals, screening and assessment tools, patient registries and training programs have been developed and will greatly improve a health or behavioral health care system's ability to achieve outcomes seen in research studies.

- Financial incentives are needed that support evidence-based, integrated models of care, rather than specialty referral and limited or no follow-up.

- Outcome or performance measurement systems that focus on the holistic health of consumers/patients will help encourage collaboration across primary care and behavioral health systems.

- Technology can be an important tool in facilitating integration, including identifying and screening patients, tracking patient progress, encouraging adherence to clinical protocols, facilitating communication between providers and evaluating the impact of integrated programs.

Introduction

In Texas and around the country, the move to integrate physical and behavioral health services is growing. Integrated health care has become a buzzword in the medical and behavioral health communities.

What is integrated health care? It has been defined in many ways, but in essence integrated health care is the systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served.

In some ways, the seeds of integration already have been planted. Primary care providers know that many of their patients have behavioral health problems like depression and anxiety. Behavioral health providers know that many of their clients have physical health problems such as diabetes and heart disease.

Although traditionally there has been a rigid division between these professions – physical health problems have been seen as the domain of primary care providers, and behavioral health problems as the domain of behavioral health providers – providers in both settings increasingly are seeing the need to address both types of problems to help their clients become healthy.

We know that physical health impacts behavioral health, and behavioral health impacts physical health. If treatment addresses only one side of the equation, the patient cannot expect to achieve health.

The question is not whether to integrate, but how. Neither primary care nor behavioral health providers are trained to address both issues. Systems that pay for these services typically are set up to pay for them separately. Shifting to integrated health care requires a fresh perspective, new skills and radical changes in service delivery.

Integrated health care is challenging. The good news is that we know a great deal about what works (and what does not) in adopting this model of care.

This publication outlines the full range of integrated health care approaches. It reviews the research evidence for these approaches. It provides descriptions of national programs doing integrated health care, as well as the current status of integration efforts in Texas. It outlines key resources for developing integrated programs.

The Hogg Foundation for Mental Health is providing the information presented here to help inform policymakers and advocates about opportunities to improve health care delivery, educate providers considering integrated health care, and empower behavioral health consumers and their family members in advocating for quality health care.

AN IMPORTANT NOTE ON LANGUAGE

One of the many ways in which the fields of primary care, mental health and substance abuse differ is in the language used to refer to people receiving services.

In the mental health and substance abuse fields, service recipients are often called “clients” or “consumers.”

In primary care, they are called “patients,” a term that has negative connotations in the mental health and substance abuse communities due to its association with a more traditional approach to behavioral health care.

For the purpose of this publication, we use the term “patient” when discussing primary care research and practice.

However, we recognize that the lack of a shared language is a barrier to integrating physical and behavioral health care. It is part of a larger barrier created by differences in the treatment philosophies of the physical and behavioral health care communities.

Why integrate physical and behavioral health care?

Over time the U.S. health, mental health and substance abuse treatment systems have developed independent of each other. They typically are operated separately, without regard for the reality that physical and behavioral health are linked.

Although many people will experience a combination of physical and behavioral health problems over their lifetime, the physical health care system is not set up to address behavioral health problems, and the mental health and substance abuse treatment systems are not set up to address medical problems. In fact, mental health and substance abuse treatment systems are often separated as well.

What is the impact of these divisions? The systems often fail to detect and adequately treat important aspects of people's overall health, at a significant cost to the individual, the systems themselves and society.

Common behavioral health problems in primary care

Most people seek help for behavioral health problems in primary care settings.[1,2] About half of the care for common psychiatric disorders like depression is provided in primary care settings instead of specialty behavioral health settings.[3,4] This holds true regardless of the severity of a person's psychiatric disorder.[5] Populations of color are even more likely to seek or receive care for psychiatric disorders in primary care rather than in specialty behavioral health settings.[6,7]

For adults, the psychiatric disorders most commonly seen in primary care are substance use disorders, depression, bipolar disorder and anxiety disorders.[8,9] For children and adolescents, anxiety disorders, bedwetting, disruptive behavior disorders and attention deficit-hyperactivity disorder are the most common.[10,11]

People tend to present with psychiatric disorders of mild to moderate severity in primary care settings. Since behavioral health problems are easier to treat when they are mild or moderate, this provides primary care providers with an opportunity for intervening early and preventing more chronic or severe disorders from occurring.

Behavioral health problems are common in the primary care population, but detection and treatment often are poor.

People with common medical disorders have particularly high rates of behavioral health problems.[12] Individuals with chronic diseases such as diabetes, heart disease and asthma are at increased risk for having comorbid psychiatric conditions like depression.[13,14,15,16,17,18]

When psychiatric disorders are not addressed in people with chronic medical illness, they have worse outcomes. Patients with chronic medical conditions who also have depression are less able to take care of their illnesses or follow prescribed treatment.[19] These patients feel and function worse than patients with the same medical illnesses who do not have depression.[20,21,22] They are more likely to die from their illnesses than those without depression.[23] These patients also have higher medical costs.[24,25]

Behavioral health

Refers to both mental health and substance use.

Comorbidity

The co-existence of two or more physical or behavioral illnesses at the same time.

Behavioral health specialist

A mental health or substance abuse treatment provider such as a psychiatrist, social worker, psychologist, licensed chemical dependency counselor or psychiatric nurse.

Why do most people seek help for behavioral health problems in primary care?

Only about half of individuals referred for specialty mental health care follow through with a visit.[26,27,28,29] People prefer to be treated in primary care for a variety of reasons.

Some avoid seeing a specialist because they are uninsured or their insurance does not adequately cover behavioral health services. In Texas, the state's restrictive eligibility criteria for public mental health services lead people whose psychiatric diagnoses are ineligible for treatment to seek care in other settings, including primary care clinics.

Cultural beliefs and attitudes toward mental illness lead some people, especially those in ethnic minority groups, to seek help for behavioral health issues in primary care settings.[30]

For people in rural settings, the closest specialty mental health clinic can be miles away. This is especially true in sparsely populated areas of South and West Texas.

Providing appropriate behavioral health treatment in the primary care setting presents an important opportunity to reach people who cannot or will not seek care in a specialty mental health setting. Treating mental health problems in the primary care setting also can be crucial because many who seek help there have milder symptoms that, if treated appropriately, can be prevented from developing into a more disabling disorder.

What are the challenges of detecting and treating behavioral health problems in primary care settings?

Behavioral health problems often go undetected and untreated in the primary care setting.[31] Primary care clinicians frequently miss psychiatric disorders in their patients.[32,33,34] When providers do detect psychiatric disorders, they often fail to provide adequate treatment.[35,36,37,38,39]

Populations of color, children and adolescents, older adults and uninsured or low-income patients seen in the public sector are especially unlikely to receive appropriate care for psychiatric disorders.[40,41,42,43,44,45,46,47,48]

Patient, provider and system factors all contribute to the challenges of effectively providing behavioral health care in primary care settings.[49]

Patients may not recognize or be willing to admit that they are having behavioral health problems, making it difficult for providers to detect them. When these problems are uncovered, patients may be unwilling to participate in treatment due to stigma.

Primary care providers may lack necessary training and treatment resources. The limited time they have to spend with patients can be a barrier as well.

Treatment of children and adolescents is particularly challenging for primary care providers. Although more primary care providers are treating children with psychiatric medications, they often do so uneasily in the face of serious public concerns about the use of medications with young children, the use of antipsychotic medications and the significant potential side effects associated with some antidepressants and stimulants.[50,51,52]

At the system level, insurance benefits for behavioral health treatment are typically more limited than for other medical benefits, and primary care providers may not be able to bill for behavioral health services they provide.

LESSONS LEARNED

Why integrate behavioral health into primary care settings?

- Most people seek help for behavioral health problems in primary care settings.
- Behavioral health problems often go undetected and untreated in primary care.
- People with common medical disorders like diabetes have higher rates of behavioral health problems.
- When psychiatric disorders are not addressed in people with chronic medical illnesses, they have worse psychiatric and medical outcomes.
- Populations of color, children and adolescents, older adults, and uninsured or low-income patients seen in the public sector are especially unlikely to receive appropriate care for psychiatric disorders.
- Treating behavioral health problems in the primary care presents an important opportunity to intervene early and prevent more disabling disorders, and also to reach people who cannot or will not access specialty behavioral health care.

Common physical health problems in behavioral health care settings

Adults receiving treatment in behavioral health settings often have physical health conditions as well. The most common disorders are cardiovascular disease, diabetes, hypertension, arthritis and digestive disorders.[53]

Physical health problems are common in behavioral health settings, but detection and treatment often are poor.

It is less clear whether children with mental health problems are at an increased risk for medical problems.[54,55] However, their growing use of behavioral health medications associated with significant medical risks, such as the development of obesity and diabetes, make physical health issues a critical consideration for this population as well.

Severe mental illness

A term used to refer to psychiatric disorders like schizophrenia and bipolar disorder that are associated with major disruptions in people's ability to function.

Individuals with severe mental illnesses such as schizophrenia, bipolar disorder or major depression are at an increased risk of medical comorbidity.[56] More importantly, they die of physical disorders more often and at an earlier age than the general population. A 2006 study demonstrated that people with severe mental disorders die an average of 25 years earlier than the rest of the population.[57]

Serious emotional disturbance

Mental health problems that severely limit children's ability to function at school, at home and in the family.

People with diagnosed psychiatric disorders are less likely to receive preventive medical services than the general population, even when they see a primary care provider.[58,59,60] They also are less likely to get necessary treatment for medical problems. For example, after a heart attack, people with diagnosed psychiatric disorders are much less likely to receive necessary surgical procedures than other patients with the same severity of heart problems.[61]

What prevents people with behavioral health problems from getting adequate primary care?

Individuals with severe mental illnesses typically have less access to primary medical care than the general population. In one study, two-thirds of individuals with severe mental illnesses served in a community mental health clinic were unable to name a primary care provider, with many reporting either no routine physical health care or use of the emergency room as their primary source of care.[62]

For individuals with severe mental illnesses or serious emotional disturbances, navigating a different treatment system and communicating with providers who are not familiar with mental illness are important barriers to primary care treatment. Lack of transportation and lack of insurance also can prevent people with mental illnesses from seeking physical care.

On the provider side, primary care clinicians may have inadequate time to effectively assess and communicate with patients with mental illness. They may also be less willing to accept these patients because of stigmatizing attitudes toward mental illnesses and the people who have them.

What are the challenges of detecting and treating physical health problems in behavioral health settings?

Less is known about the extent to which physical health care is delivered in behavioral health settings. Despite the fact that the majority of individuals

served in behavioral health settings have medical conditions, more than half of these medical conditions go unrecognized.[63] Some older surveys suggest that psychiatrists rarely conduct physical examinations in an outpatient setting, with many reporting they are not confident in their ability to conduct them.[64,65,66]

Behavioral health providers often fail to ensure children and adolescents have had a recent physical exam or to make referrals to a pediatrician.[67] Youth served in behavioral health settings usually do not receive monitoring of vital signs such as weight and blood pressure or laboratory tests recommended for their prescribed medications.[68]

A 2007 national survey of community behavioral health centers found that although these centers recognize the importance of medical care for their clients, many are limited in their capacity to provide it.[69] The most common identified barriers to providing medical services are reimbursement difficulties, workforce limitations, lack of adequate office space and lack of referral options.

LESSONS LEARNED

Why integrate physical health care into behavioral health settings?

- Adults receiving treatment in behavioral health settings often have common physical health conditions as well, such as cardiovascular disease, diabetes and hypertension.
- Although most people served in behavioral health settings have medical conditions, more than half of those conditions go unrecognized.
- Individuals with severe mental illnesses typically have less access to primary medical care than the general population.
- People with severe mental disorders die of physical ailments an average of 25 years earlier than the rest of the population.
- Community mental health centers recognize the importance of medical care for their clients, but often are limited in their capacity to provide it.

Different Models of Recovery

A significant barrier to integrated health care is the different models of (or approaches to) recovery in the primary care and mental health fields.

In the medical model, the focus is on the person's illness. Recovering from a mental illness means that someone has had a reduction of symptoms and a reduced need for treatment. In the medical model, the individual complies with treatment.

In the recovery model, recovering from a mental illness means that someone has improved their quality of life and level of functioning despite the illness. The focus is on the person's life and health, not the illness. The recovery model also emphasizes the individual's active role in their recovery. In the recovery model, the individual is an active participant in his or her care, deciding what kind of care is delivered and how.

In recent years, the mental health community has begun moving away from the medical model to embrace the recovery model. Traditional mental health systems and providers and the medical community in general continue to work from the medical model.

