

Eleventh  
in a Series  
of  
Technical  
Reports

# Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities

Editors:

Joe Parks, MD  
David Pollack, MD

Research Editor:

Stephen Bartels, MD

Technical Writer:

Barbara Mauer, MSW, CMC

**National Association of State Mental Health Program Directors  
(NASMHPD) Medical Directors Council**

66 Canal Center Plaza, Suite 302, Alexandria VA 22314  
703-739-9333 FAX: 703-548-9517

[www.nasmhpd.org](http://www.nasmhpd.org)

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# Executive Summary

The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council developed this eleventh technical paper through a series of pre-meeting conference calls, review of materials and a work group summit of medical directors and commissioners as well as researchers and other technical experts.

The work group reviewed current literature, consulted with leading researchers and provider organizations that are successfully implementing integration models for “safety net” populations, and shared examples of efforts underway at state and local levels. There is ongoing research regarding the medical cost offsets that may accrue through provision of Behavioral Health (mental health and substance abuse) as well as Behavioral Medicine services to the primary care population, including early screening for and delivery of Substance Abuse (SA) services in Primary Care (PC)—thus, the report generally references Behavioral Health (BH) services rather than solely Mental Health (MH) services.

The discussion considered both population-based and person-centered approaches to care. Recognizing that the emphasis and level of activity will vary from state to state, the report focuses separately on the need for overall system coordination, the needs of persons with serious mental illness, and needs of populations served in primary care.

The report integrates two conceptual models that assist in thinking about population-based and systemic responses. The first, *The Four Quadrant Clinical Integration Model*, is a population-based planning tool developed under the auspices of the *National Council for Community Behavioral Healthcare (NCCBH)*. Each quadrant considers the Behavioral Health (SA and MH) and physical health risk and complexity of the population subset and suggests the major system elements that would be utilized to meet the needs of the individuals within that subset of the population. The quadrants can be briefly described as:

- I. The population with low to moderate risk/complexity for both behavioral and physical health issues.
- II. The population with high behavioral health risk/complexity and low to moderate physical health risk/complexity.
- III. The population with low to moderate behavioral health risk/complexity and high physical health risk/complexity.
- IV. The population with high risk and complexity in regard to both behavioral and physical health.

Additionally, the report references *The Care Model*, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. *The Care Model* was developed by the *Improving Chronic Illness Care Program* to speed the transformation of healthcare, from a system that is essentially

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reactive — responding mainly when a person is sick — to one that is proactive and focused on keeping a person as healthy as possible.

The Council commissioned this report with attention to:

1. The new role of Community Health Centers in providing behavioral health services and the need for collaborative planning due to this new role;
2. The needs of the people served by state mental health authorities; and,
3. The evidence for integrating behavioral health services into primary care.

Each of these are briefly discussed below, along with selected recommendations from the full technical report, which is organized into segments on Overarching Focus: Overall System Coordination (Quadrants I, II, III and IV); Population Focus: Serious Mental Illness/Substance Abuse (Quadrants II and IV); and Population Focus: Primary Care (Quadrants I and III). Each segment includes an overview and discussion of related research as well as detailed action recommendations. Footnotes can be found at the end of the full report.

## ***1. The New Role of Community Health Centers and The Need for Collaborative Planning***

The Health Resources and Services Administration (HRSA) Primary Care Integration Initiative is currently being implemented across the country in Federally Qualified Health Centers (FQHCs), more broadly referred to as Community Health Centers (CHCs).

Existing sites may apply for expansion grant funding to add BH services. Additionally, all newly funded CHC sites must provide dental, mental health and substance abuse services. Grant applications must specify planned staffing, and if services are to be provided by contract, a copy of the contract. CHCs are making decisions about hiring their own BH staff or contracting for BH services as they prepare their grant applications.

As “safety net” providers, CHCs serve a broader scope of patients than just the Medicaid population. Many states focus their public mental health systems on the SMI Medicaid population, with minimal levels

### **About HRSA and CHCs**

- **HRSA’s goal is to eliminate disparities of underserved patients with primary mental health and substance abuse disorders**
- **There are over 1000 CHCs, serving over 3,500 communities and 15 million patients (2004)**
- **By 2006, HRSA projects an additional 1,200 sites and double the people served**
- **As of 2003, over 250 BH expansion grants were awarded**
- **HRSA Target 2006: 75% of CHCs will provide MH services, 49% will provide SA services**
- **Over 70,000 FTE staff in 2003**
  - **145 FTE psychiatrists**
  - **>2000 BH clinicians**
- **Nearly 45 million patient visits in 2002, including 2 million BH visits**

*Curtin, NACHC*

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of support for non-SMI or uninsured populations—consequently, there isn't a good match of target populations between the two systems. The recent financing and development of behavioral health services in CHCs was intended to address this gap. Attachment B provides more extensive background information on CHCs.

Currently, there is no role for the State Mental Health Authority (SMHA) or the local system in the planning, distribution or coordination of these additional CHC services. The implications for system-wide duplication and competition for the scarce resources of BH staff and funding, as well as the opportunity to improve consumer access to behavioral health and healthcare services, suggests that coordination is a priority at the national, state and local levels.

The American Association of Community Psychiatrists has recommended that behavioral healthcare providers at the local level incorporate a systematic program for coordinating or integrating with primary care provider organizations in their communities. Such a program would include, at a minimum:

- Effective means of bi-directional communications with Primary Care Providers (PCPs);
- Determination of what information is most essential to share; and,
- Adoption of appropriate confidentiality and consent protocols.

The **Overarching Focus: System Coordination (Quadrants I, II, III, and IV)** segment of the report speaks to this set of issues and is grounded in the following principle: **Increased integration of behavioral health and healthcare services is a priority at the national, state, local and person levels. Good public policy will work to sustain, support and require integration of services between the two “safety net” systems of CHCs and SMHA providers with integration ranging from coordination of care to full integration of medical and behavioral services.**

Communication is the key to coordinating care for all populations. Future policy should acknowledge the importance of BH/PC integration and support the expectation of communication and coordination at the federal, state, local and person level. The communication and coordination gap exists at all levels, but will require federal leadership to change the current “silo” environment and address cross-cutting issues.

The New Freedom Commission recommends the development of a comprehensive state plan across all mental health activities. The guidelines for the comprehensive state plan and waiver submissions should include a requirement to address primary care integration issues:

- For persons with SMI, how will health issues be identified and addressed by providers of mental health services?
- For persons served in primary care, how is coordination achieved at both the system level and the person level, especially in regard to HRSA funded sites?

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SMHA Directors, along with the Directors of Substance Abuse, Medicaid, and the Office of Primary Care/State Health Officer, should be convened into a State Integration Team that meets regularly to achieve the following (see the full report for a complete listing of detailed recommendations):

- Adopt and disseminate a model HIPAA-compliant release of information form to be used at entry into mental health, substance abuse or healthcare services funded by the state.
- Review the state Primary Care Strategic Plan prepared for HRSA regarding current and future distribution of CHCs.
- Review new CHC site and BH expansion applications to HRSA.
- Develop coordination of financing mechanisms and a shared interest in managing the pools of funding towards better outcomes.
- Assure that the state Medicaid Plan appropriately reflects all strategies developed.

Recommendations for federal entities include:

- SAMHSA should amend its matrix to add primary care integration to the areas of top focus for the organization.
- SAMHSA and HRSA should work together on a site planning tool that intersects with other planning efforts and would be used in the Primary Care Association state strategic plans. This would include consideration of SMHA providers as new FQHC site applicants and provision of technical assistance to them in areas where development of an applicant organization is needed.
- HRSA's Bureau of Health Professions and Bureau of Primary Health Care need to spell out a coordinated agenda in regard to workforce issues. HRSA and SAMHSA, along with the Department of Labor (DOL) should develop a master agenda in regard to meeting BH workforce needs, including the focused skills needed in PC settings.
- SAMHSA, HRSA and CMS should collaborate in policy and financing approaches to establish shared goals for BH/PC Integration and develop financing methods that support implementation of the Care Model in BH and PC settings.
- The National Associations (NASMHPD, NASADAD, NASMD, NACHC, and NCCBH) should develop a model Memorandum of Understanding for communication and coordination at the state and local level.

## ***2. The Needs of the People Served by State Mental Health Authorities***

Through the evolution of public mental health services, people principally served by state mental hospitals were (and are) provided with health, dental and vision services as well as mental health services. In the community, however, persons with serious mental illness (SMI) frequently have difficulty accessing health, dental and vision services and often

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rely on emergency rooms (ERs) for their care, which burdens the ER system, results in discontinuous care for the individuals, and may contribute to polypharmacy issues. Many of these individuals also have co-occurring SA disorders. When persons with SMI are able to access healthcare, their medical conditions are often missed; also, their healthcare concerns may not be taken seriously or treated appropriately.<sup>i</sup> Research has demonstrated that persons with SMI have high levels of medical co-morbidity. More recently, research has described a relationship between some second generation antipsychotic medications and increased risk for diabetes, obesity and high cholesterol.<sup>ii</sup>

In some states, as Medicaid or SMHA program eligibility has been restricted, individuals formerly served by the SMHA have moved into CHCs to receive ongoing management of their psychotropic medications, as well as brief counseling services in some sites. CHCs recognize their responsibilities in serving these individuals, but are concerned about being able to appropriately serve the needs of this population.

**The Population Focus: Serious Mental Illness/Substance Abuse (Quadrants II and IV)** segment of the report speaks to this set of issues and is grounded in the following principle: **Physical healthcare is a core component of basic services to persons with serious mental illness. Ensuring access to preventive healthcare and ongoing integration and management of medical care is a primary responsibility and mission of mental health authorities.** Recommendations for SMHAs include:

- Develop a partnership between the SMHA and the State Medicaid Agency (SMA) regarding opportunities to better manage resources and assure the best clinical outcomes for the populations in Quadrants II and IV.
- Develop a population-based plan for the healthcare needs of persons with SMI. This should include a set of preventive assessment standards and guidelines for healthcare monitoring.
- Assign the same SMHA priority to a stable primary care home as to stable housing and medication adherence.
- Sponsor training for PCPs in treating persons with SMI for medical conditions, including recognition and appropriate treatment of presenting healthcare concerns.
- Support the creation of parallel service integration models for persons with developmental disabilities and pilot/research these models.

There will always be a need for specialty BH services. The SAMHSA specialty BH Evidence-Based Practices (EBPs) are frequently not office-based, but community-based; to assure fidelity, the EBP should be delivered by an individual with specific training, skills and knowledge. Recommendations for delivery system improvements include:

- Adopt the Care Model for organizing and tracking BH services. Demonstrate the ability of the SMHA providers to deliver outcomes comparable to those being delivered by CHCs for healthcare concerns.
- Assure that assessment of healthcare status is an ongoing component of BH services and that there is a high level of communication between BH providers and PCPs.

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- Recognize that, for the population in Quadrant IV, the BH/PCP/specialist team is the true “medical home” that needs to be developed, based on person-centered and individualized planning and specifically identified responsibilities for each member of the team.
  - Clarify the role of local mental health authorities in provision of a crisis response system that is responsive to all components of the system, including the Quadrant IV population.
  - Support the use of BH case managers to accompany consumers to primary care visits, with the consent of the consumer, to assist in medical advocacy and incorporation of self-care recommendations into ongoing wellness planning.
  - Consider opportunities for SMHA provider and CHC co-location or merger.

### ***3. The Evidence for Integrating Behavioral Health Services into Primary Care***

Many integration initiatives and research reports have focused on depression because of the broad scope of the problem (more than 19 million Americans each year are diagnosed and treated for some type of depression) and the degree to which it is under-recognized and under-treated in primary care settings (30-40% not identified and about 10% only on benzodiazepines<sup>iii</sup>). The cost of depression in healthcare and the workforce has been well documented—among the five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) that account for 49% of total healthcare costs and 42% of illness-related lost wages, mood disorders rank third in healthcare costs, first in work loss costs and second in total costs.<sup>iv</sup> As discussed in detail in the full report, there is a robust body of research about the incidence of depression in the population seeking healthcare services and the interventions that result in improved healthcare outcomes.

The **Population Focus: Primary Care (Quadrants I and III)** segment of the report speaks to this set of issues and is grounded in the following principle: **Behavioral healthcare is a core component of essential services to persons seeking primary healthcare. Ensuring access to preventive, ongoing, and appropriate behavioral health service is a primary responsibility and mission of general healthcare providers.**

The Council recognizes that a focus on Quadrants I and III will be dependent on the context and system development in each state. While the recommendations in the other two focus segments (System Coordination, Serious Mental Illness) are intended for all SMHAs, this segment is intended for use by SMHAs that are additionally planning for the population served in primary care. Recommendations for SMHAs include:

- Use the State Team and State Plan recommended in System Coordination as the venue for creating a state level framework to provide guidance for local partnerships.