Many mental health consumers and advocates are wary of integrating physical and mental health care due to primary care's reliance on the medical model. Because one aspect of integrated care is the delivery of mental health services in primary care settings, mental health consumers and advocates are concerned that integration could mean a move away from the recovery model back to the medical model.

It is critically important to recognize these concerns and to incorporate a recovery approach into any integrated care system. Integrated health care is not incompatible with a recovery approach. But efforts under way to educate the traditional mental health system about recovery must be extended to the primary care system as well.

What do we know about how to integrate physical and behavioral health services?

With the recognition that physical and behavioral health problems often co-occur, researchers and clinicians have begun examining ways to improve how care for these problems can be coordinated, or integrated. In this chapter, research on various approaches to integrating behavioral health services into primary care settings and physical health care services into behavioral health settings is reviewed.

Improving behavioral health treatment in primary care settings

For more than 30 years, researchers and clinicians have looked at ways to improve the detection and treatment of psychiatric disorders in primary care settings. This section reviews existing research on the range of tools, strategies and models that have been developed and tested.

Screening

Since the 1970s, researchers have studied screening tools as a way to improve primary care providers' detection of mental disorders. In these studies, primary care practices use patient questionnaires to screen for common psychiatric disorders like depression. The approach may also involve providing primary care practitioners with feedback about the screening results. For example, a nurse in the primary care setting may be responsible for reviewing patients' screening responses and alerting primary care providers when patients screen positive for a mental or substance use disorder.

Some studies have shown that screening and provider feedback can increase primary care providers' identification of mental disorders. However, studies consistently have found that effective screening alone does not impact patients' mental health outcomes.[70,71,72] Improving the detection of mental disorders appears to be of little use unless patients receive quality care following detection. As a result, the U.S. Preventive Services Task Force recommends that routine screening for depression in primary care should be done only if the practice is able to provide effective treatment following detection.[73]

The research clearly indicates that screening is helpful in detecting psychiatric disorders in primary care, but that screening alone does not result in improved outcomes for patients.

Provider Education and Training

Numerous programs have been developed to improve primary care providers' ability to treat psychiatric disorders through education and training.

In one approach, providers participate in structured training programs to learn about psychiatric disorders like depression and their appropriate detection and treatment. In another approach, providers receive training in the use of evidence-based treatment guidelines and are instructed to follow the guidelines when treating psychiatric disorders.

Treatment guidelines

Descriptions of best practices for assessment or management of a health condition.

However, even the most comprehensive of these programs resulted in only minimal or short-lived changes in providers' practices and patient outcomes.[74,75,76,77,78,79,80]

The research is clear that physician education and treatment guidelines alone do not improve the quality of mental health care.

Referral to Specialty Providers

Some researchers have studied primary care referrals to mental health providers as a means to improve outcomes for primary care patients with mental health problems. They have found that patients, especially those in ethnic minority groups, often fail to follow through with their primary care provider's referral to a specialty mental health provider.[81] Those who do follow through rarely receive evidence-based, effective care, and their care is rarely coordinated with the referring provider.[82,83,84,85]

Evidence-based

A treatment practice or approach that is shown to be effective by a strong body of research evidence.

The enhanced, or facilitated, referral model was developed to address the difficulties with follow-through. In this approach, referrals to a specialty behavioral health provider are augmented with supports designed to increase the likelihood of follow-through, such as free transportation to the specialist, follow-up reminders and coordination of care between the primary care and specialty providers. Research on this approach has been mixed. Some studies have failed to demonstrate that enhanced referral is associated with increased follow-through, while others have shown some improvements in rates of follow-through and in patients' behavioral health outcomes with this approach.[86,87,88]

Co-location

Locating behavioral health specialists and primary care providers in the same facilities.

These findings beg the question of whether there are enough specialty mental health providers to refer to in the first place. Primary care providers are frequently unable to find appropriate specialists to refer patients to for mental health care.[89] One study found that primary care providers, especially those working in managed care settings, view specialty mental health providers as being far less available than other specialists.[90]

Specialty mental health providers may be less accessible for multiple reasons, including the greater restrictions on mental health benefits in most health plans.[91] In many parts of Texas (and much of the U.S.), specialty mental health providers may be less accessible simply because there are insufficient numbers of them, especially in rural areas.[92,93,94,95]

In sum, the existing research indicates that referrals may not improve patient outcomes unless the referral process is enhanced with additional supports.[96,97,98] Referral to specialty mental health services is helpful and necessary for some individuals, but referrals alone are likely insufficient to improve most patients' outcomes.

Co-location

The co-location model houses behavioral health specialists, usually master's- or doctoral-level providers, and primary care providers in the same facility. With co-location, primary care patients can receive medical and behavioral health services in the same clinic or practice. The idea behind this approach is that co-location gives patients easier access to specialty care and reduces the stigma of seeking behavioral health treatment, which should translate into better outcomes.

While the research literature on co-location is limited, the approach has been shown to offer some benefits. Several studies demonstrate that co-located behavioral health specialists can deliver effective interventions in the primary care setting.[99,100,101]

The co-location model helps primary care providers connect their patients with specialty behavioral health care. With co-location, a primary care provider can introduce the patient to the behavioral health specialist at the time of referral. This strategy, sometimes called a "warm hand-off," has been shown to increase patients' acceptance of and follow-through with referrals.[102]

Co-location also increases the opportunity for the behavioral health specialist and primary care provider to consult on both separate and shared cases. This may happen informally through hallway meetings or through formal staff meetings.[103] Co-location, however, does not ensure that providers collaborate in the treatment of shared clients, and the amount of coordination that actually occurs may vary greatly across clinics.

Although the research is somewhat limited, it appears that co-location can improve patient outcomes. However, the effectiveness of co-location is likely to be limited without systematic coordination of physical and behavioral health care for patients.[104,105] Simply placing a behavioral health specialist in a primary care practice is unlikely to improve patients' outcomes unless their care is coordinated and based in evidence-based approaches.

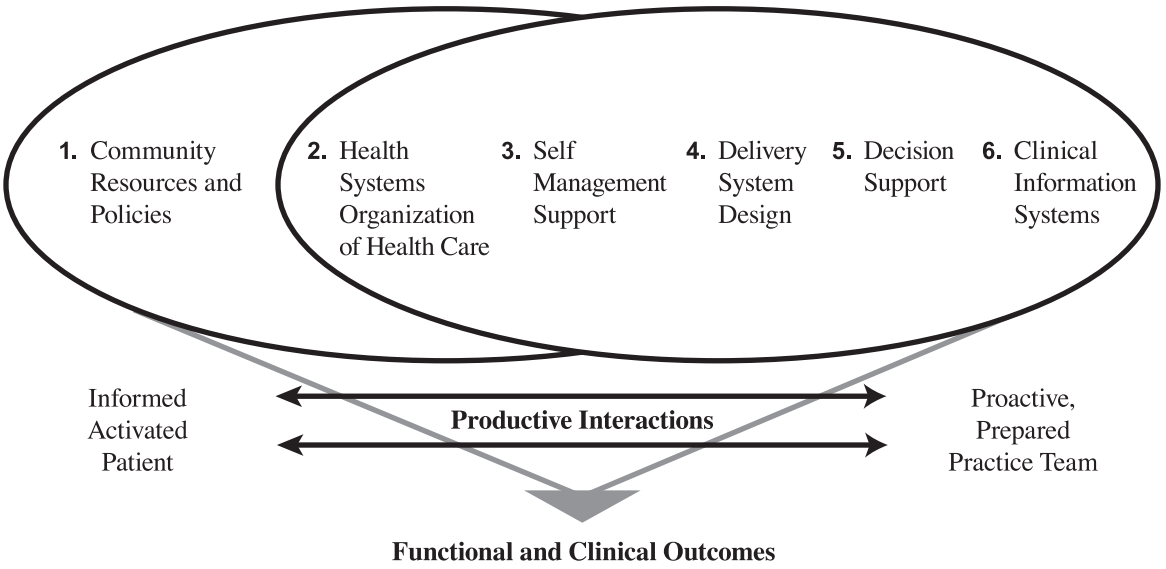
Collaborative Care

The collaborative care approach is rooted in the understanding that the problems associated with managing depression and other psychiatric disorders in primary care are the same problems associated with managing any chronic or recurrent condition in primary care.[106,107,108]

Primary care practices are designed to manage acute problems like sinus infections and sprained ankles, not longer-term or recurrent problems like asthma or diabetes. With this orientation to acute problems, patients with long-term problems tend to fall through the cracks. For example, a primary care provider may detect depression in a patient and prescribe an antidepressant, but follow-up assessment or care is unlikely. Patients may not follow through in taking the prescribed treatment, or the prescribed treatment may be insufficient; however, primary care is not structured to monitor the response to treatment and adjust care as needed over time.[109]

To address the limitations of an acute care focus, Wagner developed the chronic care model in the 1990s (see figure on the next page).[110] The collaborative care model is an adaptation of the chronic care model for psychiatric disorders.

The Chronic Care Model for Treatment of Chronic Illness in Primary Care



Collaborative care is a mental health adaptation of the chronic care model developed by Wagner in the 1990s. The model grew out of the awareness that primary care is designed to treat acute problems like sinus infections, making it difficult to appropriately manage longer-term and recurrent problems like diabetes and asthma.

The chronic care model reorganizes primary care delivery to improve outcomes for patients with chronic conditions. The model emphasizes:

- Productive interactions between informed, motivated patients and prepared physicians.
- Self-management support that empowers patients to take greater responsibility for their own health.
- Decision-support tools that assist physicians and staff in providing the recommended care.
- Clinical information systems that track the care of individual patients as well as populations.
- Health care organization buy-in and physician incentives that promote quality chronic illness care.

Wagner, E.H., Austin, B.T., & Von Korff, M. (1996). Organizing care for patients with chronic illness. *Milbank Quarterly, 74(4),* 511-544.

In collaborative care, a behavioral health care manager and a consulting psychiatrist are integrated into the primary care or pediatric setting. Care managers are trained mental health professionals or paraprofessionals who are responsible for tracking patients with identified mental health needs, educating them about their behavioral health problems, and regularly monitoring their response to treatment via clinical assessment tools. Care managers use a patient registry to track their large caseloads effectively.

A consulting psychiatrist meets regularly with the care manager to review the care manager's caseload, focusing on new patients and patients who are not responding to treatment. The psychiatrist provides the care manager with treatment recommendations that are passed on to the treating primary care provider. Care management and psychiatric consultation may be provided in person or by phone or televideo link.

Stepped care is often an element of collaborative care. With a stepped approach, patients receive less intensive or more intensive levels of care depending on the type of disorder, its severity or the person's response to treatment.[111] For example, a patient with mild depression may receive supportive counseling, while a patient with severe depression may receive psychiatric medication plus psychotherapy. In other cases, a patient with anxiety who has not responded to psychotherapy may begin taking psychiatric medication as well.

Numerous studies have found collaborative care to be effective. The model has been used successfully to treat depression, anxiety disorders and bipolar disorder, among other conditions.[112,113] The model is most effective when close attention is paid to patients' medication adherence and care managers are adequately trained and supervised by an experienced psychiatrist.[114]

Collaborative care has been shown to be effective for adolescents, adults and older adults with and without comorbid medical illnesses and from different ethnic groups.[115,116,117,118,119,120] However, it has not been well-tested with children. Collaborative care has worked in a range of health care s ettings.[121,122,123,124,125,126] The model also has been found to be cost-effective.[127,128,129,130]

In sum, significant research evidence demonstrates that collaborative care improves outcomes for a wide range of patients.

Primary Care Behavioral Health Model

Developed in the 1990s by Strosahl and Robinson, the primary care behavioral health model redesigns the role of the behavioral health specialist in the primary care setting. In this model, the behavioral health specialist primarily serves as a consultant to the primary care provider and focuses on optimizing the provider's quality of behavioral health care for patients.[131]

With the primary care behavioral health model, the behavioral health consultant's expertise is used strategically to address the entire population of individuals seen in the primary care office, rather than just those with psychiatric diagnoses. Much of the behavioral health specialist's work targets behavioral issues related to medical diagnoses, instead of traditional behavioral health problems like depression and anxiety.

Patient registry

A log or database of all patients with a particular illness or condition.

For example, behavioral health consultants in this model spend significant time working with patients who have diabetes or heart disease to change their diet and exercise habits, instead of doing psychotherapy with patients who have depression or anxiety. Another key feature of this model is that patients needing specialized behavioral health care are typically referred to a specialist.[132]

The behavioral health consultant may provide brief treatment, but mainly supports behavioral health treatments provided by the primary care provider.

The primary care behavioral health model has been adopted by numerous organizations, but it has not yet been systematically evaluated.[133] Although likely beneficial, the effectiveness of the model is not yet known.