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- Develop approaches in which some financing comes from the SMHA and some from the healthcare system.
  - Develop a response to HRSA PIN 2004-05 (see Attachment B) that explores the funding options from both budget streams, assuming sufficient evidence of cost effectiveness is established.
  - Work with the Medicaid agency to implement and utilize appropriate CPT codes for provision of services (e.g., adoption of the 96150-96155 CPT codes [see Attachment B] or use of E&M codes as appropriate) and describe the clinical professional status and skill sets required for billing.
  - Assure that the models adopted for reimbursement are consistent with the research base (e.g., algorithms, registry tracking, collaborative, and stepped care).

Recommendations for SMHA providers and CHCs working together to meet the needs of the “safety net” populations include:

- Clarify the mission and roles between the organizations and develop specific transfer of care protocols.
- Explore opportunities to “rent” or place SMHA provider staff in CHCs (see Attachment C).
- Consider shifting more psychiatry into CHCs, while case management and the SMI evidence-based BH services remain in SMHA provider agencies.

The Council is aware that considerable work is necessary to heal the long-standing “mind-body split”. We hope that this report and its recommendations provide support and direction for those working on the healing process.

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# Introduction

The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council developed this eleventh technical paper through a series of pre-meeting conference calls, review of materials and extensive discussions at a work group summit held July 19-20, 2004 in Portland, OR. Participants included State Mental Health Authority (SMHA) medical directors and commissioners as well as researchers, medical leadership from the National Association of Community Health Centers, leaders from organizations that are both CHCs and Community Mental Health providers (community mental health providers are subsequently referenced throughout as SMHA providers), a representative from a State Medicaid Agency and other technical experts. A complete list of participants is included as Attachment A.

The Council commissioned this report with attention to:

- The new role of Community Health Centers in providing behavioral health services and the need for collaborative planning due to this new role;
- The needs of the people served by state mental health authorities; and,
- The evidence for integrating behavioral health services into primary care.

The work group reviewed current literature, consulted with leading researchers and provider organizations that are successfully implementing integration models for “safety net” populations, and shared examples of efforts underway at state and local levels. The discussion considered both population-based and person-centered approaches to care. Recognizing that the emphasis and level of activity will vary from state to state, the Council agreed upon the following principles:

- Increased integration of behavioral health and healthcare services is a priority at the national, state, local and person levels. Good public policy will work to sustain, support and require integration of services between the two “safety net” systems of CHCs and SMHA providers with integration ranging from coordination of care to full integration of medical and behavioral services.
- Physical healthcare is a core component of basic services to persons with serious mental illness. Ensuring access to preventive healthcare and ongoing integration and management of medical care is a primary responsibility and mission of mental health authorities.
- Behavioral healthcare is a core component of essential services to persons seeking primary healthcare. Ensuring access to preventive, ongoing, and appropriate behavioral health service is a primary responsibility and mission of general healthcare providers.

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# Conceptual Models

## I. The Four Quadrant Clinical Integration Model

This model is a conceptual framework for population-based planning and understanding the diverse integration initiatives that are currently underway. It was developed under the auspices of the National Council for Community Behavioral Healthcare (NCCBH); the following discussion is excerpted from NCCBH's *Behavioral Health/Primary Care Integration Models Competencies and Infrastructures*. The Four Quadrant Clinical Integration Model is used throughout this technical paper to facilitate population-focused presentation of the research, related discussion and recommendations for action.

In order to plan clinically, there must be a definition of the population to be served. The NCCBH Four Quadrant Clinical Integration Model focuses on the populations to be served and assumes differing types of services and organizational models of integration depending on the needs of the population in each quadrant. The Model is a population-based planning tool; individuals will have differing needs at different points in their lives—the services provided should be person-centered and appropriate to needs at any point in time.

The NCCBH Four Quadrant Model builds on the 1998 consensus document for mental health (MH) and substance abuse/addiction (SA) service integration, as initially conceived by state mental health and substance abuse directors (NASMHPD/NASADAD) and further articulated by Ken Minkoff and his colleagues.<sup>v</sup> The MH/SA model describes differing levels of MH and SA integration and clinician competencies based on a four-quadrant model, divided into severity for each disorder:

- Quadrant I: Low MH-low SA, served in primary care
- Quadrant II: High MH-low SA, served in the MH system by staff who have SA competency
- Quadrant III: Low MH- high SA, served in the SA system by staff who have MH competency
- Quadrant IV: High MH-high SA, served by a fully integrated MH/SA program

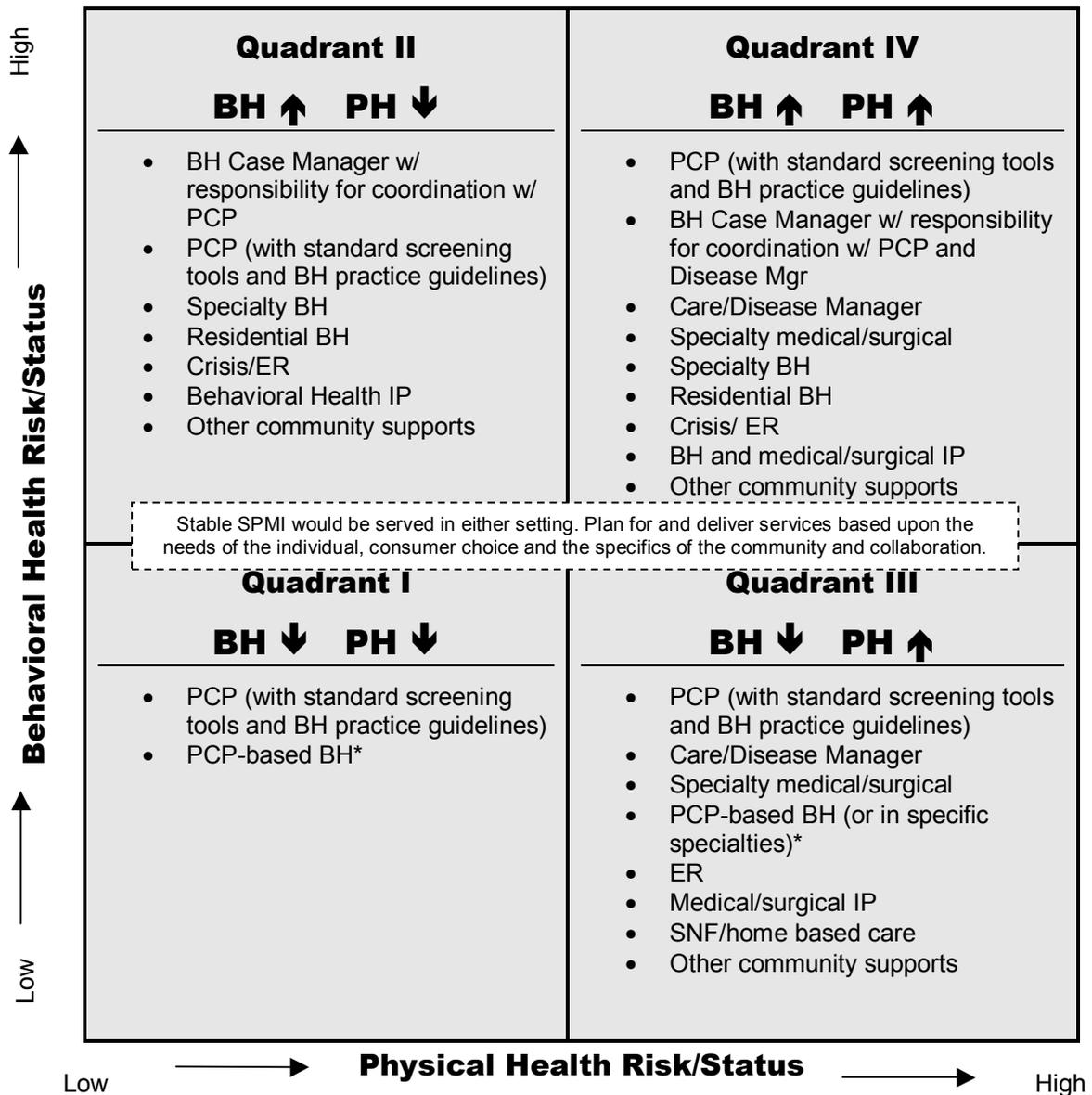
The NCCBH Model considers both MH and SA risk/complexity on the vertical Behavioral Health (BH) axis, and clinical competency in MH and SA knowledge and skills within the services provided in any quadrant.

Each Quadrant considers the behavioral health and physical health risk and complexity of the population subset and suggests the major system elements that would be utilized to meet the needs of the individuals within that subset of the population.

- **Quadrant I**

Low BH-low physical health complexity/risk, served in primary care (PC) with BH staff on site; very low/low individuals served by the PCP, with the BH staff serving those with slightly elevated health or BH risk.

## NCCBH Four Quadrant Clinical Integration Model



\*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

While the Quadrant I population is most likely to exhibit depression or anxiety, it may also include some stable individuals with SMI. The consumer of care, by seeking care in primary care, has selected a “clinical home”. Consistent with appropriate clinical practice, that should be honored; the “clinical home” should be based upon consumer choice and the specifics of the community collaboration. The primary care and specialty BH system should develop protocols, however, that spell out how acute behavioral health episodes or high-risk consumers will be handled.

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- **Quadrant II**

High BH-low physical health complexity/risk, served in a specialty BH system that coordinates with the PCP (or in more advanced integrated systems, provides primary care services within the behavioral health setting). Most individuals with SMI, children/youth with serious emotional disturbance (SED) or those with co-occurring disorders would be in this population grouping.

- **Quadrant III**

Low BH-high physical health complexity/risk, served in the primary care/medical specialty system with BH staff on site in primary or medical specialty care (e.g., oncology, cardiology, psychosomatic medicine), coordinating with all medical care providers including disease care managers. Access to BH specialists with expertise in treating persons with co-morbid chronic medical illnesses is advisable. This population group includes a large percentage of patients with chronic medical illnesses (e.g., diabetes, cardiovascular conditions) that are at risk or have evidence of BH disorders (e.g., mild to moderate depression, anxiety), some of which may be related to their primary medical conditions.

- **Quadrant IV**

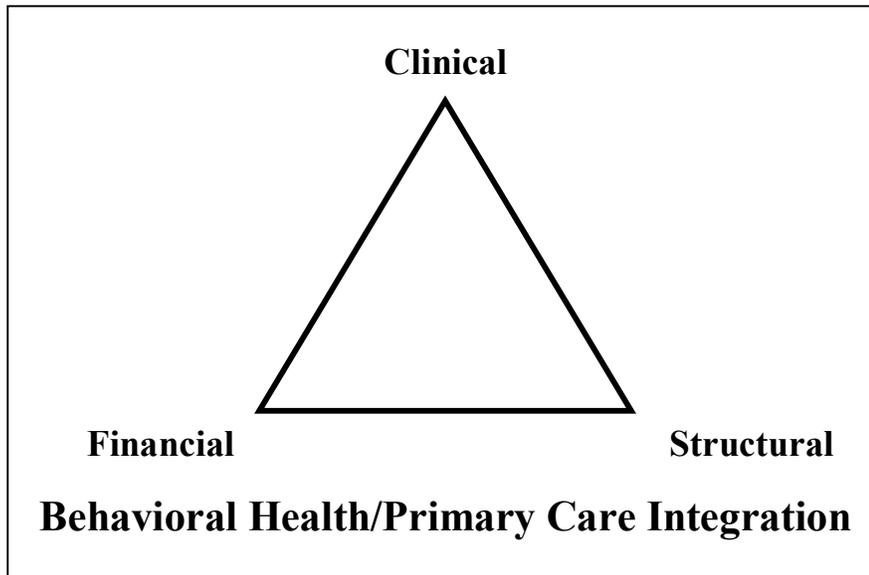
High BH-high physical health complexity/risk, served in both the specialty BH and primary care/medical specialty systems; in addition to the BH case manager, there may be a disease care manager, in which case the two managers work at a high level of coordination with one another and other members of the team. This group includes individuals with SMI/SED, co-occurring and one or more complex medical conditions (e.g., diabetes, cardiovascular conditions).

The Four Quadrant Clinical Integration Model is not diagnosis specific; it looks at degree of clinical complexity and risk/level of functioning. Diagnosis specific guidelines should be used to provide detailed guidance for the scope of the primary care provider, the primary care-based BH provider, and the specialty BH provider.

The Four Quadrant Model is also not intended to be prescriptive about what happens in each quadrant, but to serve as a template for coordinated planning in local systems, considering the resources locally available and developing alternative methods of coordination (for example, telemedicine) that may be required when specialty care (either physical or behavioral health) is delivered away from the community.