LESSONS LEARNED

How can we improve behavioral health treatment in primary care settings?

- Screening for psychiatric disorders leads to improved patient outcomes only when appropriate care follows detection.
- Without additional supports, physician education results in minimal or short-lived changes in providers' practices and in patient outcomes.
- Enhancing referrals to specialty behavioral health providers with additional supports may lead to improved follow-through and outcomes, but more research is needed.
- Placing a behavioral health specialist in a primary care practice is unlikely to improve patients' outcomes unless their care is coordinated and based in evidence-based approaches.
- Research shows that collaborative care is an effective approach and improves outcomes for a wide range of primary care patients with psychiatric disorders.
- The primary care behavioral health model is likely beneficial, but has not been systematically evaluated.

Improving physical health care in behavioral health settings

Improving the detection and treatment of medical problems in behavioral health care settings is equally critical, but much less work has been done toward this goal. This section reviews the research literature on approaches to improving medical care delivery in behavioral health care settings. Most of the approaches discussed have only been researched in a handful of studies. More research on methods for improving the physical health of people in behavioral health care settings is greatly needed.

Physical Health Screenings

Given the high rates of preventable and treatable medical conditions like diabetes in people with severe mental illnesses, physical health screenings are recommended as standard practice in behavioral health settings.[134,135] However, the impact of routine health screenings on behavioral health client outcomes does not appear to have been studied.

Considering the research on behavioral health screening in primary care settings, it seems unlikely that physical health screenings alone would improve medical care or outcomes for people with psychiatric disorders.[136] In the absence of a strong body of research literature, the conservative conclusion is that routine health screenings likely are necessary but insufficient unless followed by quality health care.

Physical Health Promotion

People with severe mental illnesses die earlier than the rest of the population, largely due to physical health conditions that can be prevented or managed through educational strategies.[137,138,139] These health promotion approaches (sometimes called wellness promotion) provide people with information or education that empowers them to better manage and improve their health.

Health promotion programs focused on exercise, nutritional counseling and smoking cessation have proven to be effective strategies for reducing rates of chronic physical illness in the general population, including people with severe mental illnesses.[140,141,142,143,144]

One promising set of approaches involves training people with mental illnesses to run health promotion programs for their peers (i.e., other people with mental illnesses). Peer-delivered curricula like the Wellness Recovery Action Plan (WRAP) have preliminary data demonstrating their positive impact.[145]

Although more research is needed, health promotion approaches show great promise for improving the overall health of people with severe mental illnesses.[146,147]

Psychiatrists as Primary Care Physicians

Another strategy to improve the physical health care of people with psychiatric disorders is to broaden the role of psychiatrists to include primary care responsibilities.[148] If trained appropriately in primary care, psychiatrists could provide physical exams and basic medical care for clients who cannot or will not access primary health care.[149]

In the 1970s there was a movement to designate psychiatry as a primary care specialty.[150] In 1979 the first combined psychiatry-primary care residency was established.[151] There are now more

Wellness

A state of physical and mental well-being.

Health promotion

Providing information and education to empower people to increase control over and improve their health.

than 20 dual-training programs through which physicians are trained and board-certified in both psychiatry and primary care.[152] One relatively small study found that the majority of physicians who go through dual training end up practicing psychiatry exclusively and report using their primary care training in their work.[153]

Although this approach seems potentially useful, there appears to be no research on whether behavioral health clients treated by dually trained psychiatrists have improved physical health outcomes.

Co-location

Co-location

Locating behavioral health specialists and primary care providers in the same facilities.

Co-locating primary care providers in behavioral health care settings is a promising strategy, although its study also has been limited. Co-locating, or embedding, primary care providers means that the providers have offices in the behavioral health practice or clinic. The co-located primary care providers may include primary care physicians, nurse practitioners or other nursing professionals. The providers may operate as consultants to behavioral health staff or work with behavioral health providers as part of a team.

Facilitated referral

An approach in which providers assist clients with accessing referrals and help coordinate their care.

A 2006 review identified six studies of the embedded primary care approach.[154] The review found that consumers are more likely to participate in embedded primary care services and that the quality of care they receive is better than usual care. It also found improved physical and behavioral health outcomes for consumers in these programs.

Another recent study of embedded primary care found that co-locating a nurse practitioner in a behavioral health setting leads to improved quality of care, increased information-sharing, increased client satisfaction, and reduced use of emergency facilities.[155]

Clearly, more research is needed, but co-locating primary care providers in the behavioral health care setting appears to be another promising approach for improving consumers' physical health outcomes.

Referrals to Primary Care Providers

Because behavioral health clinics often are limited in their capacity to provide on-site primary care, some researchers have looked at ways to improve how referrals to outside primary care providers are made. The facilitated, or enhanced, referral model was developed to improve consumers' physical health outcomes. The model is akin to the enhanced referral model studied in primary care settings.

In this model, a nurse assists consumers with accessing primary medical care, facilitating communication between providers and systems, and helping consumers follow through with medical treatment.[156] They also provide health education and advocacy to help consumers overcome barriers to adequate primary care.

One research study has shown this to be an effective model, and another is under way with funding from the National Institute of Mental Health.[157,158] Additional research is needed to understand the impact of this approach.

LESSONS LEARNED

How can we improve physical health care in behavioral health settings?

- Screening for physical health conditions is likely necessary but insufficient unless it is followed by quality health care.
- Health promotion programs show promise in reducing rates of chronic physical illness in people with severe mental illnesses.
- It is unknown whether training psychiatrists in primary care leads to improved physical health outcomes for consumers.
- Co-locating primary care providers in behavioral health care settings may improve consumers' physical health outcomes.
- Enhancing referrals with additional supports may lead to improved follow-through and outcomes, but more research is needed.

The Four Quadrant Clinical Integration Model

LOW ← Behavioral health risk/status → HIGH

Quadrant II
↑BH ↓PH

- BH Case Manager coordinates with PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

Quadrant IV
↑BH ↑PH

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager coordinates with PCP and Disease Manager
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

Quadrant I
↓BH ↓PH

- PCP (with standard screening toos and BH practice guidelines)
- PCP-based BH provider

Quadrant III
↓BH ↑PH

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH provider
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

LOW ← Physical health risk/status → HIGH

BH = Behavioral health; PH = Physical health; PCP = Primary care provider

ER = Emergency room; IP = Inpatient care; SNF = Skilled nursing facility

Frameworks for integrating physical and behavioral health care

The following models provide holistic frameworks for conceptualizing integrated health care. Rather than trying to improve behavioral health care in a primary care clinic or physical care in a behavioral health clinic, these models incorporate both sets of approaches, offering ideas for how to bridge the two systems.

Both models discussed here are conceptual frameworks for designing integrated programs. There is research on programs that have used the models to design their services, but the models themselves do not necessarily lend themselves to research.

Four Quadrant Model

The four quadrant model is built on the notion that what type of care people need and where that care is best delivered depend on the severity of both the individual's behavioral health and physical health needs.[159] A strength of this model is its recognition that individual needs vary, and an array of primary and specialty services need to be available and appropriately integrated.

The four quadrant model is a conceptual framework for designing integrated programs. Because it is not a service model, it has not been evaluated. However, the model has been used by integrated programs with evaluation data to support them, including Washtenaw Community Health Organization, which is described in the national models chapter of this report.

Systems of Care Model

Another framework for integration is the systems of care model. This model recognizes that children with serious emotional disturbance are likely to interact with a number of child-serving entities, such as behavioral health, primary care, child welfare, juvenile justice and the school system. Each of these systems plays a role in supporting youth and families, enhancing resilience and improving functioning.

The systems of care model emphasizes a youth- and family-driven treatment plan that integrates all relevant service providers and identifies other supports needed by the family. Integration between the primary care and behavioral health providers (and other child-serving entities) occurs through regular care meetings in which all participants work with the youth and family to agree upon goals and outcomes and monitor progress.

Systems of care sites have incorporated pediatric physical and behavioral health providers in different ways, and many of these initiatives are early in their development. In Worcester, Mass., medical residents studying at the University of Massachusetts Medical School receive training in systems of care principles such as strength-based, family-driven care and tour local service sites.[161] At this systems of care site, primary care providers are members of the care planning team and physical health status is included as an indicator of outcomes.[162] Several sites are working with community health centers to coordinate services among the systems of care sites, including co-locating behavioral health services in the primary care setting.[163]

The systems of care model is a powerful framework for shaping the delivery of services for children and youth with serious emotional disturbance, and offers useful lessons for other integration efforts.

LESSONS LEARNED

How can we conceptualize integrating care across systems?

- The four quadrant and systems of care models are conceptual frameworks for designing integrated programs.
- The four quadrant model is built on the notion that the type of care people need and where that care is best delivered depend on the severity of the person's behavioral health and physical health needs.
- The systems of care model recognizes that children with serious emotional disturbance are likely to interact with many systems, including behavioral health, primary care, child welfare, juvenile justice and the school system.
- The systems of care model emphasizes a youth- and family-driven treatment plan that is integrated across all relevant service providers.

What barriers interfere with integrating care?

While there is good research on the usefulness of many integrated health care approaches, a variety of barriers can keep primary care and behavioral health organizations from putting them in place. This section examines the clinical, organizational, financing and policy barriers that can get in the way of implementing integrated health care.

Clinical barriers

The mental health, substance abuse and health treatment systems have developed independently, with their own languages and cultures. Behavioral health and primary care providers can find it difficult to understand the context in which the other provides services. Primary care providers and psychiatrists are unlikely to interact regularly because their separate systems of care prevent them from forming the kinds of relationships primary care providers develop with other medical specialists.[164]

Cultural differences between primary care and substance use systems, which many primary care providers view as a social service or a criminal justice issue, are even greater than those between primary care and mental health.[165] The concept of integration can be foreign and even unwelcome.

Many primary care physicians report they have had insufficient training to provide mental health services and do not feel comfortable with these skills. They may be unaware of reliable and valid screening measures and may not have access to effective behavioral health interventions. They may not be aware of community resources to support patients and their families and may lack access to evidence-based models of integrated care.[166,167]

Similarly, many behavioral health practitioners report they do not have the training they need to provide quality primary care services. They may not have up-to-date knowledge about best practices for treating various medical conditions. Although dual-training programs exist, they are uncommon and may not necessarily lead to integrated care.[168]

Primary care physicians may have no interest in treating behavioral health conditions, just as psychiatrists may have no interest in providing physical health care. The stigma surrounding mental disorders and substance abuse may keep individuals from seeking or accepting behavioral health care in either setting and may impact primary care providers' openness to providing behavioral health treatment.[169]

Clinical barriers

Obstacles to integrating care that stem from how treatment is traditionally provided and how providers are traditionally trained in different fields.

Organizational barriers

Barriers to integrating care also exist at the organizational level. In the primary care setting, services are designed to treat acute problems, with brief appointments and little time for coordination with other providers. Individuals with psychiatric conditions often require more time for assessment, ongoing monitoring and education about self-management strategies. Primary care providers may not have this flexibility in their schedules.[170]

Primary care systems generally do not have mechanisms in place to support communication and consultation with psychiatrists. When providers are in separate locations, regular

Organizational barriers

Obstacles to integrating care that stem from how physical and behavioral health care organizations are traditionally structured.

communication is difficult and requires time and effort. A lack of access to psychiatrists may keep primary care providers who would like to consult from doing so.[171,172]

Behavioral health specialists also may find their service setting is not conducive to providing primary care services. Psychiatrists typically have little time to extend their appointments to include a physical examination or discussion of medical conditions. Behavioral health clinics may lack nursing staff to take vital signs and assist physicians with monitoring treatment. Clinics also may lack the space and equipment to provide medical services.[173]

It is clear that integrating care in either the primary care or specialty behavioral health setting requires significant effort to develop the necessary infrastructure and re-work clinic processes.

Policy barriers

Obstacles to integrating care that stem from laws and regulations on how physical and behavioral health care organizations can provide services and share information.

Financial barriers

Obstacles to integrating care that stem from how physical and behavioral health care are paid for.

Policy barriers

A variety of legal and policy issues can pose barriers to effective integration. Issues around sharing health information can interfere with collaboration. Laws and regulations protect the privacy of individuals' health records, but also make the timely exchange of information more difficult.[174] Many organizations report that the use of an integrated electronic health record has improved their ability to communicate about patients' treatment progress and service needs, but this type of system requires significant planning to comply with privacy regulations.[175,176]

Public health and mental health centers may be subject to rules or regulations that limit the services they can provide.[177,178] This may limit the centers' flexibility in their use of funding and the roles that staff can play. Organizations also may have restrictions on the populations they can serve, which can lead to gaps in services in the community. For example, in the Texas public mental health system adults with obsessive compulsive disorder or post-traumatic stress disorder, psychiatric conditions that can be debilitating, are not eligible for treatment in the community mental health system except in extreme circumstances.[179] As a result, many people with these ineligible diagnoses must seek help in primary care settings. However, many primary care physicians may not feel qualified to provide appropriate treatment to people with more complex behavioral health needs.

Financial barriers

The most frequently cited barriers to integrated health care are the difficulties in paying for it. Some barriers are created by the overall structure of health care funding. Other barriers are caused by the inability to bill for critical types of services across health funders.

Misalignment of Health Care Funding Incentives

In Texas' public sector, physical health, mental health and substance use services are financed separately. Public health and behavioral health care services are funded in a variety of ways, including local taxes, patient fees, Medicare, Medicaid, general revenue allocated by the Texas Legislature, federal block grant funds from the Substance Abuse and Mental Health Services Administration, other state and federal grants, funding for federally qualified health centers (FQHCs) from the federal Health Resources and Services Administration (HRSA), and the Children's Health Insurance Program (CHIP).

Medicaid is the largest source of physical and behavioral health funding in Texas. The program is limited to low-income and disabled adults and children. Approximately 11 percent of all Texans and 26 percent of Texas children are enrolled in Medicaid or CHIP.[180]

Urban areas of the state and their surrounding counties are under Medicaid managed care, and most of the Medicaid managed care health plans subcontract behavioral health coverage to separate behavioral health plan organizations. In this payment system, behavioral health care is sub-capitated.

The one exception to this financing arrangement for urban centers is the NorthSTAR initiative, which covers the Dallas service area. NorthSTAR is a capitated system, in which Medicaid behavioral health funds have been blended with state general revenue and federal funds for behavioral health services.

In the rural areas of the state, Medicaid operates on a primary care case management model. With this approach, primary care providers bill for primary care services on a fee-for-service basis and also receive a monthly case management fee for each patient in their care.[181]

FQHCs are becoming an increasingly important public provider of behavioral health services for indigent adults and children who are not enrolled or cannot enroll in Medicaid, Medicare or CHIP.[182] These community health centers provide primary care services regardless of a person's ability to pay or citizenship status. All FQHCs are required to provide or contract for behavioral health services whether or not those services are covered in the state Medicaid plan.[183]

FQHCs receive federal grants that compensate them for providing services that cannot be billed through other payers. For Medicaid and Medicare patients, the state reimburses FQHCs through an advantageous payment arrangement called a prospective payment system, instead of a discounted capitation or fee-for-service arrangement.[184]

In the private sector, about 52 percent of Texans have health insurance through their employer or a family member's employer.[185] Health insurers often cover physical health and behavioral health at different rates or levels and administer their behavioral health plans through separate entities. Some of these insurers pay for health care on a traditional fee-for-service basis; others use capitation.

Multiple financing barriers to integrated health care stem from the structure of payment arrangements used by both public and private payers. These different arrangements may include incentives that lead providers to deliver fewer services. For example, integrating physical and behavioral health care often requires primary care providers to spend more time with patients, but capitated payment systems do not compensate them for the extra time spent.[186] In fact, many health plans offer primary care physicians bonuses based on how many visits they provide in a week. The additional time spent identifying and treating psychiatric disorders can prevent providers from getting these bonuses.[187]

Incentive problems are not limited to capitated payment systems. In fee-for-service systems, providers may avoid providing behavioral health services because they typically are reimbursed

Capitation

An approach to paying for health care in which a fixed amount is paid to a health care organization or provider for each person served, regardless of what services are provided.

Fee-for-service

An approach to paying for health care in which a health care organization or provider is paid according to the services provided to a person.

Managed care

An approach to paying for health care in which a payer controls the costs and quality of services through a variety of techniques.

Payer

An entity that provides health care benefits or payment.

at a lower rate for these services than for services related to a physical health diagnosis.[188]

In addition, when behavioral health plans operate separately from physical health plans, as is true for much of Texas, the primary care provider may have an incentive to avoid providing behavioral health services. In this situation, behavioral health plans may contract with separate behavioral health providers to offer such services. The contractual and reimbursement arrangements carved out for behavioral health organizations may even prevent the primary care provider from being able to bill for providing these services.[189]

Incentive issues also can cut across capitated and fee-for-service systems. Same-day billing restrictions are a major impediment to integrated health care. Depending on the payer, a primary care provider may be unable to bill for providing both physical and behavioral health services on the same day. Some payers also restrict billing by primary care and behavioral health providers in the same practice on the same day.[190,191]

Some key integrated health care services are associated with few if any incentives to encourage their use. Payers traditionally encourage the use of psychotropic medications and referral for specialty care, providing less support for psychotherapy and collaborative treatment models consistent with integrated health care.[192] Screening and assessment of behavioral health problems typically are not encouraged by incentives either.[193]

Overall, the lack of incentives for integrated care across payer types represents a major barrier to sustainable, effective integration.

Billing and Reimbursement Practices

Another set of financing barriers that occur across private and public payers involve the lack of reimbursement for key integrated health care practices. Generally, payers do not reimburse for clinical care management functions, such as monitoring patients' response and adherence to treatment, or for consulting between primary care providers and psychiatrists.[194]

Behavioral services provided to prevent or manage medical disorders, such as brief interventions to improve adherence to diabetes treatment, generally have not been reimbursed. In 2002, a new set of billing codes called Health Behavioral Assessment and Intervention Codes was created to bill for these services, but acceptance of these codes by funding entities has been slow.[195,196]

In some cases, integrated health care practices are reimbursable, but there are problematic restrictions on who can provide these services and whether they can be provided remotely. For example, the use of Health Behavioral Assessment and Intervention Codes typically is restricted to certain categories of specialty behavioral health providers like psychologists.[197,198] Certain billing codes that theoretically could be used to pay for clinical care management functions are restricted to specific types of providers and may not be used when these services are provided by phone.[199]

It is clear that significant financial barriers stand in the way of adopting integrated health care approaches. The next section looks at potential options for addressing these barriers in Texas.

LESSONS LEARNED

What barriers interfere with integrating care?

- Clinical barriers include differences in primary care and behavioral health cultures, providers' lack of training, providers' lack of interest and stigma.
- Organizational barriers include difficulties with communication and consultation across physical and behavioral health providers, the physical separation of different provider types, and primary care's orientation to treating acute problems.
- Policy barriers include legal obstacles to sharing information across provider systems and regulations that limit the services organizations can provide.
- Financial barriers are complex and include issues related to the alignment of incentives in health care funding, as well as the inability to bill for key integrated services.

What do we know about how to pay for integrated health care in Texas?

The scope of this publication does not allow for an in-depth analysis of the range of options for financing integrated health care in Texas. This section, however, does offer an overview of some approaches. The options presented apply to any health funder – public or private – except where noted. No single option will be a good fit for every health plan or system. The solutions must be tailored to fit the unique context of each.

Alignment of incentives

Many of the financing barriers discussed in the previous section are the result of misaligned incentives. That is, how health care services are reimbursed may directly or indirectly discourage the use of integrated health care practices and services. To make integrated health care sustainable, payment systems must match provider payments to the delivery of quality, cost-effective services. This may take different forms.

Health plans can change their contracts with behavioral health plan sub-contractors in different ways to encourage integrated care. For example, primary care providers can be added to a behavioral health plan's provider network, giving primary care providers an incentive to screen and treat patients with psychiatric disorders in their practice. The plan also can offer psychiatric consultation or care management to primary care providers as an incentive to treat these patients.[200]

Health plans and provider organizations can foster the delivery of integrated care by modifying how they pay primary care providers. In capitated systems, this can mean increasing the capitation rate for individuals with severe mental illnesses, including those with comorbid chronic physical health conditions.[201] In fee-for-service systems, an option may be to allow providers to bill for services to individuals with behavioral and physical comorbidities at a higher rate.[202] In systems that give bonuses to providers based on how many patients they see, behavioral health-related visits could be weighted more than less complex physical health-related visits.[203]

Health plans and provider organizations also can implement performance standards for primary care providers that encourage the treatment of behavioral health disorders. For example, providers may receive bonuses based on their rates of behavioral health screening or referrals.[204] Payers may require primary care providers to collaborate with behavioral health providers in a variety of ways, such as exchanging data.

The same approaches can be taken with behavioral health providers to encourage physical health screening, referral and treatment. For example, behavioral health contracts could require that all mental health consumers' treatment plans include physical health goals or that behavioral health providers must coordinate consumers' care with physical health providers.[205]

Paying for integrated care services

Other approaches to making integrated health care financially sustainable entail paying for integrated health care services including care management, psychiatric consultation and behavioral management of physical illnesses such as diabetes.

Care management

A set of evidence-based integrated care practices in which patients are educated about their behavioral health problems and regularly monitored for their response and adherence to treatment.

Care management, a key component of collaborative care, can be paid for through a variety of means.

One option would be to include care management in a health plan or provider organization's administrative costs. Large primary care practices can employ care managers with credentials that allow them to bill for a portion of their time. For example, a licensed social worker potentially could bill for some care management activities under psychotherapy codes.[206] A health plan may decide to pay for or employ care managers to cover a large practice, set of practices or region.[207] With sufficiently large patient volume, employing a care manager can be a cost-effective strategy for payers and large practices.

Another option is to make care management a reimbursable activity. Capitated health plans can include care management in the capitation rate or pay a monthly care management fee for patients with behavioral health needs and other chronic conditions that require sustained monitoring.[208]

In fee-for-service systems, care management can be approved as medically necessary for certain conditions and added as a reimbursable service. There are existing codes in both the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding systems that payers could approve for care management practices. For example, a care manager's face-to-face monitoring of a patient's treatment adherence and response could be billed under CPT code 99211. The code allows for the evaluation and management of an existing patient without a physician's presence and currently is included in the Texas Medicaid plan.[209] In the HCPCS system, care managers could potentially bill for treatment monitoring under code M0064. A series of care coordination codes in the CPT classification could be used as well.

Payers can make psychiatric consultation reimbursable by approving the addition of certain existing codes as well. CPT code 99371, for example, covers telephone consultation between a physician and another health care professional such as a social worker.

To compensate providers for offering behavioral management of people's chronic physical illnesses like diabetes, payers can approve the use of Health Behavioral Assessment and Intervention Codes. For example, CPT code 96150 covers an initial assessment to determine the psychological and social factors affecting the patient's physical health. CPT code 96152 applies to an intervention provided to address the psychological, behavioral and social factors affecting a patient's physical health and well-being. CPT code 96153 applies to similar interventions offered in a group format.[210]

For these billing and coding changes to be viable, attention must be paid to the provider or credential level eligible to provide the service, the ability to provide the service by telephone, and same-day billing restrictions.[211]

For example, the Texas Medicaid program restricts the use of the M0064 code to certain provider or credential types, applies same-day billing restrictions to both M0064 and 99211 codes, and does not allow the use of the 99371 telephone consultation code.

The issue of provider and credential types is critical, in large part because of workforce realities. Texas has severe shortages of both primary care and behavioral health providers.[212] Broadening the categories of providers that can be reimbursed for integrated services – within the confines of their qualifications to provide such services – would maximize physical health and behavioral health care provider organizations' chances of recruiting sufficient numbers of providers to offer the needed services.

Restrictions on telephone services and same-day billing are key issues because they impact the ability of physical health and behavioral health care provider organizations to engage people in treatment. Transportation and child care costs can make it difficult for people to come to their providers' offices and can be especially problematic for low-income and ethnic minority groups.[213] Offering services – when appropriate – by telephone and scheduling multiple appointments on the same day are helpful ways to minimize those costs.

If provider organizations cannot tailor the provision of integrated services to match the realities of a limited workforce and their clients' financial situation, the services will not be sustainable.

LESSONS LEARNED

How can integrated services be made financially viable?

- Health plans and provider organizations can encourage integrated care delivery by modifying how they pay providers or implementing performance standards for providers.
- Care management can be made be sustainable by including it in administrative costs or by making it a reimbursable activity.
- Payers could approve the use of existing billing codes for care management services, psychiatric consultation and behavioral management of physical illnesses such as diabetes.
- When making these reimbursement changes, attention must be paid to the provider or credential level eligible to provide the service, the ability to provide the service by telephone, and same-day billing restrictions.

What efforts are under way to integrate care in Texas?

Survey of Texas primary care and behavioral health providers

To learn more about the efforts under way across Texas to provide integrated care, the Hogg Foundation for Mental Health conducted an online survey of primary care and behavioral health providers in 2008.