The examples used in the Four Quadrant Clinical Integration model are for adult populations; the same template can be used to create models that are specific for children and adolescents, or older adults, reflecting the unique issues of serving those populations (for example, the role of schools and school-based services in serving children).

Next steps in working with the Four Quadrant model would include understanding the metrics for population distribution within each Quadrant and the implications for pooled funding initiatives.



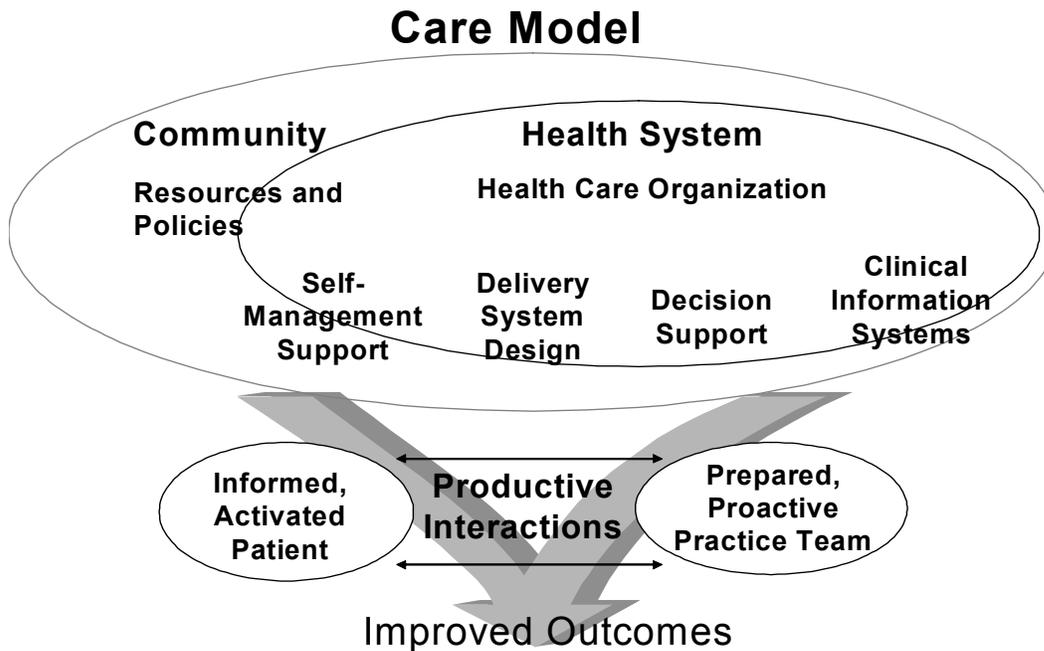
Integration that is financial (e.g., benefit packages, carve-ins, shared risk pools or other incentives) or structural (e.g., services delivered under the umbrella of the same organization, BH specialty services co-located with primary care services) will not necessarily assure clinical integration. However, clinical integration can be difficult to achieve without financing mechanisms and structures or infrastructure that support the collaborative effort. Clinical integration—what is experienced by the consumer in relationship to the providers—is the goal. To achieve that goal, it is important to be clear about which integration mechanisms are being selected and why.

## **II. The Care Model**

*The Care Model* summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels and was developed to speed the transformation of healthcare, from a system that is essentially reactive — responding mainly when a person is sick — to one that is proactive and focused on keeping a person as healthy as possible. The Care Model was developed by Ed Wagner and his colleagues under the *Improving Chronic Illness Care Program*.<sup>vii</sup>

The Care Model is now in use in a variety of healthcare settings, providing a structured approach for clinical improvement and has been used to develop specific approaches for serving patients with diabetes, cardiovascular disease, asthma and depression. The Care Model is referenced in this technical paper as an organizing structure for redesign of PC and BH delivery systems to better achieve desired patient outcomes.

The HRSA Bureau of Primary Health Care, (BPHC) with the Institute for Healthcare Improvement (IHI), formed the *Health Disparities Collaboratives* as a multi-year national initiative to implement models of patient care and change management in order to transform the CHC system of care for underserved populations.



The organizing principles for each Health Disparities Manual follow the key elements of the Care Model; many of the components apply to all chronic diseases (e.g., diabetes, asthma, and depression), while specific tasks and tools are unique to a specific disease.

The key change concepts found in the *Depression Collaborative Manual* include:

### ***Organization of Healthcare/Leadership***

- *Make sure senior leaders and staff visibly support and promote the effort to improve chronic care*
- *Make improving chronic care a part of the organization's vision, mission, goals, performance improvement, and business plan*
- *Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources*
- *Assign day-to-day leadership for continued clinical improvement*
- *Integrate collaborative models into the quality improvement program*

### ***Decision Support***

- *Embed evidence-based guidelines in the care delivery system*
- *Establish linkages with key specialists to assure that primary care providers have access to expert support*
- *Provide skill-oriented interactive training programs for all staff in support of chronic illness improvement*

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- *Educate patients about guidelines*

### ***Delivery System Design***

- *Identify depressed patients during visits for other purposes*
- *Use the registry and care monitoring to proactively review care and plan visits*
- *Assign roles, duties and tasks for planned visits to a multidisciplinary care team. Use cross training to expand staff capability*
- *Use planned visits in individual and group settings*
- *Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls and home visits*

### ***Clinical Information System***

- *Establish a registry (Note: while this concept is in broad use in CHCs and many primary care networks, it is not well known or understood by BH providers)*
- *Develop processes for use of the registry, including designating personnel to enter data, assure data integrity, and maintain the registry*
- *Use the registry to generate reminders and care planning tools for individual patients*
- *Use the registry to provide feedback to care team and leaders*

### ***Self-Management***

- *Use depression self management tools that are based on evidence of effectiveness*
- *Set and document self management goals collaboratively with patients*
- *Train providers and other key staff on how to help patients with self management goals*
- *Follow up and monitor self management goals*
- *Use group visits to support self management*

### ***Community***

- *Establish linkages with organizations to develop support programs and policies*
- *Link to community resources for defrayed medication costs, education and materials*
- *Encourage participation in community education classes and support groups*
- *Raise community awareness through networking, outreach and education*
- *Provide a list of community resources to patients, families and staff*

#### **More about CHCs**

- **650 CHCs have participated in Health Disparities Collaboratives; 71 in the Depression Collaboratives**
- **The Depression Collaborative is based on research and tools, including the Care Model**
- **All new CHC BH sites must participate in the Depression Collaborative**
- **Teams are required to report on specific measures. Recent results:**
  - **>3500 patients in registries**
  - **63% w/ self management goals**
  - **70% w/ PHQ-9 score in last 6 months**
  - **20% w/> 50% decrease in PHQ-9 score**
  - **20% seen for follow up within 4-8 weeks**

*Curtin, NACHC*

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The aim for the Depression Collaborative is to delay or decrease the complications of depression by patient self-management, clinical decision support, positive delivery system re-design, clinical information systems and strong partnerships with local community organizations. The key measures include: the percent of patients with a 50% reduction in the Patient Health Questionnaire [PHQ-9] score; documented PHQ-9 reassessment between 4-8 weeks of last new episode PHQ (AHRQ guidelines suggest that if there is no response at 6 weeks, treatment needs to be changed or augmented); documented PHQ-9 score within the last 6 months; and self-management goal setting.

### **III. The Models and Evidenced-Based Practices**

A second version of the Four Quadrant Model cross-walks the likely use of Evidence-Based Practices (EBPs) to each of the Quadrants.<sup>viii</sup> It focuses on EBPs currently under development by HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as other work in public and private healthcare sectors.

The SAMHSA EBPs differ from the office-based “therapy” models that often come to mind when people think about mental health services.<sup>ix</sup> The focus on wellness, self-management and recovery are consistent with some of the concepts in the Care Model. The cross-walk demonstrates that some EBP components should be used with all populations (U.S. Preventive Services Task Force), while others are quite specific to a level of BH risk and complexity (SAMHSA). The Care Model is useful in all quadrants, because the Care Model integrates the concept of using a registry, tracking of health status, self-management goal setting, and intervention geared to the appropriate level, given the risk and complexity status of the individual.



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# Overarching Focus: System Coordination (Quadrants I, II, III, and IV)

## I. Principle

The current patchwork of BH systems, as well as separate BH and PC service delivery and financing streams require federal, state and local officials to develop new approaches to address the six goals of the New Freedom Commission:

1. Americans understand that mental health is essential to overall health.
2. Mental healthcare is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental healthcare is delivered and research is accelerated.
6. Technology is used to access mental healthcare and information.

Increased integration of behavioral health and healthcare services is a priority at the national, state, local and person levels. Good public policy will work to sustain, support and require integration of services between the two “safety net” systems of CHCs and SMHA providers with integration ranging from coordination of care to full integration of medical and behavioral services.

The healthcare issues faced by persons with SMI must be addressed as a part of these strategies—the aging of the SMI population and the impact of psychotropic medications are a “perfect storm” for which BH systems are unprepared.

## II. Research

The *President’s New Freedom Commission, Achieving the Promise: Transforming Mental Health Care in America* and the *Surgeon General’s Report on Mental Health* together have documented an environment with high rates of behavioral health disorders, low rates of detection, limited access to treatment, and barriers to the provision of appropriate and effective evidence-based treatments to culturally diverse populations.

## III. Discussion

Throughout the deliberations of the work group, coordination issues at the federal, state and local level were identified as major barriers to successful BH/PC integration for all populations.

The populations not served by SMHAs are being directed toward CHCs—the Health Disparities Collaboratives and resulting nationwide data make compelling arguments for CHCs as cost-effective providers. The implications for system-wide duplication and

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competition for the scarce resources of BH staff and funding are significant. The opportunity to better serve the entire “safety-net” population is well documented.

At the federal level, there is fragmentation and lack of coordinated knowledge transfer as BH/PC Integration initiatives expand. Many of the disconnections regarding financing begin at the federal level and require coordination and problem solving among federal agencies. Medicaid state plans also need to be updated to support integration practice changes.

The application of the Balanced Budget Act (BBA) rules in Medicaid managed care states (e.g., the repeal of the upper payment limit; review of encounter data for rate setting and disallowance of flexible services and prevention oriented expenditures; close examination of the state plan against the encounter data; and, questions regarding case management services) makes integration efforts more difficult to implement.

Federal and state categorical funding for specific target populations also make it difficult to adequately support BH services in primary care. A related issue is the state level regulatory and paperwork requirements that accompany most SMHA program efforts. Primary care based services require brief assessment, intervention and documentation. SMHA providers wanting to work with CHC partners are disadvantaged if they must complete lengthy assessments and paperwork in order to access SMHA funding for persons seen in a primary care setting. There is a concern that current federal and state policies make it impossible for SMHA providers to be responsive to community needs, creating an environment in which they may not be able to survive to serve the population of persons with SMI/SED.

At the local level there are opportunities for SMHA providers and CHCs to achieve alignment of interests and knowledge through coordination and sharing of competencies including: cross appointment to agency boards; sharing of BH billing expertise; SMHA provider acting as the Administrative Services Organization (ASO) for CHC in billing BH funding streams; and, recruitment, cross training and location of clinical staff.

A major federal and state system issue is workforce development specific to BH clinicians working in primary care settings. In addition to the familiar difficulties in recruiting due to location or non-competitive salary and benefit plans, leaders of successful programs report that it is difficult to find clinical staff with the skills and knowledge to be effective “bridgers” between the two systems; they also report that there are few candidates among their employees for whom additional training would result in effective performance.

It was suggested that it is better to send no one into a primary care setting than to send a BH clinician without the skills and orientation needed, and the question was raised as to whether CHCs have a standard job description and approach to the hiring, training and supervision of BH clinicians in their settings. CHCs and SMHA providers need to be prepared to jointly address the need for appropriately qualified staff and should work collaboratively to cross-train, share staff, work for curriculum change and develop

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training sites that produce the next generation of BH clinicians prepared to work in primary care.

**Competencies of BH Providers in Primary Care Settings**

Can be any licensed practitioner--training, orientation and skills are the key:

- **Finely honed clinical assessment skills (both MH and SA)**
- **Cognitive behavioral intervention skills**
- **Group and educational intervention skills**
- **Consultation skills**
- **Communication skills**
- **Psychopharmacology and Behavioral Medicine knowledge base**
- **Flexible, independent and action/urgency orientation**
- **Solution rather than process orientation**
- **Prevention orientation**
- **Team and collaboration orientation**
- **Clinical protocols and pathways orientation**
- **Focus on impacting functioning, not personality**
- **Experience with the SMI population and how the public BH system works**
- **Understanding of the impact of stigma**
- **Strong organizational and computer competency**
- **Bilingual and culturally competency in serving the major population groups seen in the primary care clinic**

*Freeman, Cherokee Health Systems*

*Wilson, Swope Health Services*

*Mauer, NCCBH Consulting Service/MCPP Healthcare Consulting*

## **IV. Recommendations**

Communication is the key to coordinating care for all populations. Future policy should acknowledge the importance of BH/PC integration and support the expectation of communication and coordination at the federal, state, local and person level.