The Texas Association of Community Health Centers and the Texas Council of Community Mental Health and Mental Retardation Centers distributed the survey link to their member organizations. A Texas health policy institute sent the survey link to organizations in eight communities they work with through a federal Mental Health Transformation State Incentive Grant from the Substance Abuse and Mental Health Services Administration. The foundation also e-mailed the survey link to the Texas Department of State Health Services' mailing lists of physical and behavioral health contractors.

A total of 382 organizations were contacted and 170 of them completed surveys for a response rate of 45 percent. Many of the results presented here are from smaller portions of the total sample to account for incomplete responses.

The majority of respondents were either health care administrators (37 percent) or behavioral health administrators (27 percent). The rest of the respondents described themselves as primary care providers (12 percent), behavioral health providers (18 percent), or other (6 percent). The sample consisted of a variety of organization types, including community health centers (48 percent) and community mental health centers (17 percent).

Most respondents reported that their organization had implemented some integrated strategies (62 percent), and several described their implementation as complete (13 percent). Most indicated that their integration efforts focus on bringing behavioral health services into a primary care setting (58 respondents, 62 percent). Fewer indicated that they were working to integrate primary care services into a behavioral health setting (8 respondents, 9 percent) or were attempting both approaches (26 respondents, 28 percent).

The respondents who are working to treat behavioral health problems in primary care reported using a wide variety of strategies, the most common of which were:

- Screening for substance abuse (92 percent)
- Screening for psychiatric disorders – other than substance abuse (90 percent)
- Referrals to off-site specialty behavioral health providers (88 percent)
- General counseling (87 percent)
- Training primary care staff on behavioral health issues (75 percent)
- Co-treatment by primary care and specialty behavioral health providers (70 percent)

Adults were the age group most often targeted with the above strategies (90 percent). Depression (79 percent), anxiety (67 percent) and substance abuse (53 percent) were the most common conditions targeted.

These respondents' organizations paid for behavioral health services in primary care through a variety of funding streams, the most common of which were:

- Patient fees (48 percent)
- Federal grant funding (47 percent)
- Medicaid billing (45 percent)
- State grant funding (42 percent)

Their major reported barriers to integration were primarily financial, including:

- Physicians' limited time (43 percent)
- Lack of reimbursement for paraprofessionals' services (41 percent)
- Workforce shortages (40 percent)
- Lack of reimbursement for clinical care management (38 percent)
- Lack of reimbursement for screening services (38 percent)
- Lack of reimbursement for consultation between primary care and behavioral health providers (37 percent)
- Primary care providers' inability to bill for behavioral health services (33 percent)

The respondents who are treating physical health problems in behavioral health settings reported using multiple strategies, the most common of which were:

- Patient education on physical illnesses and risk factors (83 percent)
- Referrals to off-site physical health providers (81 percent)
- Monitoring of key physical indicators like blood pressure (78 percent)
- Screening for common physical illnesses like diabetes (74 percent)

Adults were the age group most often targeted with these integration strategies (84 percent). The most common physical illnesses and risk factors targeted included:

- Diabetes (77 percent)
- Lack of exercise (72 percent)
- Nutrition (72 percent)
- Obesity (72 percent)
- Hypertension (63 percent)

These respondents' organizations paid for physical health services in behavioral health settings through various funding types, including:

- Patient fees (56 percent)
- Medicaid billing (54 percent)
- General revenue (54 percent)

As on the primary care side, the major reported barriers to integrating physical health services into behavioral health settings were primarily financial, including:

- Lack of reimbursement for consultation between primary care and behavioral health providers (55 percent)
- Workforce shortages (45 percent)
- Inability to bill for medical screening (45 percent)
- Inability to bill for medical procedures (43 percent)
- Behavioral health providers' limited time (40 percent)

In many ways, the results of the Texas survey mirror the literature on national efforts. Most of the efforts under way in Texas are focused on integrating behavioral health services into primary care settings. The strategies used vary, and the most common target groups are adults with depression, anxiety and substance abuse.

There is less activity in Texas around integrating physical health care into behavioral health settings. The strategies being used are more basic, such as screening. Adults are the focus of these efforts as well, and a wide variety of physical health conditions are being targeted.

Financing issues are the most significant barriers to integrating care in Texas, according to the survey responses, but it should be noted that workforce shortages are also seen as very important.

Overview of selected Texas initiatives

As the Hogg Foundation's survey makes clear, a number of Texas organizations are actively involved in integrating physical and behavioral health care. A few of these programs are highlighted here.

Center for Health Care Services – University Health System, Bexar County

An interesting collaboration between the Center for Health Care Services (CHCS), the San Antonio area's community mental health center, and the University Health System (UHS), the public hospital district which is affiliated with an academic medical school, is paving the way for several integrative efforts.

CHCS has located behavioral health staff in UHS's Texas Diabetes Institute to provide individual, group and family therapy to patients with diabetes. In addition, CHCS has located its psychiatric crisis center in the large UHS hospital. This has allowed for the co-location of psychiatric crisis staff and an urgent care clinic, which has been advantageous for both partner organizations. Behavioral health providers can immediately refer individuals for a physical examination and can quickly seek medical clearance for psychiatric hospitalization, if needed. The urgent care clinic can easily refer individuals needing behavioral health services as well. This collaboration will be replicated next in a new alcohol detoxification program.[214]

E-Merge Integrated Behavioral Health Program, Austin

E-Merge is a collaborative effort of the City of Austin's Federally Qualified Health Centers (FQHCs) and the Austin Travis County Mental Health Mental Retardation Center, the area community mental health center. Launched in 2002 with the goal of improving the care of adults and children with mental health or substance use problems, E-Merge developed its own "home-grown" model for integration.

E-Merge is active in 13 primary care clinics. In this model, the primary care provider remains the main contact for the patient. The primary care provider's work is complemented by co-located, licensed mental health professionals referred to as behavioral health consultants.[215] The behavioral health consultants provide brief individual therapy, supportive group therapy and education on self-management of behavioral health problems. Psychiatric consultation is provided on-site by two psychiatrists.[216]

Funding for the program comes from a variety of sources, including Medicare and Medicaid reimbursement, FQHC funding and funding from the county health district.

A qualitative evaluation of the E-Merge program has shown a decrease in the use of emergency rooms for mental health care and a decrease in primary care visits. Patients have experienced reductions in the severity of depression and report an improvement in their overall health and functioning. Providers and administrators in the program are supportive of the approach.[217]

Frew Integrated Pediatric and Mental Health Program, multiple locations

In 2007, the State of Texas reached a settlement with plaintiffs to provide improved health care for children in the state Medicaid program. Of the total settlement amount, close to $6 million was approved for the Integrated Pediatric and Mental Health Program. In this pilot program, six clusters of pediatric practices around the state will pilot an integrated model of care derived from Strosahl and Robinson's Primary Care Behavioral Health Model.[218]

The University of Texas Health Science Center at San Antonio's psychiatry department will oversee the pilot. The pediatric practices will be a University of Texas Health Science at San Antonio pediatric clinic, several San Antonio private practices, Brownsville Community Health Center, Harlingen Pediatric Associates, Cooks Children's Pediatrics in Dallas, Parkland Health and Hospital System in Dallas, Lubbock Community Health Center and Texas Tech University's pediatric clinic in El Paso.[219]

Each site will hire up to five master's-level mental health professionals, and will have limited access to a child psychiatrist for consultation. The sites will focus on treating attention deficit-hyperactivity disorder, oppositional defiant disorder, depression and autism, as well as adjustment issues.[220]

In this approach, the pediatrician will be the prescribing provider. The psychiatrist will provide consultation to the pediatrician and will supervise the master's-level clinicians who will do psychoeducation and psychotherapy as indicated. The sites will have access to a modified electronic medical record to track diagnoses, assessment scores, etc. They will administer pre- and post-assessment tools such as the Child Behavior Checklist.[221]

Frew settlement funds will pay for the pilot program. The Integrated Pediatric and Mental Health Program proposal also contains recommended changes to Texas Medicaid rules to allow primary care providers to bill for mental health professionals' services using Health Behavioral Assessment and Intervention Codes and for consultation with a psychiatrist.[222]

Harris County Community Behavioral Health Program

Created in 2005, the Harris County Community Behavioral Health Program is a collaboration among Baylor University, the Harris County Hospital District and the Houston Council on Alcohol and Drugs. The hospital district is one of the largest publicly funded health care providers in the country. With a goal of decreasing the wait for mental health services, the primary care integration initiative placed psychiatrists, psychotherapists and substance abuse counselors in all 11 county primary care clinics and in five partnering centers, such as a school-based clinic and a homeless shelter.[223]

In the Harris County program, psychiatrists accept referrals from primary care providers and provide consultation to assist primary care providers in their own management of patients' behavioral health problems. When patients are referred to the psychiatrists, the psychiatrists evaluate and stabilize them, then return them to the primary care provider for maintenance care.[223]

The Community Behavioral Health Program has initiated several educational opportunities for primary care staff, including case conferences, small-group learning and formal lectures. Training rotations for primary care and psychiatry residents, psychology interns and nursing students also are available.

Although funded initially through grants, the program currently is funded by the Harris County Hospital District and Baylor College of Medicine.[224]

In an evaluation of the program's first year, patients experienced a small, significant reduction in symptoms, had shorter waits for an initial appointment and had significantly more behavioral health visits. Both behavioral health and primary care providers reported they believed the program increased access and improved the quality of behavioral health care.[225]

Hogg Foundation for Mental Health Integrated Health Care Initiative, multiple locations

In 2006, the Hogg Foundation launched a three-year grant program focused on improving the detection and treatment of mental health problems in primary care settings. The foundation is funding seven primary care provider organizations to implement the collaborative care model. Collaborative care experts are providing training and consultation to the grantees. Each site is approaching collaborative care in a different way.

Hogg Foundation for Mental Health's Integrated Health Care Initiative

Grantee organization	Target age groups	Target diagnoses	Behavioral health partner
Brownsville Community Health Center	Adults	Depression and anxiety disorders	The University of Texas Health Science Center at San Antonio
Nuestra Clinica del Valle (San Juan)	Adults and adolescents	Depression and anxiety disorders	The University of Texas Health Science Center at San Antonio
Parkland Health and Hospital System (Dallas)	Adults	Depression	N/A; psychiatrists and psychotherapists on staff
People's Community Clinic[1] (Austin)	Adults and adolescents	Depression and anxiety disorders	Austin Travis County Mental Health Mental Retardation Center
Project Vida Health Center (El Paso)	Adults	Depression and anxiety disorders	El Paso Mental Health and Mental Retardation Center (psychiatric consultation); Family Service of El Paso (psychotherapists)
Su Clinica Familiar (Harlingen)	Adults, adolescents, and children	Depression, anxiety disorders and attention-deficit hyperactivity disorder	Rio Grande State Center (adult psychiatric consultation); The University of Texas Health Science Center at San Antonio (child psychiatric consultation)
Texas Children's Pediatric Associates (Houston)	Children	Attention deficit-hyperactivity disorder	Texas Children's Hospital's Learning Support Center

The grant program includes a rigorous cross-site program evaluation that will examine costs and patient outcomes related to the collaborative care model. The goal of the program is to develop solutions for overcoming barriers to implementing collaborative care in real-world settings.[226]

[1] *St. David's Community Health Foundation* is a funding partner for People's integrated program.

Lone Star Circle of Care, Williamson County

Located in Georgetown, Lone Star Circle of Care is an FQHC with eight suburban and rural clinics. Since 2006, the organization has had a full-time psychiatrist who provides services to adult patients with mental health needs. A child psychiatrist recently was hired to provide services to youth as well. A psychologist and psychiatric social workers provide therapy and support services, primarily to youth and families. In addition to psychiatric evaluations and medication management, the psychiatrists provide consultation to primary care physicians on behavioral health issues. Staff report that the opportunity for informal consultations regarding patient care is key to the success of this model.[227,228]

Financing for the program comes from grants to the Lone Star Circle of Care (including a grant from St. David's Community Health Foundation), Medicaid and Medicare reimbursement, and FQHC funding.[229]

In an external evaluation of the integrated behavioral health program, service recipients reported significant declines in depression and improved general health. Participants did not have any significant change in the use of emergency rooms for care or in the number of primary care visits. Preliminary cost analyses indicated that the program did increase costs somewhat, but the costs for successfully treated patients were similar to or less than those found in the literature.[230]

Texas Adolescent Behavioral Health in Primary Care Initiative, multiple locations

The Texas Adolescent Behavioral Health in Primary Care Initiative is a collaborative effort among three state agencies, six professional organizations and associations, two patient advocacy organizations and eight academic health institutions. Initiated in December 2003, this project aims to improve adolescent health through increased recognition of behavioral health problems, improved quality of treatment, and the development of sustainable, replicable models of implementation.