### **A. State Mental Health Authorities**

The New Freedom Commission recommends the development of a comprehensive state plan across all mental health activities. The guidelines for the comprehensive state plan and waiver submissions should include a requirement to address primary care integration issues:

- For persons with SMI, how will health issues be identified and addressed by providers of mental health services?

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- For persons served in primary care, how is coordination achieved at both the system level and the person level, especially in regard to HRSA funded sites?

SMHA Directors, along with the Directors of Substance Abuse, Medicaid, and the Office of Primary Care/State Health Officer, should be convened into a State Integration Team that meets regularly to achieve the following (which can then be reported in the comprehensive state plan):

- Adopt and disseminate a model HIPAA-compliant release of information form to be used at entry into mental health, substance abuse or healthcare services funded by the state.
- Review the state Primary Care Strategic Plan prepared for HRSA regarding current and future distribution of CHCs.
- Review new CHC site and BH expansion applications to HRSA.
- Develop coordination of financing mechanisms and a shared interest in managing the pools of funding towards better outcomes. Develop differing strategies for financing Quadrant II and IV services (for the SMI population) versus Quadrant I and III services (for the primary care population).
- Adopt care management approaches that build on existing case management capacity in the BH system.
- Develop opportunities to bring together the state Primary Care Association with the state association of SMHA providers as well as bring together the CHC clinician networks (e.g., medical directors) with SMHA provider leadership.
- Assure that the state Medicaid Plan appropriately reflects all strategies developed.

## **B. Federal Level Activities**

The communication and coordination gap exists at all levels, but will require federal leadership to change the current “silo” environment and address cross-cutting issues. Recommendations include:

- SAMHSA should amend its matrix to add primary care integration to the areas of top focus for the organization. The Action Plan developed in response to the New Freedom Commission should clearly spell out integration initiatives and pledge the active participation of SAMHSA in multi-agency federal level initiatives that address BH/PC integration.
- SAMHSA and HRSA should work together on a site planning tool that intersects with other planning efforts and would be used in the Primary Care Association state strategic plans. This would include consideration of SMHA providers as new FQHC site applicants and provision of technical assistance to them in areas where development of an applicant organization is needed.
- HRSA’s Bureau of Health Professions and Bureau of Primary Health Care need to spell out a coordinated agenda in regard to workforce issues. HRSA and SAMHSA, along with the Department of Labor (DOL) should develop a master federal agenda in regard to meeting BH workforce needs, including the focused skills needed for

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effective BH/PC Integration. This initiative should build on and coordinate with the work of the Annapolis Coalition (with funding from SAMHSA and the Agency for Healthcare Research and Quality, the American College of Mental Health Administration and the Academic Behavioral Health Consortium have formed the Annapolis Coalition. The mission of the Coalition is to promote major reforms in the quality and relevance of education and training for behavioral healthcare<sup>xi</sup>).

- SAMHSA, HRSA and CMS should collaborate in policy and financing approaches to establish shared goals for BH/PC Integration and develop financing methods that support implementation of the Care Model in BH and PC settings.
- The National Associations (NASMHPD, NASADAD, NASMD, NACHC, and NCCBH) should develop a model Memorandum of Understanding for communication and coordination at the state and local level. Additional areas of collaborative activity include: approaches to serving the population with SMI and complex medical conditions (Quadrant IV), methods for staff sharing, and other implementation issues.

## **Population Focus: Serious Mental Illness/ Substance Abuse (Quadrants II and IV)**

### **I. Principle**

Physical healthcare is a core component of basic services to persons with serious mental illness. Ensuring access to preventive healthcare and ongoing integration and management of medical care is a primary responsibility and mission of mental health authorities. Promising models to meet this mission include:

- Case management coordination and facilitation of healthcare;
- Medical care management or disease management that targets persons with SMI;
- Provision of preventive healthcare screening and monitoring by SMHA providers; and,
- Integrated or consolidated SMHA provider / CHC services.

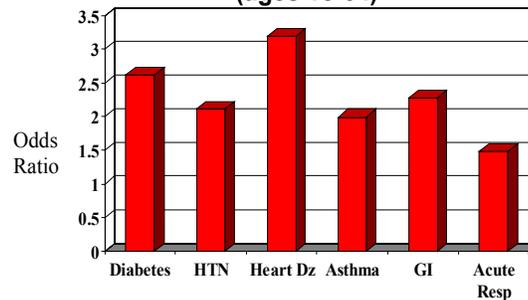
### **II. Research**

When persons with SMI are able to access general healthcare, they may find that their healthcare concerns are not taken seriously or treated appropriately. Compared to the body of research regarding depression in primary care, there are far fewer studies that look at the healthcare needs of the SMI population and models for improving their health outcomes. Available research tells us that:

- Men with schizophrenia live about 10 less years than those without schizophrenia. Women with schizophrenia live about 9 less years than those without schizophrenia.
- Persons with SMI have higher rates of medical co-morbidities than the general population.

- Older patients with psychotic disorders are especially vulnerable to poor quality of medical care.
- Poor quality of care may explain a substantial portion of excess mortality.
- Integrating medical and psychiatric care may provide a means of improving healthcare quality and clinical outcomes.<sup>xii</sup>

**Increased Medical Comorbidity in Psychotic Disorders Massachusetts Medicaid Study FY 98 (ages 18-64)**



All significant compared to non-psychosis groups  
Dickey et al. , 2002, Psychiatric Services

People who take some second generation antipsychotic (SGA) drugs may be at increased risk for obesity, diabetes and high cholesterol. A review panel recently concluded that “there is considerable evidence” that treatment with SGAs can lead to rapid weight gain. Studies also show an association between SGA use and the development of pre-diabetes, diabetes, and elevated blood lipid levels. The panel concluded that the SGAs differ in their risk profiles and recommended that doctors prescribing antipsychotic drugs first perform detailed baseline screenings.<sup>xiii</sup>

In a study of older adults with SMI, Druss examined the Medicare claims records of patients age 65 or older (N=88,341) who had been hospitalized for acute Myocardial Infarction (MI) and found that:

- Those with a psychiatric illness had a 19% greater 1-year mortality;
- Their post-MI treatment included 26% less reperfusion therapy (for those with schizophrenia, 52% less), 10% less B-blocker, 9% less aspirin therapy, 12% less Angiotensin treatment; and,
- After adjusting for differences in these quality indicators, there was no difference in 1-year mortality.<sup>xiv</sup>

Persons with SMI frequently have difficulty accessing health, dental and vision services and often rely on ERs for their care, which burdens the ER system, results in discontinuous care for the individuals, and may contribute to polypharmacy. Recent data analysis by Washington State on FY2002 ER usage by the Medicaid eligibility group of the Aged, Blind and Disabled (N=130,274) showed that persons with a MH, SA, or co-occurring disorder make up a substantial proportion of persons using ER services. As rates of ER utilization climb, so does the proportionate representation of those with a MH, SA, or co-occurring disorder.

A small group (N=198) is made up of persons who have had more than 31 visits, collectively accounting for over 9,000 ER visits. Within this group, 89% of the users with more than 31 visits have a MH, SA, or co-occurring diagnosis. This group as a whole had a high volume of pain medication prescribed—99% of those who visited the ER 31 times

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or more received prescriptions for narcotic analgesics, with an average of 42 prescriptions per person in FY2002 and an average cost of \$1,137 per person.<sup>xvi</sup>

A recent Missouri study of Medicaid recipients with a diagnosis of schizophrenia (N=19,700) served in CY2003 found that combined pharmacy and healthcare costs for the top 2000 of the total group exceeded \$100 million as compared to \$45 million for the bottom 10,000 in the group. This means that the average cost per recipient in the “Top 2000” was more than \$50,000, over ten times higher than the average cost per recipient in the Bottom 10,000. In further analysis comparing the characteristics of the Top 2000 with those of the Bottom 10,000, it was found that the Top 2000 tended to have:

- Lower medication adherence, as reflected by failure to refill prescriptions;
- Higher incidence of co-occurring chronic medical conditions, such as hypertension, diabetes, chronic congestive heart failure and coronary artery disease, chronic obstructive pulmonary disease (COPD), asthma and/or HIV;
- Higher incidence of co-occurring alcohol and other drug abuse problems;
- Lack of a stable “Medical Home”; and,
- More complex medication plans: i.e., more drugs taken and greater risk of drug-drug interactions and side effects across behavioral and physical medications.<sup>xvii</sup> By implication, this means these individuals are at greater risk for medication non-adherence and adverse health outcomes.

### **III. Discussion**

The work group focused on developing models and strategies to address the clinical and systems issues outlined in the research summary.

There are promising practices that have been or are currently being researched that focus on persons with SMI and their healthcare needs, including:

- Primary care as provider of psychiatric services;
- Psychiatrists trained to treat basic medical problems;
- Dually-boarded psychiatry and family/internal medicine;
- Case manager linking mental health and medical systems;
- Nurse healthcare management and health skills training; and,
- Medical providers integrated into a SMHA provider organization.

Additional ideas for building relationships between BH providers and PCPs to support better healthcare for persons with SMI include:

- Study ongoing integrated care demonstrations being employed within the VA, including integrated approaches being used in Mental Health Clinics (Quadrant II), and team-based approaches such as the Primary Ambulatory Care and Education (PACE) model at the Sepulveda VA Medical Center (Quadrant IV);

- Develop Behavioral Medicine fellowships for Family Medicine and Internal Medicine practitioners;
- Enhance Medicaid disease management programs by using BH case managers and nurses already “on the ground” as a part of the disease/care management process;
- Use consumer groups as a venue for health and self-management education;
- Use technology to improve communication and data-sharing;
- Route utilization data regarding ER utilization, polypharmacy, healthcare utilization to SMHA providers, so they can be informed and work collaboratively with the PCPs; and,
- Use case managers to provide training and materials for persons with SMI regarding how to effectively interact with the healthcare system.

**Nurse Healthcare Management and Health Skills Training for Elderly with Severe Mental Illness**

**Integrated Model**

- **Nurse Health Care Case Manager: monitoring, facilitation, and coordination of primary/preventive healthcare.**
- **Health education and illness-management skills training**

**Pilot Study Results**

- **Increased rates of preventive healthcare, eye care, and dental care**
- **Newly detected medical problems in 1/3 of sample: gall bladder disease, hypothyroidism, ischemic heart disease, cellulitis, esophageal web**
- **Improved illness self-management skills**

*Bartels SJ et al*

HRSA and SAMHSA must work together to develop strategies for addressing the health disparities of the SMI population. CHCs are particularly concerned about the needs of the population in Quadrant IV and how to manage the complexity of their healthcare and behavioral health needs. Integration at all levels of care will be necessary to address the healthcare needs of populations in Quadrant II and Quadrant IV and to support PCPs in appropriately serving these populations.

## **IV. Recommendations**

### **A. State Mental Health Authorities**

SMHAs have the leadership role in building a culture of responsibility for assuring that comprehensive healthcare services are provided for all persons with SMI. Recommendations include:

- Develop a partnership between the SMHA and the State Medicaid Agency (SMA) regarding opportunities to better manage resources and assure the best clinical outcomes for the populations in Quadrants II and IV. Opportunities include: protocols for prescribing of second generation antipsychotic medications; a drug utilization review process that includes PCPs and SMHA psychiatrists; and, disease management and case management coordination.
- Develop a population-based plan for the healthcare needs of persons with SMI. This should include a set of preventive assessment standards (see USPSTF

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recommendations) and guidelines for healthcare monitoring (for example, ADA/APA protocols for diabetes monitoring).

### **Overview of Skills Training**

#### **Components**

- **Skills training classes (to learn skills)**
- **In vivo trips (to practice skills with support in community)**
- **Homework (to practice skills without assistance)**
- **Involvement of indigenous community supports (to prompt and reinforce skills in natural settings)**

#### **Curriculum: Skills Training Modules**

- **Leisure Time**
- **Effective Communication**
- **Handling Medications**
- **Living Independently in the Community**
- **Making and Keeping Friends**
- **Making a Visit to the Doctor**
- **Healthy Living**

*R01: The HOPES Study, Rehabilitation and Healthcare for Older Adults with SMI – under way*

- Assign the same SMHA priority to a stable primary care home as to stable housing and medication adherence. Medication adherence goals should include appropriate access and care monitoring related to non-psychiatric as well as psychiatric medications.
- Create an initial consent to treatment form that includes information sharing with primary care (see recommendation regarding a model release in the segment on System Coordination).
- Sponsor training for PCPs in treating persons with SMI for medical conditions, including recognition and appropriate treatment of presenting healthcare concerns.
- Support the creation of parallel service integration models for persons with developmental disabilities and pilot/research these models.

### **B. Delivery System Initiatives**

There will always be a need for specialty BH services. The SAMHSA specialty BH EBPs are frequently not office-based, but community-based; to assure fidelity, the EBP should be delivered by an individual with specific training, skills and knowledge.

- Adopt the Care Model for organizing and tracking BH services. Demonstrate the ability of SMHA providers to deliver BH outcomes comparable to

those being delivered by CHCs for healthcare concerns.

- Assure that assessment of healthcare status is an ongoing component of BH services and that there is a high level of communication between BH providers and PCPs.
- Develop models that assure a cooperative relationship between BH providers and PCPs, including care management when there is also a BH clinician within the PC setting. If both systems are using the Care Model, this coordination will be enhanced.
- Recognize that, for the population in Quadrant IV, the BH/PCP/specialist team is the true “medical home” that needs to be developed, based on person-centered and individualized planning and specifically identified responsibilities for each member of the team. The care plan has the goal of supporting the person to be as independent as possible by providing access to integrated healthcare with components that can be refused (the team needs to be grounded in a rights/recovery perspective and alert to the potential issue of coercion).

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- Clarify the role of local mental health authorities in provision of a crisis response system that is responsive to all components of the system, including the Quadrant IV population.
  - Educate case managers and treatment teams to facilitate access to healthcare services for all consumers of care. This might include the identification of a person as a champion and troubleshooter on healthcare access issues.
  - Assure that case management and psychosocial rehabilitation wellness planning incorporates health content as well as psychiatric content.
  - Support the use of BH case managers to accompany consumers to primary care visits, with the consent of the consumer, to assist in medical advocacy and incorporation of self-care recommendations into ongoing wellness planning. Others who might accompany consumers would be family or peers (with the caution that it is the consumer's voice that is heard, similar to cautions regarding translation services provided by family or peers).
  - Place BH outreach/engagement staff in primary care settings to identify persons with SMI who are not enrolled in services and work to engage them in appropriate specialty BH services.
  - Consider opportunities for SMHA provider and CHC co-location or merger.

## **Population Focus: Primary Care (Quadrants I and II)**

### **I. Principle**

Behavioral healthcare is a core component of essential services to persons seeking primary healthcare. Ensuring access to preventive, ongoing, and appropriate behavioral health service is a primary responsibility and mission of general healthcare providers. Promising and evidence-based models to meet this mission include:

- Co-located (or better yet, embedded) collaborative behavioral healthcare in primary care; and,
- Depression care management and stepped care.

### **II. Research**

There is a robust body of research regarding depression in primary care, where up to a third of patients are on depression medications. Among the five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) that account for 49% of total healthcare costs and 42% of illness-related lost wages, mood disorders rank third in healthcare costs, first in work loss costs and second in total costs.<sup>xviii</sup>

System change is needed to support the primary care provider and patient in treatment adherence. Effectiveness is a function of multiple efforts, as demonstrated below.

## Effectiveness Studies of Depression in Primary Care

|               | Tx Guidelines | Case ID/ Screening | Patient Ed | Physician Ed | Tracking Systems | Tx Coord. | MH Spec. | Effective |
|---------------|---------------|--------------------|------------|--------------|------------------|-----------|----------|-----------|
| Schulberg     | +             | +                  | +          | +            | +                | +         | ++++     | Yes       |
| Mynors-Wallis | +             | +                  | +          | +            | +                | +         | +++      | Yes       |
| Katon         | +             | +                  | +          | +            | +                | +         | ++       | Yes       |
| Katzelnick    | +             | +                  | +          | +            | +                | +         | ++       | Yes       |
| Rost          | +             | +                  | +          | +            | +                | +         | +/-      | Yes       |
| Hunkeler      | +             | +                  | +          | +            | +                | +         | +/-      | Yes       |
| Simon         | +             | +                  | +          | +            | +                | +         | -        | Yes       |
| Simon         | +             | +                  | +          | +            | +                | -         | -        | No        |
| Callahan      | +             | +                  | +          | +            | -                | -         | -        | No        |
| Goldberg      | +             | +                  | +          | -            | -                | -         | -        | No        |
| Dowrick       | +             | +                  | -          | -            | -                | -         | -        | No        |

from Simon

While treatment guidelines, screening, patient and provider education and tracking systems are all necessary, they are not sufficient. First and second generation studies show that:

- Lectures and/or distributing guidelines do not change behavior nor outcomes;
- Adding patient tracking with a care manager significantly improves outcomes; and,
- Including a MH specialist in an integrated treating or consulting role improves outcomes the most.

Third generation studies are building on these models to further refine the most effective approaches.<sup>xix</sup> The studies summarized below are the most notable in demonstrating conclusions regarding effectiveness.

### 3rd Generation Depression System Change Interventions

|                           | IMPACT                | RESPECT   | PRISMe                   | PROSPECT              |
|---------------------------|-----------------------|-----------|--------------------------|-----------------------|
| Change                    | Depression Specialist | TCM       | Integrated Mental health | Depression Specialist |
| Care Mgmt                 | On-site               | Off-site  | N/A                      | On-site               |
| Patient Education         | Yes                   | Yes       | Variable                 | Yes                   |
| Psychiatric supervision   | Face to face          | Telephone | N/A                      | Face to face          |
| Psychotherapy supervision | Telephone             | N/A       | N/A                      | Face to face          |
| Rx algorithm              | Yes                   | No        | No                       | Yes                   |

In the recently completed *PRISMe* study (N=2,022), with “the best referral process imaginable”, only 49% of the patients referred actually were engaged in

specialty BH services, compared to 71% in the integrated model. Findings include:

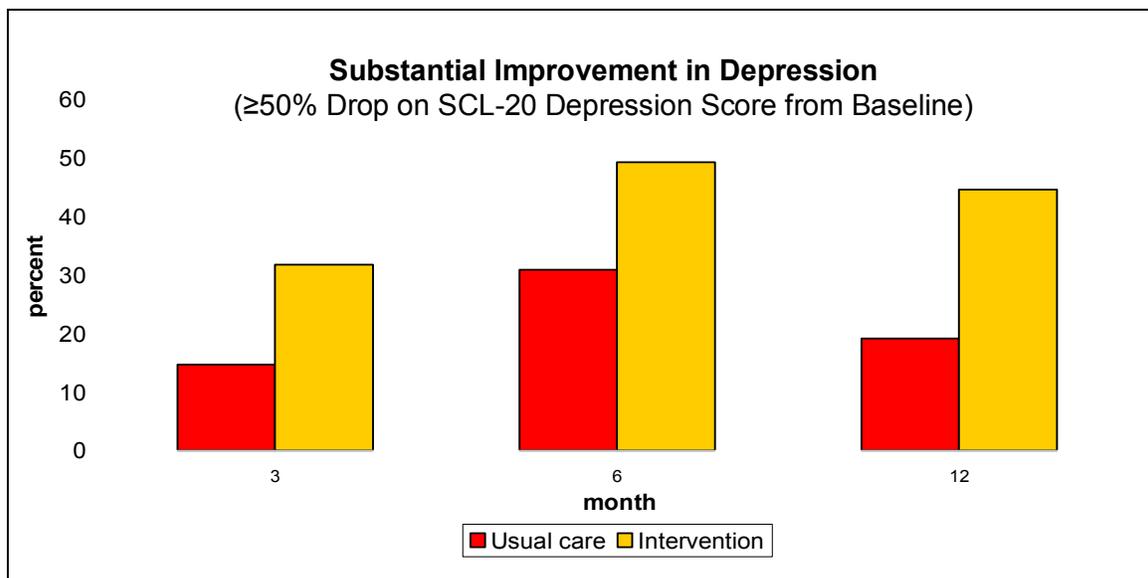
- Greater engagement in MH/SA services;
- Greater engagement for more severe symptoms and worse functioning;
- High engagement among suicidal elderly; and,

- Engagement demonstrated across different clinics and ethnicities.

Although the *PRISMe* primary care-based BH providers didn't have treatment algorithms, they achieved outcomes close to those achieved by specialty BH providers.<sup>xx</sup>

The *IMPACT* collaborative care model that achieved the results demonstrated below (N=1801) included:

- A care manager—Depression Clinical Specialist
  - Patient education
  - Symptom and side effect tracking
  - Brief/structured psycho-therapy (PST-PC)
- Consultation/weekly supervision meetings of care manager with:
  - Primary care physician
  - Team psychiatrist
- A stepped protocol using antidepressant medications and/or 6-8 sessions of psychotherapy (PST-PC).<sup>xxi</sup>



Unützer et al, JAMA 2002; 288:2836-2845.

Two additional national projects have been building on the research to develop further “spread” of the findings and link them to other components. *Depression in Primary Care: Linking Clinical and System Strategies* is a five-year, Robert Wood Johnson Foundation funded, national program with the goal of increasing the use of effective models for treating depression in primary care settings. The program was developed to address three issues:

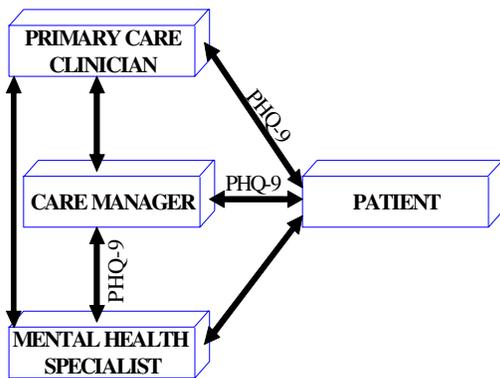
- Depression is a serious and prevalent chronic disease that should be conceptualized in a way that is parallel to other chronic conditions (e.g., asthma, diabetes, etc.).

- Longitudinal chronic illness care approaches to depression treatment are effective, but not currently implemented by health systems and practitioners.
- Putting these approaches into place requires a combination of clinical and economic systems strategies at multiple levels, engaging patients/consumers, providers, practices, plans, and purchasers.

The National Program Office for *Depression in Primary Care* has developed a clinical framework for all partnering organizations to follow. This framework, or Flexible Blueprint, is based on the Care Model described in an earlier section of this paper.<sup>xxii</sup>

The *MacArthur Initiative on Depression and Primary Care* focus is to improve care and outcomes nationwide for patients with depressive disorders treated in PC practices.

### MacArthur Initiative Three-Component Model (TCM)



### MacArthur Initiative Process of Care

#### 1. Recognition And Diagnosis

- Red flags of depression
- Two question screen recommended by USPSTF: Over the past 2 weeks, have you:
  - Felt little interest or pleasure in doing things?
  - Felt down, depressed, or hopeless?

- PHQ-9 administration and interpretation
- Suicide risk

#### 2. Treatment Selection

- Present treatment options
- Elicit patient preference

#### 3. Initial Treatment

- Provide key educational messages
- Set self-management goal
- Explain, recommend, initiate care management

#### 4. Care Management Process

- Treatment initiation adherence
- Treatment monitoring with PHQ-9

#### 5. Acute Phase Follow-Up

- Clinician visit coordinated with care management contact
- Modify treatment when sub-optimal response

#### 6. Continuation & Maintenance Phase

- Continue treatment after remission<sup>xxiii</sup>

### PHQ - 9 Symptom Checklist

|  | Not at all<br>0          | Several<br>days<br>1                | More than<br>half the<br>days<br>2  | Nearly<br>every<br>day<br>3         |                                     |                     |                          |
|--|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|---------------------|--------------------------|
| 1. Over the last two weeks have you been bothered by the following problems?   |                          |                                     |                                     |                                     |                                     |                     |                          |
| a. Little interest or pleasure in doing things   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |                                     |                     |                          |
| b. Feeling down, depressed, or hopeless  | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |                                     |                     |                          |
| c. Trouble falling or staying asleep, or sleeping too much   | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                                     |                     |                          |
| d. Feeling tired or having little energy   | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |                                     |                     |                          |
| e. Poor appetite or overeating   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |                                     |                     |                          |
| f. Feeling bad about yourself, or that you are a failure . . .   | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |                                     |                     |                          |
| g. Trouble concentrating on things, such as reading . . .  | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |                                     |                     |                          |
| h. Moving or speaking so slowly . . .  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |                                     |                     |                          |
| i. Thoughts that you would be better off dead . . .  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |                                     |                     |                          |
| 2. ... how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? |                          |                                     |                                     |                                     |                                     |                     |                          |
| Not difficult at all   | <input type="checkbox"/> | Somewhat Difficult                  | <input type="checkbox"/>            | Very Difficult                      | <input checked="" type="checkbox"/> | Extremely Difficult | <input type="checkbox"/> |
| Subtotals:   |                          |                                     |                                     |                                     |                                     |                     |                          |
| TOTAL:   |                          |                                     |                                     |                                     |                                     |                     |                          |

The MacArthur Three Component Model demonstrates the relationship between the PCP, the care manager and the specialty BH provider and how care monitoring becomes an

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essential element for reviewing and revising care to achieve remission (often referred to as “stepped” care).