The recently completed feasibility phase of this initiative involved implementing the clinical protocol at five diverse primary care sites, including FQHCs, a residency training clinic, a school-based clinic and an Army medical facility. The clinical model involves behavioral health screening and assessment, patient education and self-management instruction, and training for primary care providers and staff on evidence-based treatment algorithms and interventions.[231]

One of the unique characteristics of this effort is its focus on the implementation process. Using a well-defined implementation model, project leaders established a state leadership team and local implementation teams, assessed each site's readiness for implementation and provided frequent on-site technical assistance.[232]

A preliminary qualitative analysis suggests that primary care providers value the changes and have worked to identify and resolve barriers to integrated care.[233] Client outcomes were not evaluated in this feasibility phase.[234] Project stakeholders are identifying next steps for this initiative.

What efforts are under way to integrate care outside Texas?

Numerous integrated health care initiatives are under way across the United States. Each program has unique characteristics and various approaches to providing and financing clinical services. The collection of integrated health care programs presented here is by no means exhaustive; there are too many to include all of them. However, the selection provided will give readers a sense of the many ways in which integrated health care is being carried out in the U.S. today.

Federal programs

Health Disparities Collaboratives

The Health Disparities Collaboratives is a major initiative of the federal Health Resources and Services Administration (HRSA) designed to eliminate health disparities and improve health care delivery for all people served in HRSA-supported health centers. Approximately 800 health centers are participating in the program.[235]

Originally launched in 1998, the Health Disparities Collaboratives model developed out of Wagner's chronic care model, previously discussed in this publication.[236] There are separate collaboratives for a range of chronic illnesses including depression.

HRSA provides participating health centers with expert faculty training, platforms for shared learning across participants, access to assessment tools and an electronic database for tracking patient data. The initiative has been evaluated in numerous studies.[237]

U.S. Air Force Behavioral Health Optimization Project

The United States Air Force has worked to provide integrated behavioral health and primary care within the unique military health system. This initiative involved creating a manual to identify the core principles of integrated care and training mental health providers in this model.[238] In the initial implementation, several psychologists and social workers were trained in Strosahl and Robinson's primary care behavioral health model, discussed previously in this publication, and then were trained to be "expert trainers" who could train others in the Air Force.

This train-the-trainer approach resulted in the eventual training and location of behavioral health providers in 40 military treatment facilities across the country. Approximately 30 mental health interns a year receive training on primary care behavioral health at four internship sites. Staff are currently working to develop standards and criteria to credential providers in integrated care, as well as a certification for primary care behavioral health trainers.[239]

Taking the Air Force's lead, the United States Army and Navy are undertaking projects to improve behavioral health screening, assessment and treatment in primary care, focusing primarily on training psychology interns in integrated care.[240]

Veteran's Health Administration Primary Care – Mental Health Integration Initiative

In 2004, the Veteran's Health Administration (VHA) created the Mental Health Strategic Plan, which encompassed the goals of the President's New Freedom Commission on Mental Health.[241] One of the major goals of the plan is to integrate mental health services into primary care. To achieve this goal, the VHA invited proposals from health care centers across the nation including both individual facilities and regional service networks, and awarded $32 million in grants to 92 integrated care programs.[242]

The VHA programs are using one of three integrated models. The co-located collaborative model places behavioral health providers in the health clinic. These providers share responsibility for evaluation and treatment with primary care practitioners. They also provide consultation to primary care staff on behavioral issues and brief interventions with patients to address a range of mental health and physical health issues. This model has been termed the White River Junction Model and has demonstrated increased access to services and high satisfaction from consumers and providers.[243]

The care management model involves a care manager, usually a nurse, who works with patients to facilitate adherence to treatment, monitor treatment response, and develop self-management skills. Two care management approaches are supported by the VHA. The Translating Initiatives for Depression into Effective Solutions (TIDES) model involves regional nurse care managers who provide telephone support for primary care providers' management of individuals with depression and assist with referrals to specialty care when necessary.[244] The Behavioral Health Laboratory (BHL) model involves a software-based structured assessment that results in one of three treatment recommendations – watchful waiting, initiation of treatment by the primary care provider or referral to specialty mental health care. Follow-up support also is provided to the primary care provider.[245]

The third model is a blending of both co-location and care management and has been selected by the VHA as the preferred model to implement over time. In this model, a mental health provider located on-site provides brief interventions and consultation, while a care manager provides assessment and education services, usually by phone.

In addition to the grants, the VHA has created a Center of Excellence in New York, sponsored national conferences and other educational activities, created tools to track service delivery, and developed system performance measures that reflect the goals of integrated care.[246]

Private insurer initiatives

Aetna Depression Management Initiative

Aetna is a large nationwide insurance and employee benefit organization, providing services in all 50 states. In 2006, Aetna launched a depression management program using the Three Component Model developed through the MacArthur Foundation's integrated health care initiative (described later in this section).

In the model, primary care providers are reimbursed for screening and assessment of depression, have access to psychiatrists for consultation and are assisted by Aetna care managers who routinely follow up with patients and track their progress in treatment. Aetna offers Three Component Model training for both primary care physicians and office staff through a web-based program.[247]

Aetna's program is notable for its nationwide focus and its incentive system, which pays primary care providers about 30 percent more per visit when screening for or managing depression.[248] Although outcomes of this initiative are still preliminary, early results have found improvements in mental health measures and reduced costs.[249]

United Healthcare and United Behavioral Health Life Solutions Program

United Healthcare, a large nationwide insurance carrier, has initiated a program intended to improve the health outcomes of individuals with comorbid medical and behavioral health problems. The Life Solutions program is a unique strategy to integrate care where a physical health plan and behavioral health plan share management of individuals with comorbid conditions. The program focuses on early screening for depression, anxiety and substance abuse; assessment and intervention by providers in the behavioral health organization; and integration and co-management with primary care services. In addition, primary care providers have access to a toll-free dedicated line offering psychiatric consultation. Care managers provide telephone outreach to engage individuals in behavioral health services.[250]

The Life Solutions program uses United Behavioral Health's outcomes measurement system to track the individual's progress in treatment.[251] In an initial evaluation of the program, more individuals accepted referrals to behavioral health providers, fewer individuals sought mental health assistance in the medical setting, and combined medical and mental health costs decreased significantly for those who were treated by a mental health specialist.[252]

Foundation-led initiatives

California Endowment Integrated Behavioral Health Initiative

The California Endowment, a statewide private health foundation, has invested in integrating substance use and mental health services into primary care clinics serving low-income and minority clients. Through this four-year initiative, the foundation has made grants aimed at assisting FQHCs and similar organizations in California with integrating behavioral health services into existing clinic programs.[253]

The first phase involved funding nine demonstration sites. In 2006, the California Endowment made grants via the Tides Center to assist clinics in planning for system changes and provided technical assistance on evidence-based models. Processes to gather information on patient and provider satisfaction and patient outcomes were created, allowing for the identification of best practices at these demonstration sites.

Grants for up to 10 more clinics are planned in the second phase of the initiative.[254] In 2008, the second round of grants will be made. Phase one grantees will have a formal role as mentors to the new grantees.

A unique aspect of this initiative is the development of a learning community that encourages sharing of knowledge, tools and lessons learned at implementation sites. Through this and other communication strategies, the impact of the initiative can reach beyond the grantees.

An evaluation of the grantee organizations will focus on patient satisfaction and outcomes, as well as provider satisfaction. A separate evaluation of the foundation initiative is focused on the achievement of the project's goal to increase access to integrated, effective behavioral health services.[255]

MacArthur Initiative on Depression and Primary Care

The goal of the MacArthur Foundation initiative was to develop models to assist primary care physicians in recognizing and treating individuals with depression.[256] Starting in 1995, early work focused on understanding current depression care in the primary care setting, studying effective treatment programs and exploring educational and systemic strategies to improve depression care. A large body of research was developed and used to guide development of the comprehensive Three Component Model[257] for integrating mental health services in primary care.

The Three Component Model of depression care includes a prepared primary care physician and practice, a depression care manager and mental health specialists, all working together in a team-based approach. Also included is telephone support for the patient by the care manager and regular feedback to the physician about the patient's response to treatment using an assessment of depression severity. Mental health specialists supervise depression care managers, and primary care physicians have access to informal consultation with a psychiatrist.[258]

The next phase of the initiative focused on a project called Re-Engineering Systems in Primary Care Treatment of Depression (RESPECT-Depression), which sought to establish the Three Component Model in five health care organizations. Sixty primary care practices were randomly assigned to provide either enhanced depression care or treatment as usual. In an effort to create a model that could be implemented with existing resources, RESPECT used existing quality improvement structures and limited provider training. The study showed that patients in the intervention sites were more likely to be asked about suicidal thoughts, were more likely to be offered educational material and support for self-management, and received more follow-up visits. Although the proportion receiving medication management and/or counseling did not vary between groups, patients treated in the intervention sites had a better response to treatment and were more likely to achieve remission of their depression.[259]

Based on the wealth of knowledge garnered through these efforts, the MacArthur Initiative has produced and widely distributed a depression management toolkit that provides practical tools necessary for implementing this model, including patient education handouts and assessment tools.[260] The initiative has ended, but these materials continue to serve as useful resources.

Robert Wood Johnson Foundation Initiative – Depression in Primary Care: Linking Clinical and System Strategies

This five-year initiative first focused on implementing a chronic care approach to managing depression in eight demonstration sites. In the initiative's final years, the focus shifted to removing key financial and structural barriers to integrated care. Funded demonstration sites treated adults with depression using the chronic care framework developed by Wagner and colleagues.[261]

In addition to changes in service delivery, the Robert Wood Johnson initiative emphasized changes to financial incentives for providing integrated care. Examples of strategies implemented by the demonstration sites include paying primary care providers for providing depression treatment, funding a care management function to support physicians, and providing consultation by a mental health specialist to primary care providers working with patients with depression.

The initiative also included a number of research grants that provided additional information about strategies to improve the quality of depression care, the effectiveness of adding incentives or removing barriers to care, and innovative improvements to the clinical information supports for treatment of depression in primary care.[262] The foundation also distributed leadership grants aimed at developing new leaders with a commitment to studying the treatment of depression as a chronic illness.[263]

Like the MacArthur Foundation initiative, this program has ended, but the knowledge generated from it continues to be an important resource for those interested in integrating care.

Other national programs

Armstrong Pediatrics, Pennsylvania

Armstrong Pediatrics is a large, rural pediatric practice near Pittsburgh, Pennsylvania. The practice collaborates with Western Psychiatric Institute and the Family Counseling Center to implement a stepped collaborative care model for children and adolescents with mental health problems in several clinics. The collaborative care team consists of the primary care providers, an advanced practice nurse with psychiatric training, a psychiatric social worker, and a part-time child and adolescent psychiatrist.[264]

After a child is identified by the primary care provider as having mental health issues, the nurse practitioner conducts an assessment and determines initial treatment recommendations. Some youth are treated by the primary care physician with support by the nurse practitioner. In those cases, the social worker is available to provide brief, on-site psychotherapy for some children and families and the psychiatrist may conduct a psychiatric evaluation and consultation. Some youth with more severe disorders are referred to the community mental health clinic for specialty care.

In one study, Armstrong found that 67 percent of children with newly identified mental health issues could be managed by the primary care physician and nurse practitioner alone. Another 19 percent received on-site mental health services from the social worker or psychiatrist. Only 13 percent were referred to the specialty mental health clinic, and 1 percent were referred for emergency evaluation or hospitalization.[265]

Cherokee Integrated Program, Tennessee

Cherokee Health Systems is a community-based healthcare system in eastern Tennessee that is focused on providing safety-net health services for the region. Originating as a community mental health center, the organization shifted its focus to providing integrated behavioral health and primary care more than 25 years ago. In addition to being a community mental health center, Cherokee has acquired FQHC status as well.[266] It has sites in 13 counties, all of which treat behavioral, physical and dental health problems in the same setting. The system is fully integrated financially with a unified budget for mental health and primary care.[267,268]

Cherokee uses Strosahl and Robinson's primary care behavioral health model (previously discussed in this publication). In the model, behavioral health clinicians are co-located in primary care settings, providing consultation and brief behavioral interventions to a wide variety of patients. With a strong emphasis on training, Cherokee sponsors a number of professional programs that train clinical, counseling and school psychologists in integrated care. The organization has found integrated care has led to significant reductions in use of medical, mental health and crisis services.[269]

Colorado ACCESS Depression Integration Initiative

Colorado ACCESS is a nonprofit managed care organization that provides physical and behavioral health care for Medicaid, Medicare and State Children's Health Insurance Program enrollees in the Denver area. The organization was a site in the MacArthur Foundation's RESPECT initiative and the Robert Wood Johnson Depression in Primary Care initiative.