Cost-effective care is delivered when “...clients use less medical care if they are able to get mental health services. When this happens, the decrease in cost of medical care may be greater than the cost associated with use of mental health services. The net savings generated are referred to as ‘cost offsets’. This means that savings generated in medical care offset the costs of mental healthcare.”<sup>xxiv</sup> The pursuit of medical cost offsets has been one of the drivers of financial integration.

The first large scale BH/primary care integration models and research developed within staff model HMOs such as Kaiser, Health Partners and Group Health—the financing stream is integrated, although internal negotiations are necessary to establish the resource base for BH services. In these settings, BH clinicians may be located in primary care or specialty services (e.g., Pain Clinic) as well as in specialty BH programs, and any medical cost offsets from investments in BH are accrued at the organizational level.

One of the findings from recent national projects is that medical cost offsets may be documented in the research environment, but it is difficult to identify them in real world settings. A presentation for the *Depression in Primary Care: Linking Clinical and System Strategies* sites on making the business case for quality improvement of depression care included the following points:

- Improved primary care depression interventions do not appear to further reduce health plans’ overall costs;
- Better detection and treatment is likely to generate higher costs by expanding the size of the treated population;
- Time horizon matters (e.g., how much time elapses between the investment and the return); and,
- Quality investments by one stakeholder can accrue to another stakeholder.<sup>xxvi</sup>

**Costs Associated With Collaborative Models**

- **More appropriate use of services, indicators of quality improve**
- **Relatively more cost-effective, but no reduction or slight increase in healthcare costs**
- **Identification of new or under treated cases in shift from case-based to population-based identification**
- **Need to add care managers and BH clinicians—how do we pay for this?**

*Dobscha, Portland Veteran’s Administration*

Analysis of data on Medicaid enrollees in Washington and Colorado suggests a hypothesis that requires further research. It may be that funding for BH services to the Quadrant I and III populations is not in the “base/capitation” of either the SMHA or the SMA/Medicaid health plans. Mental health services have not historically been delivered to the Medicaid Quadrant I and III populations. Yet, based on the data regarding prevalence of BH diagnoses in the Medicaid population as well as the impact of providing BH services on Medicaid healthcare costs, significant medical cost offsets may

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be found in the Medicaid population, which would warrant the investment in expanded BH service capacity.

Washington State plans to propose a budget with SA treatment on demand for the Medicaid population, based on its research that demonstrates medical cost offsets when SA services are provided. The two-year-old program “showed that early, effective treatment of drug and alcohol problems not only paid dividends in medical spending but in public safety...What we found was that funding was one of the major barriers for treatment—in effect, DASA’s funding has allowed it to serve only a quarter of those in need of—and eligible for—DASA services.”<sup>xxvii</sup>

### **III. Discussion**

There is an exciting opportunity to implement this research on the impact of delivering BH services in primary care and achieving improved BH status for the broader population. Acknowledging this, the work group discussion, however, focused on the policy issues that need attention.

There are tensions between the two “safety net” systems. Some CHCs report lack of timely access to SMHA services (often in regard to psychiatry) for CHC referrals. SMHA providers are unhappy with the infusion of new BH resources into CHCs, when the SMHA system has been starved for resources. There are differing financing mechanisms, cultures, communication styles, and confidentiality rules. (See Attachment C.)

CHCs have a special relationship with Medicaid. In fee-for-service states, CHCs are paid a differential rate for services; in managed care states, they are paid a prospective payment intended to address costs above payments made by managed care plans. While not fully cost reimbursement, it is a more generous payment system than that for SMHA providers.

In October 2003, HRSA issued Program Information Notice (PIN) 2004-05 regarding Medicaid Reimbursement for Behavioral Health Services, stating that SMAs “are required to reimburse FQHCs...for behavioral health services provided by those practitioners...whether or not those services are included in the State Medicaid plan”. (See Attachment B for an overview of CHCs, payment differences and more information about HRSA PIN 2004-05.)

It is well recognized that the use of current behavioral codes may be problematic in documenting care delivered to patients with primary medical illnesses, who may have behavioral complaints related solely to their medical illness. New Health and Behavior Assessment and Intervention CPT Codes 96150-96155 were adopted by Medicare over two years ago in order to address this issue. These codes are intended for use by certain healthcare providers (not solely a CHC provider) when BH services are provided in relationship to a physical (not behavioral) diagnosis; the codes would support some Quadrant I and III work, if adopted by payors. For physicians, it may be preferable to utilize an E & M code for care delivered to these patients as it more appropriately describes the type of care delivered. To date, SMAs and commercial plans have been

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slow to adopt and pay for these new codes. (See Attachment B for a specific listing of the new CPT codes.)

Taken together, however, the HRSA and CMS actions speak to federal support for the delivery of BH services in a primary care setting. Given the role of Medicaid in funding “safety net” services, the financing of BH services in CHCs is a point of tension that must be addressed state by state. From the perspective of the SMAs, given the reductions already taken in Medicaid programs, an increase in payments to CHCs means a reduction somewhere else in the Medicaid budget.

The SMHA director will be wondering where the money is going to come from to finance an expanded mission. SMHA providers are concerned that funding for serving the primary care population will come from capitation/programs serving the SMI population. Some believe that it is necessary for SMHAs to re-engage with the needs of the broader population—as services have been targeted to the SMI population, SMHA programs have been increasingly marginalized and lack the broad support needed to survive in the current environment. Many SMHA providers serve a broader population than the SMHA funded SMI population, working to leverage funding from other sources—a broader population base served means a broader political base in support of MH services. Providing BH services in primary care is also a strategy to improve the health seeking behaviors of senior and culturally diverse populations in the communities served by SMHA providers.

Working jointly with primary care providers offers the opportunity to broaden the mission of SMHAs and SMHA providers and address the needs of those who have been unable to access BH services in the past.

Among the successful models are organizations that are both CHCs and SMHA providers—their successes demonstrate that if “turf” issues are not in play, integration implementation can focus on finding the right clinical staff, applying the research, building the relationships and improving outcomes for consumers. Ongoing integrated care demonstrations are also being employed within the VA system, including promising on-site primary care-based programs for the Quadrant I and III populations.

| <b><u>Basic Operational Checklist for BH/PC Integration Programs</u></b> |                                      |
|--|--------------------------------------|
| • <b>Staff orientation</b>   | • <b>Relationship building</b>       |
| • <b>Steering group oversight</b>  | • <b>Outcomes monitoring</b>         |
| • <b>Clarify roles and responsibilities</b>                              | • <b>Policy development</b>          |
| • <b>Design and decisions using data</b>                                 | • <b>Fiscal and reporting issues</b> |
| • <b>Communication planning</b>  | • <b>Payor issues</b>                |
| • <b>Patient education tools</b>   | • <b>Consultative support</b>        |
| • <b>Physician leadership</b>  |                                      |

*Wilson, Swope Health Services*

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Financing mechanisms are still a challenge, however, even for organizations reimbursed through global payment methods. Issues include:

- Is BH consultation in a PC setting a medical or MH service? (Proponents of embedded BH consultants in PC settings believe this should be defined as a medical service.)
- How do PCPs get reimbursed for visits when a DSM diagnosis is detected and coded?
- Why is there a prohibition on same day services from a PCP and a BH provider? (Some state Medicaid programs will not process a claim for BH service provided on the same day as primary care service within the same provider organization, which undermines the concept of a “warm hand-off” from the PCP to the BH provider.)
- How will the system resolve issues of BH program licensure, documentation and data submission, clinician licensure, credentialing and supervision for BH services provided in primary care settings?
- Which entity (Health Plan or BH Plan) bears financial responsibility when BH is carved out?

## **IV. Recommendations**

The Council recognizes that a focus on Quadrants I and III will be dependent on the context and system development in each state. While the recommendations in the other two focus segments (System Coordination, Serious Mental Illness) are intended for all SMHAs, this segment is intended for use by SMHAs that are additionally planning for the population served in primary care.

### **A. State Mental Health Authorities**

SMHAs have a leadership role in building a culture that moves beyond the historical barriers in both the SMHA system and CHC system. Recommendations include:

- Use the State Team and State Plan recommended in the section on System Coordination as the venue for creating a state level framework to provide guidance for local partnerships. (See References for the Oregon example.)
- Develop approaches in which some financing comes from the SMHA and some from the healthcare system (see Attachment C: Multnomah/Care Oregon diagram).
- Develop a response to HRSA PIN 2004-05 that explores the funding options from both budget streams, assuming sufficient evidence of cost effectiveness is established (see Attachment B for more detail on PIN 2004-05).
- Work with the Medicaid agency to implement and utilize appropriate CPT codes for provision of services (e.g., adoption of the 96150-96155 CPT codes [see Attachment B] or use of E&M codes as appropriate) and describe the clinical professional status and skill sets required for billing.
- Assure that the models adopted for reimbursement are consistent with the research base (e.g., algorithms, registry tracking, collaborative, and stepped care).

- Supply PCPs with materials already developed for BH consumer education and self-management, as well as for staff training and professional development.

**B. Delivery System Initiatives**

SMHA providers and CHCs working together to meet the needs of the “safety net” populations will need to:

- Clarify the mission and roles between the organizations and develop specific transfer of care protocols.
- Explore opportunities to “rent” or place SMHA provider staff in CHCs (See Attachment C) and explore the use of non-BH trained personnel for specific support functions (e.g., registry input) and language and culturally specific outreach.

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| <p style="text-align: center;"><b><u>BH Consultant: Clinical Interventions and Goals</u></b></p> <ul style="list-style-type: none"> <li>• <b>Improve patient adherence</b></li> <li>• <b>Support patient self-management</b></li> <li>• <b>Agent of behavioral change</b></li> <li>• <b>Decrease over or under utilization</b></li> <li>• <b>Reduce health-risk behaviors and increase health-enhancing behaviors</b></li> <li>• <b>Monitor and improve population outcomes</b></li> <li>• <b>Provide consultation and training to the PC team</b></li> </ul> <p style="text-align: right;"><i>Freeman, Cherokee Health Systems</i></p> |
|---|

- Consider shifting more psychiatry into CHCs, while case management and the SMI evidence-based BH services remain in SMHA provider agencies. Placement of psychiatrists in CHCs will not by itself fulfill the role of BH consultants as part of a PC team (see box above). Psychiatry services would include PCP training, telephone consultation (ideally available nights and weekends, not restricted to medications), and consultations with referred patients. (Note that some states are addressing the telephone consultation capacity through academic medical centers.)

The Council is aware that considerable work is necessary to heal the long-standing “mind-body split”. We hope that this report and its recommendations provide support and direction for those working on the healing process.

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# Footnotes

- <sup>i</sup> Druss, Rohrbaugh, Levinson, Rosenheck, *Integrated medical care for patients with serious psychiatric illness*; Archives of General Psychiatry, 58:9; September 2001; pp 861-868
- <sup>ii</sup> *Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes*; American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity, Diabetes Care; 27:2, February 2004
- <sup>iii</sup> Ford, D. M.D.,M.P.H., *Decision Support/Depression*. Power Point presentation to HRSA Health Disparities Collaboratives National Congress, September 2004. Based upon materials from Cole et al and Egener et al.
- <sup>iv</sup> Bartels, S. M.D., M.S, *Integrating Mental Health In Primary Care: An Overview of the Research Literature* PowerPoint presentation to NASMHPD Technical Report: Behavioral Health/Primary Care Integration—Guidance for Public Sector Implementation Work Group, June 2004
- <sup>v</sup> Minkoff, K. Dual diagnosis: an integrated model for the treatment of people with co-occurring psychiatric and substance disorders in managed care systems. Presented to National Council for Community Behavioral Healthcare conference, March 2002.
- <sup>vi</sup> The NCCBH model builds on the 1998 consensus document for mental health (MH) and substance abuse/addiction (SA) service integration, as developed by state mental health and substance abuse directors (NASMHPD / NASADAD). <http://www.nccbh.org/>
- <sup>vii</sup> Improving Chronic Care website: [www.improvingchroniccare.org/change/index.html](http://www.improvingchroniccare.org/change/index.html)
- <sup>viii</sup> *Behavioral Health / Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices*, NCCBH, Winter, 2004
- <sup>ix</sup> <http://www.mentalhealthpractices.org/>
- <sup>x</sup> <http://www.mentalhealthpractices.org/>
- <sup>xi</sup> <http://www.acmha.org>
- <sup>xii</sup> Bartels, S. M.D., M.S *Integrating Psychiatric and Medical Care for Persons with SMI*, PowerPoint presentation to NASMHPD Technical Report: Behavioral Health/Primary Care Integration—Guidance for Public Sector Implementation Work Group, June 2004
- <sup>xiii</sup> *Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes*; American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity, Diabetes Care; 27:2, February 2004
- <sup>xiv</sup> Druss, Rohrbaugh, Levinson, Rosenheck, *Integrated medical care for patients with serious psychiatric illness*; Archives of General Psychiatry, 58:9; September 2001; pp 861-868
- <sup>xv</sup> Blank et al., *Psychiatric Services*, in press
- <sup>xvi</sup> Mancuso, Nordlund and Felver, *Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness*; Washington State Department of Social and Health Services; April 2004
- <sup>xvii</sup> *The Comprehensive Neuroscience Medication Risk Management Program*; presentation to the State of Missouri, April 27, 2004
- <sup>xviii</sup> Bartels, S. M.D., M.S, *Integrating Mental Health In Primary Care: An Overview of the Research Literature* PowerPoint presentation to NASMHPD Technical Report: Behavioral Health/Primary Care Integration—Guidance for Public Sector Implementation Work Group, June 2004
- <sup>xix</sup> Bartels, S. M.D., M.S, *Integrating Mental Health In Primary Care: An Overview of the Research Literature* PowerPoint presentation to NASMHPD Technical Report: Behavioral Health/Primary Care Integration—Guidance for Public Sector Implementation Work Group, June 2004
- <sup>xx</sup> *ibid*
- <sup>xxi</sup> Project Impact, website [www.impact.ucla.edu/summary.html](http://www.impact.ucla.edu/summary.html)
- <sup>xxii</sup> *Depression in Primary Care: Linking Clinical and System*, website [www.wpic.pitt.edu/dppc](http://www.wpic.pitt.edu/dppc)
- <sup>xxiii</sup> MacArthur Initiative on Depression and Primary , website [www.depression-primarycare.org](http://www.depression-primarycare.org)

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<sup>xxiv</sup> Anderson N, Estee, S. *Medical Cost Offsets Associated with Mental Health Care: A Brief Review*. DSHS. December 2002

<sup>xxv</sup> Anderson N, Estee, S. *Medical Cost Offsets Associated with Mental Health Care: A Brief Review*. DSHS. December 2002

<sup>xxvi</sup> Barry, C. et al. Presentation to Annual Meeting: Depression in Primary Care. October 2003.

<sup>xxvii</sup> *Cost Savings in Medicaid Medical Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State*; Washington State Department of Social and Health Services; June 1997

<sup>xxviii</sup> *Cost Savings in Medicaid Medical Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State*; Washington State Department of Social and Health Services; June 1997

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# Attachments

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## A. List of Meeting Participants

### MEDICAL DIRECTORS

**David Pollack, M.D.** (Technical Report Editor)  
Medical Director  
Office of Mental Health & Addiction Services  
Department of Human Services  
500 Summer St NE., E-86  
Salem, OR 97301-1118

**Joe Parks, M.D.** (Technical Report Editor)  
Medical Director  
Department of Mental Health  
1706 East Elm Street, P.O. Box 687  
Jefferson City, MO 65102

**Kenneth Marcus, M.D.**  
Medical Director  
Department of Mental Health & Addiction Services  
410 Capitol Avenue, Mail Stop #14 Comm  
P.O. Box 341431  
Hartford, CT 06134

**Stephen J. Bartels, M.D.**  
Medical Director  
Division of Behavioral Health  
Department of Health & Human Services  
State Office Park South  
105 Pleasant Street  
Concord, NH 03301

### COMMISSIONER

**Brian Hepburn, M.D.**  
Director  
Mental Hygiene Administration  
Department of Health & Mental Hygiene  
Spring Grove Hospital Center  
55 Wade Avenue, Dix Building  
Catonsville, MD 21228

### NASMD REPRESENTATIVE

**Doug Porter**  
Assistant Secretary  
Medical Assistance Administration  
Department of Social & Health Services  
P.O. Box 45500  
Olympia, WA 98504-5500

### NAC/SMHA REPRESENTATIVE

**John Allen**  
Director  
Bureau of Recipient Affairs  
Office of Mental Health  
44 Holland Avenue, 8<sup>th</sup> Floor  
Albany, NY 12229

### EXPERT FACULTY

**Dennis Freeman, Ph.D.**  
Chief Executive Officer  
Cherokee Health Systems  
6350 W. Andrew Johnson Parkway  
Talbott, TN 37877

**Susan Wilson, Ph.D.**  
Vice President, Behavioral Health  
Swope Health Services  
3801 Blue Parkway  
Kansas City, MO 64130

**Mark Spofford, Ph.D.**  
Behavior Assessment and Change Manager  
Kaiser Center for Health Research  
3800 Interstate Avenue  
Portland, OR 97227-1110

**Tom Curtin, M.D.**  
Associate Vice President for Clinical Affairs  
National Association for Community Health  
Centers, Inc.  
7200 Wisconsin Avenue, Suite 210  
Bethesda, MD 20814

**Steven Dobscha, M.D.**  
Staff Psychiatrist  
Assistant Professor of Psychiatry  
Department of Veterans Affairs  
Oregon Health Sciences University  
P.O. Box 1034 (P71DMH)  
Portland, OR 97207

**Joel Young**  
Program Manager for Health Systems Planning  
Department of Human Services  
800 NE Oregon Street, Suite 930  
Portland, OR 97232

**TECHNICAL WRITER / FACILITATOR**

**Barbara J. Mauer, MSW CMC**  
NCCBH Consulting Service  
MCPH Healthcare Consulting  
414 Olive Way, Suite 207  
Seattle, WA 98101

**NASMHPD STAFF**

66 Canal Center Plaza, Suite 302  
Alexandria, VA 22314  
Ph: (703) 739-9333  
Fax: (703) 548-9517

**Robert W. Glover, Ph.D.** x129  
Executive Director

**Roy E. Praschil** x120  
Director of Operations

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## **B. An Overview of Community Health Centers**

### **How Did CHCs Get Started?**

- They were established in the 1960s as a part of the War on Poverty and unlike Community Mental Health Centers, have retained their status as a direct federal program
- They focus on those with little, or no ability to pay for medical care
- CHCs have grown in number, size, and complexity of services, but remain responsive and effective community service programs

### **How are CHCs Organized?**

- The National Association of Community Health Centers (NACHC) is a national membership organization, parallel to National Council for Community Behavioral Healthcare (NCCBH)
- There is a nationwide network of safety-net providers supported by federal grants under the U.S. Public Health Service Act (PHSA) – referred to as 330-funded grantees. Specifically, they include:
  - Community Health Centers
  - Migrant Health Centers
  - Health Care for the Homeless Programs
  - Public Housing Primary Care Programs
  - School Based Health Centers
- There are state and regional Primary Care Associations that receive HRSA support to provide training, technical assistance and planning support to CHCs

### **What is an FQHC?**

- A Federally Qualified Health Center, which is also known as a Health Center and/or 330-funded grantee
- There are FQHC Medicaid and Medicare services and reimbursement provisions in federal law
- National and state associations use FQHC when speaking with lawmakers and regulatory agencies, otherwise use the term Health Centers
- A FQHC Look-Alike is designated by HHS and receives FQHC payments, but does not receive 330-grant funds

### **How Many CHCs are There and Whom do they Serve?**

- In the early 1970s, there were 140 CHCs serving 1.4 million people
- As of March 2004 , there were over 1000 CHCs, serving 15 million people
- By 2006, HRSA projects an additional 1,200 sites and double the people served

- 
- They serve over 5 million people with no insurance (38.9% of the population served)
  - The low-income population is a target population
    - At or below 100% of poverty, 67.2%
    - At or below 200% of poverty, 88.4%
  - CHCs care for:
    - 1 in 5 low income children
    - 1 in 9 rural residents
    - 1 in 9 Medicaid beneficiaries
    - 1 in 7 minorities
    - Over 700,000 farm workers
    - Over 600,000 homeless persons

### **What Services Do CHCs Provide?**

- Primary health, pediatrics, gynecology, geriatrics
- Dental, behavioral health
- Prevention: smoking, diet, high risk lifestyle diseases
- Staffing (2002) includes:
  - Over 25,000 FTE Medical Care Services staff who delivered >34 million visits
  - 3,900 FTE Dental Services staff who delivered 3.8 million visits
  - 1,800 FTE Mental Health and Substance Abuse staff who delivered 2 million visits

### **How are CHCs Funded?**

- 20-30% Federal Grant Support: Ongoing funding to serve the uninsured although these grants have not changed over time as the uninsured population has grown
- 25-40% Patient Revenues: This includes patient fees, Medicaid reimbursement (in 2002, 34.7% of revenues nationwide), and other public and private insurance reimbursement
- 30-40% Local Support: This includes grants, in-kind support
- For every \$1 in new federal funding, CHCs are expected to leverage \$4 in state and local funding (including Medicaid, SCHIP, foundations, local support, patient copays, other grants, etc)

### **What are the Requirements to Become a CHC?**

- Located in high-need areas: CHCs are located in inner cities, rural areas, and migrant and seasonal farm worker communities. The community must have a MUA or MUP designation

- 
- Provide high quality, comprehensive primary care: CHCs are “one-stop” shops and provide a medical home for the patients in their communities. CHCs must continually evaluate the health status of the community and provide services accordingly. CHCs also must have a quality assurance program implemented and the program must be updated annually to respond to community needs
  - Governed by community boards: At least 51% of the CHC board must be comprised of patients who utilize the Health Center’s services. This is considered one of the great strengths of the CHC model
  - Serve patients regardless of their ability to pay: While CHC services are not free, patients who are not covered by private or public insurance are charged on a sliding fee scale according to their income

### **What Are the Benefits of Becoming a CHC?**

- Grants: Access to Federal grants to support the costs of otherwise uncompensated comprehensive primary healthcare and “enabling services” delivered to uninsured and underinsured populations at sites within the approved scope of project. FQHC look-alikes are eligible to apply for new start Section 330 grants when funding is available
- Medicaid Reimbursement: Access to enhanced Medicaid reimbursement per Federal law, even if the FQHC is a subcontractor to a managed care plan
- Medicare Reimbursement: Reimbursement by Medicare for the “first dollar” of services rendered to Medicare beneficiaries (e.g., deductible is waived)
- Capital Improvements: (Potential) Access to grant support and loan guarantees for capital improvements
- Drug Pricing: Access to favorable drug pricing under Section 340B of the PHS Act. FQHCs that provide, or contract for the provision of, pharmaceuticals are entitled to favorable pricing from the drug manufacturers
- Practice Innovations: The opportunity to participate in BPHC disease management learning models
- Enrollment Workers: The right to have Medicaid eligibility workers on site, or receive reimbursement for out stationed Medicaid activities (intake and enrollment functions) conducted by Health Center personnel. Arrangements for reimbursement are on a state by state basis
- FTCA Coverage: Access to Federal Tort Claims Act (FTCA) coverage for the Section 330-supported health center and its healthcare professionals, including certain contracted professionals
- Recruitment: Access to providers through the National Health Service Corps if the Health Center’s service area is designated as a health professional shortage area

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### **Why are CHCs Involved in Behavioral Health?**

- 10% of all Health Centers patients have a primary or secondary diagnosis of drug or alcohol dependence, or severe mental health disorder (anecdotally this number is much higher, up to 50%)
- According to Health Center Medical Directors the most common mental health problems seen in Health Center patients are depression and anxiety
- HRSA's goal is to eliminate disparities of underserved patients with primary mental health and substance abuse disorders
- As of 2003, over 250 HRSA BH expansion grants were awarded; these are for up to \$150,00 a year
- HRSA is also awarding grants for up to \$650,000 a year for new access points (primary care delivery sites). These new sites must include oral health, mental health and substance abuse services as well as primary care
- The HRSA target for 2006 is that 75% of CHCs will provide MH services and 49% will provide SA services. HRSA's consultant on integration estimates that in a typical primary care practice, BH staffing should be 2-4 hours weekly for every 1000 primary care patients
- Applicant CHCs must describe their proposed delivery approach. Those intending to deliver these services through an agreement with a public mental health or substance abuse service provider must submit a signed contract or letter of agreement as part of the application
- New BH sites will be required to participate in the IHI/HRSA Health Disparities Collaboratives. Behavioral healthcare providers who want to partner with CHCs should become familiar with the key components of the Depression Collaborative and the associated outcome reporting requirements