When Colorado ACCESS began planning its collaborative care program, the organization decided how to redirect its limited funds by looking for potential cost offsets. Following an analysis of claims of medical expenses of individuals with chronic medical conditions and comorbid depression, the organization decided to integrate a depression care management program into an existing care management program for chronic medical conditions such as diabetes and asthma.[270]

Patients with the highest risk based in part on past medical expenses are given a comprehensive medical and psychiatric evaluation and considered for enrollment in the depression care management program. Care managers in the health plan work with patients and primary care physicians to optimize care.

The plan employs the care managers and a psychiatrist and recoups costs for both through reductions in inpatient care, emergency room usage and overall per-patient costs.[271] It also reimburses primary care physicians for depression care. By providing incentives for depression care and access to psychiatric consultation, primary care providers report that the model allows the physician to get support for managing complex patients with multiple disorders without requiring any substantial changes to workflow.[272]

Depression Improvement Across Minnesota – Offering a New Direction (DIAMOND)

Headed up by the Institute for Clinical Systems Improvement (ICSI), DIAMOND is a collaboration between Minnesota medical groups, health plans, the Minnesota Department of Human Services, employer groups

and patients. Basing their work on the IMPACT study of stepped collaborative care for depression (described elsewhere in this publication), the project aims to improve primary care treatment of depression provided through Minnesota health plans.[273,274]

A unique aspect of this program is its funding structure. The payers are health plans and Medicaid. A single reimbursement model was developed through the collective efforts of ICSI, health plans, the state Medicaid program and medical groups. The project funds the collaborative care model through a depression care management payment. Each of the participating health plans and the state Medicaid agency pay certified DIAMOND provider sites a depression care management payment on a periodic basis for each enrolled patient. The periodic payment is provided for the first 12 months of the patient's enrollment in the program and may be adjusted in subsequent years. The fee covers all services in the program, including the care manager, use of a patient registry, on-going patient assessment, self-management education and psychiatric consultation. It does not cover primary care or specialty care provider costs.[275]

In 2007, the National Institute of Mental Health provided funding to support the evaluation of this initiative.[276] Initial implementation at five health clinics began in March 2008, and continued deployment to 33 other medical groups will occur through 2010.[277] The expectations are that the broad payer base and strong provider involvement will enable the financial success of the program and that the model may ultimately expand to other chronic illnesses.[278,279]

Health & Education Services, Massachusetts

Health & Education Services (HES) is a nonprofit, community-based organization that provides a full continuum of behavioral health services in Massachusetts' Greater North Shore and Lower Merrimack Valley. For the past five years, HES has focused on improving the physical health care of their clients by integrating a Spanish-speaking nurse practitioner into three of their sites. The nurse practitioner has expertise in both primary care and psychiatry. She rotates among the three clinics, seeing clients for up to an hour a visit. She is available to clients on a walk-in basis for a range of basic medical services. The nurse practitioner is supervised by a primary care provider.

The program is being evaluated by researchers at Boston University. To date, HES has documented a significant drop in psychiatric admissions in their clients. They have also been successful in engaging their clients in primary care and health promotion services.[280] The full evaluation results are expected soon.

Financing has been a major challenge for HES. The bulk of the program's budget is covered by the organization's general revenue. Because Massachusetts' Medicaid program limits billing for primary care services to a client's designated primary care provider of record, the HES nurse practitioner cannot bill Medicaid for her services. HES is able to bill Medicaid and Medicare for a portion of the other services they provide, but this covers only about 10 percent of the program budget.[281] Solving these financial barriers is a major focus of the program at present.

Improving Mood – Promoting Access to Collaborative Treatment (IMPACT), multiple locations

The IMPACT project evaluated the effectiveness of a stepped collaborative care program for treating older adults with depressive disorders in primary care. Patients in 18 primary clinics across multiple states were randomly assigned to receive the intervention program or treatment as usual. The intervention model included the core components of the collaborative care model, including care management, use of a patient registry, use of a standardized depression assessment tool and psychiatric consultation, as well as a brief problem-solving therapy intervention provided by the depression care manager.

Evaluation of the IMPACT initiative showed that compared to people who received usual care, individuals in the intervention group had greater reduction in severity of depression, were more likely to have had a significant response to treatment and were more likely to have a complete remission of their depression symptoms.[282] The IMPACT intervention was shown to reduce overall medical costs after both the second and fourth year compared to usual care even after including the costs of the program.[283,284]

The John A. Hartford Foundation, the original funder of IMPACT, has provided the IMPACT team with support for disseminating this effective program nationally. A comprehensive Web site shares summaries of the outcomes of the intervention, program manuals and tools and strategies for financing services. In addition, multiple training tools are available, including a 15-hour online clinical training and in-person workshops conducted across the nation. Training and clinical supervision in problem-solving therapy is also available, as well as training for local trainers.[285]

Intermountain Healthcare's Mental Health Integration Model, Utah and Idaho

Intermountain Healthcare is a nonprofit system of hospitals, outpatient clinics and health plans serving Utah and southeastern Idaho. Initially begun as a depression care management program in the Robert Wood Johnson initiative, Intermountain Healthcare's integrated health care program has since broadened its behavioral health focus to include a wide range of tools to assist primary care physicians in screening and assessing behavioral health problems and providing stepped, evidence-based behavioral health treatment.

The Mental Health Integration Model is notable for its emphasis on pediatric care in addition to care for adults, and in its focus on a wide range of behavioral health issues. The model begins with a comprehensive assessment to determine the level of behavioral health care a patient or family likely needs. Individuals with low behavioral health needs are managed by the primary care provider with support from a care manager as needed. Individuals with moderately severe needs are served by a collaborative care team. Individuals with a high level of behavioral need, such as those who report suicide risk or history of multiple treatment failures, are referred to mental health specialists, and the clinic uses tools to facilitate communication and follow-up after the individual's behavioral health issues are stabilized.

Intermountain providers use diagnosis-specific treatment algorithms for common behavioral health disorders and assessment tools to measure progress. Numerous self-management educational tools are available for use by the primary care provider, care manager and mental health specialist.[286,287] Intermountain also has a sophisticated electronic health care record that supports collaborative care through efficient communication between team members, prompts for adhering to treatment guidelines and physician report cards documenting attainment of clinical goals.[288]

Individuals in Intermountain's depression care management program had an 8 percent decrease in costs over one year, while patients not in the program had a 19 percent increase in costs. The authors also found physicians were very satisfied with the care management program.[289]

Massachusetts Child Psychiatry Access Project

Recognizing the lack of access to child and adolescent psychiatrists, the University of Massachusetts Medical School created an innovative program in 2003 that provided real-time telephone consultation to primary care providers in central Massachusetts. A child and adolescent psychiatrist or nurse specialist provided rapid responses to participating primary care providers working with children and youth with complex or severe mental health disorders. Primary care physicians had the option to refer youth for a psychiatric evaluation to aid in their treatment planning.

In some circumstances, the child psychiatrist initiated treatment and stabilized the youth before transferring care back to the primary care setting. A few children were determined to need more intensive specialty care and were referred to the community mental health system. The psychiatric specialist also provided formal and informal training on behavioral health issues to participating practitioners. One full-time-equivalent psychiatrist was able to support139 primary care physicians treating more than 100,000 children and adolescents.[290]

Following the success of this grant-funded initiative in central Massachusetts, the state health and human services agency opted to finance six regional specialist teams with state funds, expanding coverage to the entire state. In addition to a child psychiatrist, social workers and a care coordinator also participate on the team. The team provides education and consultation to primary care providers, assists families in accessing mental health services when needed, and provides interim services to families that have to wait to access specialty care. Approximately 90 percent of all eligible primary care providers are enrolled in the current program. Massachusetts opted to allow access to all primary care providers treating children and adolescents, regardless of their insurance coverage. Physicians report satisfaction with the program and greater access to behavioral health services.[291]

North Carolina ICARE

The North Carolina ICARE partnership, composed of provider organizations, government agencies, universities and advocacy groups, is a three-year initiative aimed at improving communication and collaboration among primary care physicians and providers of mental health, substance abuse and developmental disability

services. The initiative aims to increase the capacity of primary care providers to provide evidence-based behavioral health care in the primary care setting. In addition, ICARE focuses on improving the recognition of and referral for physical health problems in individuals served in mental health settings.

Using the four quadrant model (described previously in this publication), ICARE aims to improve the use of integrated, evidence-based behavioral health practices through three primary strategies: (1) statewide training and technical assistance for providers, (2) development and support of local integrated programs, and (3) evaluation and reporting of changes that occur – from the practice level through the state level – as a result of integration.[292]

ICARE works collaboratively with a large array of integrated sites across the state. Four regional sites have been funded as pilot implementation sites. Having begun implementation in 2006 and 2007, these sites will serve as models for the rest of the state.[293]

Washtenaw Community Health Organization, Michigan

In the 1990s Washtenaw County, Michigan, began collaborating with the University of Michigan Health System on the creation of an innovative structure to provide effective, integrated mental health, substance abuse, primary and specialty care services to low-income and indigent individuals in the region. Washtenaw County is responsible for public-funded community mental health services, and the University of Michigan Health System holds the Medicaid managed care plan in the county and provides the county's indigent health program. In 2000, the partners formed a separate legal entity, the Washtenaw Community Health Organization, which allowed for pooling of funds across systems and shared risk for the population.[294] The organization has fully integrated Medicaid capitation for both mental health and primary care.[295]

Individuals enter services through a single entry point. Utilizing the four quadrant model (described previously in this publication), the community mental health provider has placed mental health professionals in primary care clinics to improve the recognition and treatment of behavioral health problems in that setting. Public health clinics also have psychiatrists available several hours per week for consultation. In the community mental health clinic, a nurse practitioner offers primary care services and coordinates with external primary care physicians as needed. Clients in the community health clinic complete a measure designed to identify health risk behaviors and health problems commonly seen in this population. The assessment tool is intended to target health promotion and prevention activities in the community mental health setting. In addition, both the public health and community mental health sites have an accessible electronic health record that includes physical and mental health information.[296]

Washtenaw Community Health Organization's preliminary evaluation found improved overall care for patients with behavioral health disorders, increased productivity in primary care and decreases in costs per person covered under the plan.[297]

Where does Texas go from here?

Texas clearly has begun the difficult work of integrating behavioral health and primary care services, as evident in the multiple programs under way across the state.

Texas has several advantages and opportunities that may support these efforts. In 2003, the 78th Texas Legislature reorganized the structure of the state health and human services agency, integrating the departments responsible for public health, mental health and substance abuse services. This provides a clear opportunity for better policy and financial integration at a state level.

Texas is an ethnically diverse state, and research has shown that ethnic minority groups are particularly hesitant to seek behavioral health services. Texas' strong track record of using *promotores*, or community health workers, to engage underserved communities in seeking health care may provide critical infrastructure to reach individuals who fail to seek help in either the primary care or behavioral health setting.

In addition, local health care financing entities such as county health districts are forming around the state, providing financial assistance to low-income, uninsured populations. These entities may help communities implement integrated care and realize the financial benefits of addressing physical and behavioral health problems holistically.

Texas also faces a number of challenges to integration. Texas has the highest rates of uninsured adults and children in the nation, with 30 percent of adults and 21 percent of children lacking health insurance.[298] Access to care is especially limited for these Texans.

When people do have health insurance, it can still be difficult to find a primary care of behavioral health provider. Forty-five percent of Texas counties are considered health professional shortage areas for primary care providers.[299] In very rural or frontier areas, access to any medical care and public transportation often are limited unavailable. Along the rural areas of the Mexico border, even the most basic infrastructure to support public health may not exist.

Texas also lacks a sufficient supply of behavioral health providers, especially child and adolescent psychiatrists, and most behavioral health providers are located in or near urban areas.[300] Sixty-nine percent of Texas counties are designated as health professional shortage areas for mental health.[301] There are concerns that this shortage will only increase as demand rises and mental health professionals retire at higher rates.[302] Access to publicly funded behavioral health services is limited, with many individuals unable to receive treatment within the system. Access to treatment for substance abuse and dependence also is restricted and service sites may be far from an individual's home.

As in many states, financing structures in Texas do not support many of the elements of integrated care. There are no mechanisms in place to reimburse providers for psychiatric consultation, and service reimbursement that is available frequently is insufficient to cover program costs. Texas Medicaid does not cover Health Behavioral Assessment and Intervention Codes, despite the increasing acceptance of these billing codes in other states. Administrators and providers working to sustain efforts to integrate consistently report difficulties ensuring financing when grant funds end.

Despite these challenges, integrated health care in Texas is moving forward.

It is clear that the primary care setting needs to play an important role in the identification and treatment of behavioral health problems. Similarly, behavioral health service settings are critical to identifying physical health risk factors and medical problems in consumers and ensuring integrated care. There are several evidence-based models for integrating care, as well as other models that show promise for improving the quality of integrated care but have yet to be fully evaluated.

It is also clear that there is no single way to integrate behavioral and primary care services, and different solutions are needed depending upon the unique characteristics of the health system. Nowhere is this truer than Texas, with its varied geography, diverse cultural communities and different models for financing health care. However, the lessons learned through numerous research and evaluation efforts as well as state and national implementation projects offer some keys for success.

With the growing recognition of the need to implement integrated health care systems for individuals with comorbid behavioral health and physical health problems, Texas is poised to become a leader in this national movement. However, the barriers to integration are abundant. Success will require the collaborative efforts of state leaders, health insurers, employers, state agencies, primary care providers, behavioral health providers, advocacy groups, consumers and universities.

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Resources

American Academy of Pediatrics

www.aap.org/mentalhealth/index.html

AAP's Task Force on Mental Health focuses on improving the detection and treatment of children's mental health problems in primary care. The Web site contains resources on systems change, links to its helpful newsletter, and a list of programs working to integrate children's care.

Diagnostic and Statistical Manual for Primary Care (DSM-PC)

American Psychiatric Association. (1995). *Diagnostic and Statistical Manual, Fourth Edition: Primary Care Version*. Washington, DC: Author.

American Academy of Pediatrics. (1996). *The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care* (DSM-PC) (Child and Adolescent Version). Elk Grove Village, Ill.: Author.

Canadian Collaborative Mental Health Initiative

www.ccmhi.ca/en/index.html

This Web site describes a variety of Canadian efforts to promote collaborative care. It also contains research overviews, program descriptions and tool kits.

Center for Health Care Strategies, Inc.

www.chcs.org/publications3960/publications_show.htm?doc_id=606732

CHCS developed a toolkit from its work with five states on the financing, delivery and administration of integrated health care. The toolkit includes tools, publications, templates and links.

Cherokee Health Systems

www.cherokeehealth.com/index.php?page=About-Us-Integrated-Care

Based in Tennessee, Cherokee is a community mental health center with federally qualified health center status. The Web site describes its fully integrated services and training programs.

Collaborative Family Healthcare Association

www.cfha.net

This association sponsors an annual conference targeted primarily at health and behavioral health providers engaged in integrating care.

Department of Veteran Affairs

www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm

The Department of Veteran Affairs has published clinical practice guidelines for the treatment of depression, including an algorithm and instruments for use in primary care.

Guidelines for Adolescent Depression in Primary Care (GLAD-PC)

www.reach-institute.net/documents/GLAD-PCToolkit.pdf

Created by a panel of experts in child psychiatry and pediatrics, consensus-derived guidelines for the management of adolescent depression have been included in a toolkit, including monitoring tools and educational handouts for families.

Health Disparities Collaboratives

www.healthdisparities.net

The Health Resources and Services Administration supports health provider organizations around the country in improving service delivery for depression and other chronic illnesses. The Web site details the models and assessment tools used by the collaboratives.

Hogg Foundation for Mental Health

www.hogg.utexas.edu/programs_ihc.html

The Hogg Foundation's Web site provides a variety of resources on integrated care, collaborative care and barriers to integration.

ICARE Partnership

www.icarenc.org

The Web site for North Carolina's ICARE Partnership offers resources on models and tools used by organizations implementing integrated care across the state.

IMPACT: Improving Mood Promoting Access to Collaborative Treatment for Late-Life Depression

impact-uw.org

Dr. Jürgen Unützer and colleagues created a highly effective collaborative care approach to treating depression in older adults. The program's Web site contains a host of valuable resources including a free online training curriculum.

Improving Chronic Illness Care

www.improvingchroniccare.org

Sponsored by Robert Wood Johnson, this initiative focuses on the implementation of chronic care management programs for a variety of conditions. This site includes descriptions of the model, training resources, tools and videos illustrating the care management visit.

Integrated Behavioral Health Project

www.ibhp.org

Funded by the California Endowment, the Integrated Behavioral Health Project is a four-year, California-based initiative of the Tides Center. The Web site includes archived training sessions, policy resources, summaries of national programs and an annotated bibliography, in addition to information about their grant program.

Integrated Primary Care

www.integratedprimarycare.com

Dr. Alexander Blount of the University of Massachusetts Medical Center maintains this Web site. It offers links to a variety of organizations, reports, training programs and resources on integrated health care.

Intermountain Healthcare: Mental Health Integration

intermountainhealthcare.org

This nonprofit health care system in Salt Lake City, Utah, has implemented collaborative care for adults and children with a range of mental health problems. The Web site provides an overview of their model (kr.ihc.com/ext/Dcmnt?ncid=51080953), as well as resources for physicians, patients and families. Intermountain's Care Process Models page contains protocols for managing specific behavioral health disorders in primary care.

MacArthur Initiative on Depression and Primary Care

www.depression-primarycare.org

The MacArthur Foundation funded this multi-site trial of collaborative care for depression. The Web site contains a care manager training manual and video presentation, tool kit for primary care physicians and other free resources. Background information on the project is available on the MacArthur Foundation's Web site.

Massachusetts Child Psychiatry Access Project

www.mcpap.org

This program gives primary care providers access to consultation and referrals from child psychiatrists by phone or in person. The Web site contains links to screening and treatment tools.

Mountain Area Health Education Center

www.mahec.net/IC

This organization in Asheville, N.C., offers a video that describes how integrated care works in its center, as well as various treatment algorithms and assessment tools for ADHD and depression.

Mountainview Consulting Group

www.behavioral-health-integration.com

Dr. Kirk Strosahl heads up this integrated care consulting firm. Web site visitors have access to message boards and a host of resources once they complete the free registration.

National Association of Pediatric Nurse Practitioners

www.napnap.org/index.cfm?page=221&sec=482

This organization offers a written guide and an associated CD for pediatric health care providers to implement child and adolescent mental health screening, early intervention and health promotion within the primary care setting. The guide includes assessment tools and patient and family handouts.

National Business Group on Health

www.businessgrouphealth.org/pdfs/fullreport_behavioralHealthservices.pdf

NBGH issued this 2005 guide for employers on evaluating, designing and implementing behavioral health services. Paying for and implementing collaborative care are central elements of the guide.

The National Child Traumatic Stress Network

www.nctsnet.org/nccts/nav.do?pid=typ_mt_ptlkt

NCTSN has created a toolkit for health care professionals to assess, prevent and manage traumatic stress related to medical trauma.

National Council of Community Behavioral Healthcare

www.thenationalcouncil.org

NCCBH offers useful reports on key policy and practice issues in integrated care. It also provides a forum for member organizations participating in an integrated care learning community.

National Center for Posttraumatic Stress Disorder

www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_screen_disaster.html

This organization offers a fact sheet for primary care practitioners regarding screening and follow-up with patients at risk for post-traumatic stress disorder, especially following a disaster or other traumatic event.

National Guideline Clearinghouse

www.guideline.gov

The Agency for Healthcare Research and Quality sponsors this database of evidence-based clinical guidelines. The database includes multiple guidelines for screening, assessment and treatment of mental health disorders, some specific to the primary care setting.

The National Implementation Research Network

nirn.fmhi.usf.edu

The National Implementation Research Network, housed at the University of South Florida, provides resources to improve the science and practice of implementation in relation to evidence-based programs and practices.

RAND Partners in Care Initiative

www.rand.org/health/projects/pic

Dr. Ken Wells led a multi-site study of a quality improvement initiative to manage depression in primary care, one strategy focusing on improving medication therapy and the other focused on psychotherapy. This site offers several clinical manuals, assessment tools and implementation resources.

Robert Wood Johnson Foundation Depression in Primary Care Initiative

www.wpic.pitt.edu/dppc

The University of Pittsburgh School of Medicine provides a summary of this foundation initiative and provides monthly reviews of academic journals, a list of available integrated care toolkits and a listserv for discussion of integrated care.

Texas Health Steps Online Provider Education

txhealthsteps.com

Intended for providers of Texas Medicaid services for children birth to 20, this Web-based training includes modules on mental health and developmental screenings in a primary care setting. Additional mental health topics are planned.

Texas Medical Association

www.texmed.org/uploadedFiles/Public_Health_And_Science/Physician_Resources/Mental_Health/IntegratingCAMentalHealth10_2008.pdf

The Texas Medical Association's Committee on Child and Adolescent Health has published a guide for physicians on integrating child and adolescent mental health into primary care.

Texas Medication Algorithm Project Online Provider Education

www.utexas.edu/pharmacy/webtmap

The Texas Department of State Health Services, in collaboration with academic partners and consumers, has developed a 12-hour online training for physicians and clinical support staff in the use of an evidence-based, algorithm-driven treatment for bipolar disorder, major depression and schizophrenia.

Washtenaw County Health Organization

www.ewashtenaw.org/government/departments/wcho/ch_integratedinit.html

This Michigan county health agency has partnered with its local funder and university health system to integrate care and pay for it. The Web site offers brochures and presentation on their innovative program.

World Health Organization and World Organization of Family Doctors (Wonca)

www.who.int/mental_health/Mental%20health%20+%20primary%20care-%20final%20low-res%20140908.pdf

This 2008 report of the WHO and Wonca reviews the rationale and evidence for integrating mental health treatment into primary care service delivery. It offers case examples of integration efforts from around the world. The report also provides basic principles that are key to any successful integration effort.

Glossary

Behavioral health – A term used to refer to both mental health and substance use.

Behavioral health specialist – A mental health or substance abuse treatment provider, such as a psychiatrist, social worker, psychologist, licensed chemical dependency counselor or psychiatric nurse.

Capitation – An approach to paying for health care in which a fixed amount is paid to a health care organization or provider for each person served regardless of what services are provided.

Care management – A set of evidence-based integrated care practices in which patients are educated about their behavioral health problems and regularly monitored for their response and adherence to treatment.

Clinical barriers – Obstacles to integrating care that stem from how treatment traditionally is provided and how providers traditionally are trained in different fields.

Co-location – An integrated health care approach in which both physical and mental health providers are located in the same building or on the same premises to increase access to those services and to reduce the stigma of seeking mental health treatment. Also spelled collocation.

Comorbidity – The co-existence of two or more illnesses at the same time.

Embedded primary care – An integrated health care approach in which primary care providers and behavioral health providers are located in the same practice or clinic to improve clients' physical health outcomes. Also called co-location.

Facilitated referral – An approach in which nursing staff assist clients with accessing referrals to primary care and help coordinate their care. Also called enhanced referral.

Evidence-based – A treatment practice or approach that is backed by a strong body of research evidence.

Facilitated referral – An approach in which nursing staff assist clients with accessing referrals to primary care and help coordinate their care. Also called enhanced referral.

Fee-for-service – An approach to paying for health care in which a health care organization or provider is paid according to what services are provided to a person.

Financial barriers – Obstacles to integrating care that stem from how physical and behavioral health care are paid for.

Health promotion – The provision of information and education to empower people to increase control over and improve their health.

Integrated health care – The coordination of physical and behavioral health care.

Managed care – An approach to paying for health care in which a payer controls the costs and quality of services through a variety of techniques.

Medical model – An approach to treatment in which recovery from a mental illness is defined as the reduction of symptoms and a reduced need for treatment, as contrasted with the recovery model.

Organizational barriers – Obstacles to integrating care that stem from how physical and behavioral health care organizations traditionally are structured.

Patient registry – A log or database of all patients in a clinic or practice who have a particular illness or condition.

Payer – An entity that provides health care benefits or payment.

Policy barriers – Obstacles to integrating care that stem from laws and regulations on how physical and behavioral health care organizations can provide services and share information.

Recovery model – An approach to treatment in which recovery from a mental illness is defined as the improvement of a person's quality of life and level of functioning despite the illness, as contrasted with the medical model.

Serious emotional disturbance – Mental health problems that severely limit children's ability to function at school, at home and in the family.

Severe mental illness – Term used to refer to psychiatric disorders like schizophrenia and bipolar disorder that are associated with greater disruptions in people's ability to function.

Treatment guidelines – Descriptions of best practices for assessment or management of a health condition.

Warm hand-off – An approach in which the primary care provider does a face-to-face introduction of a patient to the behavioral health specialist to which he or she is being referred.

Wellness – A state of physical and mental well-being.

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THE UNIVERSITY OF TEXAS AT AUSTIN

What Starts Here Changes the World