### **How are CHCs Reimbursed for BH Services?**

- CHCs have a special relationship with Medicaid. In fee-for-service states, they are paid a differential rate for services; in managed care states, they are paid a prospective payment intended to address costs above payments made by managed care plans. While not fully cost reimbursement, it is a more generous payment system. For example, in one state, when a psychiatrist sees a patient at a university clinic (psychiatric medication service 90862) the clinic is reimbursed \$12.50 via fee-for-service (FFS) Medicaid; the same visit at a community mental health center would be reimbursed \$39.92; at the CHC, that visit with a psychiatrist would be reimbursed at \$80-88 (variable due to quarterly recalculated cost basis).
- CHCs pursue payor reimbursement whenever possible, however, the various state structures and methods for Medicaid BH financing has led to considerable frustration. Half of the states are managed care states, where BH carve-outs have specific criteria, network arrangement and payment methods that are a barrier to CHC involvement
- At the end of October 2003, HRSA issued Program Information Notice (PIN) 2004-05 regarding Medicaid Reimbursement for Behavioral Health Services. PIN 2004-05

followed on a September letter from the Director of CMS. These documents were generated because some FQHCs and Rural Health Clinics had informed HRSA that they had “difficulty receiving reimbursement from State Medicaid Agencies for the provision of behavioral health services”

- The behavioral health services in question include those provided by a physician, physician assistant, nurse practitioner, clinical psychologist, or clinical social worker. The CMS letter and PIN 2004-05 state that Medicaid agencies “are required to reimburse FQHCs and RHCs for behavioral health services provided by those practitioners named above whether or not those services are included in the State Medicaid plan” and clarifies that “in order for FQHCs and RHCs to be reimbursed..., FQHC/RHC providers must be practicing within the scope of their practice under the state law”
- As of July 2004, few SMAs have acted to implement PIN 2004-05
- Some CHCs are pursuing adoption by SMAs of the Health and Behavior Assessment and Intervention CPT codes that have been adopted by Medicare

| CPT Code | Service Description  |
|----------|--|
| 96150    | Behavior assessment, clinical interview, behavior observations, psycho-physiological monitoring; face to face, 15 minute intervals |
| 96151    | Re-assessment  |
| 96152    | Behavior intervention; face to face, 15 minute intervals   |
| 96153    | Group intervention (2 or more patients)  |
| 96154    | Family intervention with patient present   |
| 96155    | Family intervention without patient present  |

## C. Relationships Among Safety Net Providers: Some Models

### Models for Renting versus Placing BH Staff in CHCs

|                      | In CHC as Primary Health  | In CHC as BH Practitioner (PIN 2004-05 option)   | As SMHA BH Practitioner Providing Services Located in CHC   |
|----------------------|---|--|---|
| <b>Diagnosis</b>     | Physical  | Psychiatric *  | Psychiatric *   |
| <b>Authority</b>     | PCP   | BH Practitioner  | BH Practitioner   |
| <b>Billing under</b> | PCP bundled services<br>99201-5, 11-15 series<br>99078 educational services- group<br>99401-4, 11-12 prevention interventions<br>0108 & 0109 for diabetes | MH benefit *<br>90804-29 series, individual<br>90853,57 group<br>90846-49 family<br>99150-5 codes as come on line<br><br>Or,<br>Health benefit<br>96000 series | MH benefit *<br>90804-29 series, individual<br>90853,57 group<br>90846-49 family<br>99150-5 codes as come on line |
| <b>Documentation</b> | In CHC medical chart  | In CHC medical chart   | CMHC records  |
| <b>Liability</b>     | CHC / BHP   | CHC / BHP  | CMHC / BHP  |
| <b>Payments to</b>   | CHC   | CHC  | CMHC  |

*Based on Bob Dyer, NCCBH 2003 Conference*

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## An Overview of Some Cultural Differences in Safety Net Organizations

| <b>CHC</b>          | <b>SMHA Provider</b>                    |
|---------------------|---|
| National System     | State Defined                           |
| Safety Net Provider | Medicaid Provider                       |
| Need-Based Services | Eligibility-Based Services              |
| Population-Focused  | Case-Focused                            |
| Prevention Oriented | Rehabilitation Oriented                 |
| Lifespan Care       | Episodic Care                           |
| Gatekeeper          | Specialty Service                       |
| Open Access         | Restricted Access                       |
| Flexible Scheduling | Rigid Scheduling                        |
| Treatment Team      | Solo Provider                           |
| Symptom Focus       | Personality Focus                       |
| Generalist          | Specialist                              |
| Governed by Users   | Governed by Community Leaders           |
|                     | <i>Freeman, Cherokee Health Systems</i> |

### A Range of Strategies for Providing BH in Primary Care

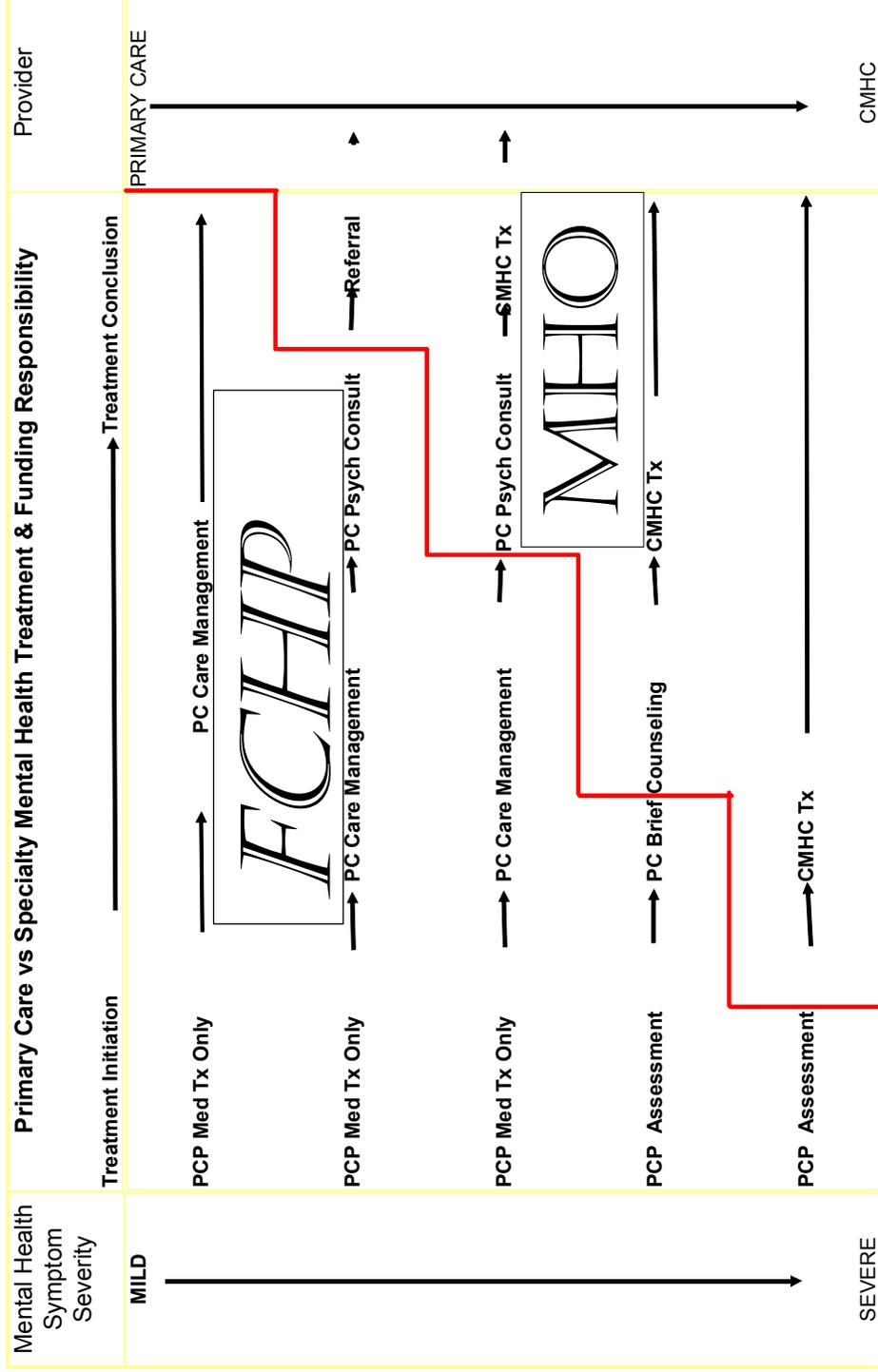
|   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. Preferential referral relationships</li> <li>2. Circuit riding</li> <li>3. Co-location</li> <li>4. Collaboration</li> <li>5. Integrated team</li> </ol> | <i>Freeman, Cherokee Health Systems</i> |
|---|---|

### Recommendations for Planning Between PC and BH Entities

|  |  |
|--|--|
| <ol style="list-style-type: none"> <li>1. Complete an environmental scan of the resources and capacity of behavioral health services and their local/federal regulatory context</li> <li>2. Assess primary care needs for primary care based behavioral health, including definition of who should be served, at what level of services, through what pathway of care</li> <li>3. Develop systemic understanding and support from administrative and clinical leadership</li> <li>4. Determine whether the primary care based behavioral health clinicians should be employed by primary care or contracted from the behavioral health provider, and what level of staffing is required (skills, disciplines, capacity)</li> </ol> | <i>American Association of Community Psychiatrists</i> |
|--|--|

# Model for Negotiation of Funding Responsibility between Medicaid Health Plan (Fully Capitated Health Plan [FCHP]) and Medicaid Mental Health Carve Out Plan (Mental Health Organization [MHO]): Multnomah County Public Health/Care Oregon/Verity

*Developed by Mark Spofford*



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## D. Web Sites

**American Association of Community Psychiatrists** — There are guidelines, such as *Guidelines for Recovery Oriented Services*, and a position paper on primary care integration. <http://www.wpic.pitt.edu/aacp/default.htm>

**American Psychiatric Association** — They have diagnosis specific practice guidelines that are applicable in a wide variety of settings. <http://www.psych.org/>

**Depression in Primary Care: Linking Clinical and System Strategies** —A five-year, national program with the goal of increasing the use of effective models for treating depression in primary care settings. [www.wpic.pitt.edu/dppc](http://www.wpic.pitt.edu/dppc)

**Health Disparities Collaboratives** — The Care Model has been implemented in efforts to improve diabetes, asthma, depression, and cardiovascular disease care. [www.healthdisparities.net](http://www.healthdisparities.net)

**Implementing Evidence Based Practices Project** — This project is focused on people who have severe mental illness and are most frequently served in the public mental health system. The EBPs are not diagnosis specific. <http://www.mentalhealthpractices.org/>

**Improving Chronic Care** —This project promotes effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of healthcare settings. [www.improvingchroniccare.org/change/index.html](http://www.improvingchroniccare.org/change/index.html)

**Institute for Healthcare Improvement** — A not-for-profit organization driving the improvement of health by advancing the quality and value of healthcare and providing leadership through a variety of initiatives, including the Health Disparities Collaboratives. The Depression manual can be downloaded from: [www.ihl.org/collaboratives/Depression\\_Apr2002.pdf](http://www.ihl.org/collaboratives/Depression_Apr2002.pdf)

**MacArthur Initiative on Depression and Primary Care** —Their mission is to improve care and outcomes nation wide for patients with depressive disorders treated in primary care practices. [www.depression-primarycare.org](http://www.depression-primarycare.org)

**National Council for Community Behavioral Healthcare**— They have a primary care resource center with the Four Quadrant Background Paper and Crosswalk to EBPs, State Assessment Tool for assessing the policy and financing environment for integration, and presentations and tools from conference presenters. [www.nccbh.org](http://www.nccbh.org)

**National Guideline Clearinghouse** — A public resource for evidence-based clinical practice guidelines. NGC is sponsored by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, in partnership with the American Medical Association and the American Association of Health Plans. There are over 1000 disease/condition guidelines that can be accessed. [www.guideline.gov](http://www.guideline.gov)

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**Project IMPACT** — A multi-center study to test the effectiveness of a new disease management model for late life depression that addresses some of the treatment barriers. [www.impact.ucla.edu/summary.html](http://www.impact.ucla.edu/summary.html)

**U.S. Army** — Their depression guideline includes the guideline itself, metrics, information for providers and for patients, implementation materials and other useful supports. The metrics section provides a detailed look at measuring evidence-based practice. [www.qmo.amedd.army.mil/depress/depress.ht](http://www.qmo.amedd.army.mil/depress/depress.ht)

**U.S. Preventive Services Task Force (USPSTF)** — The group was convened by the U.S. Public Health Service to rigorously evaluate clinical research in order to assess the merits of preventive measures, including screening tests, counseling, immunizations, and chemoprevention. <http://www.ahcpr.gov/clinic/uspstfix.htm>