GET IT TOGETHER

How to Integrate
Physical and Mental Health Care
for People with Serious Mental Disorders

June 2004
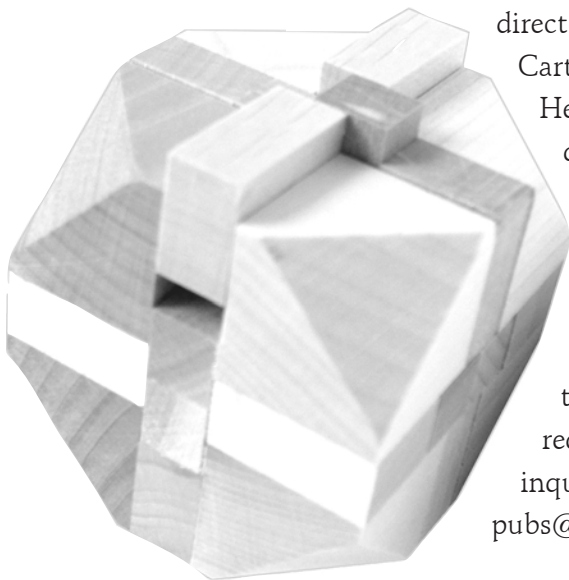
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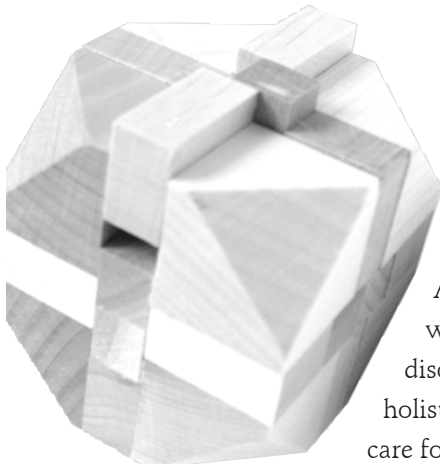
CONTENTS

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How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

INTRODUCTION

Adults and children with serious mental disorders need holistic, high-quality care for both physical and mental health and for substance abuse (behavioral health) disorders. Science confirms the need, because medical and psychiatric conditions are each affected by the person's physical and mental health.

Yet fragmented care remains the norm for individuals with serious mental disorders. The delivery systems for mental health, substance abuse and physical health care are separate, often with different financing arrangements and policy-setting.

This report discusses integrated health care with a primary focus on the needs of adults with serious mental illnesses and children with serious mental or emotional disorders, most of whom receive care through state and county public mental health systems.

Data on comorbidity show that many individuals whose primary diagnosis is a medical/surgical condition have a co-occurring mental disorder, often depression or anxiety. Those with a serious mental disorder are also more likely than the general population to have a serious medical disorder, and many have a co-occurring substance abuse problem.[1] This comorbidity contributes to the high cost of health care for individuals who receive specialty mental health services, placing these disorders sixth among the 15 most expensive health conditions.[2]

Moreover, individuals with serious mental disorders — despite their need for services to address both physical and behavioral health conditions—often face significant inequalities both in access to care and in the quality of care due to their racial, ethnic or socioeconomic status.[3] In particular, adults with serious mental disorders have high rates of poverty and a significant percentage of both adults and children with these disorders are from minority racial or ethnic groups.

A further compounding problem is that the U.S. health care system is geared toward the needs of people with acute conditions. Less attention is given to co-occurring conditions and to coordination of care for those with long-term needs.[4] As a result, individuals with chronic conditions often have to coordinate their own care.[5]

Unfortunately, creating the structures and incentives necessary for integration of physical and behavioral health care is not simple, and there is much confusion

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and uncertainty about how to accomplish it.[6] Given the discrete worlds of mental health, substance abuse and medical/surgical care, even coordination of care across disciplines is not often effectively achieved, much less integration of separate delivery systems.

Integration of physical and mental health care is critical.

Integration of care is an urgent necessity. The Institute of Medicine has called for the "coordination of care across patient conditions, services and settings over time," and the U.S. Surgeon General terms ongoing communication between an individual's caregivers essential for the delivery of high-quality care.[7] As a further benefit, integration promotes greater recognition of the impact and importance of mental health conditions and encourages parity for mental health care—not in insurance coverage, but within health care systems.

Improving integration of care would have immediate advantages. It would:

✦ improve quality of care for medical conditions for people with serious mental disorders;

✦ improve safety through appropriate medication management and recognition of and treatment for co-occurring physical or behavioral health disorders;

✦ reduce costs as a result of more efficient and effective use of resources;

✦ promote earlier access to care for both behavioral health and physical disorders; and

✦ increase consumer satisfaction and likely improve compliance with medical and mental health treatment.

Fragmented care, on the other hand, leads to:

✦ under-diagnosis of mental health issues in primary care;

✦ difficulty for individuals with serious mental disorders in accessing and utilizing physical health care services effectively;

✦ potential for injury due to incomplete information about an individual's condition;

✦ inadequate consultation across disciplines, compromising effective treatment for those who are in more than one system;

✦ a lack of clear lines of responsibility for clinical outcomes;

✦ higher costs, resulting from inefficiencies and poorly managed care; and

✦ inadequate understanding of the psychobiological components of all diagnoses.

Although the concept of integration is widely endorsed, substantial barriers must be overcome, relating, among other things, to financing, contracts, accountability, data management, confidentiality and culture clashes.[8] As a result, system-wide integration of care, particularly for people with serious mental disorders, is virtually non-existent in most areas of the country.

State and federal policies to foster integration are needed.

System-wide integration of care will require implementation of new public policies designed to overcome the barriers that have led to today's fragmented systems. Appropriate policies will vary, however, depending on the target population and its usual source of care.

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Many individuals will have need of mental health treatment during their lifetime, but most will not have such severe problems as to require long-term specialty care. In fact, more than half of all people with mental health problems are seen only in the general medical sector.[9] A significant body of literature documents the prevalence of mental health and substance abuse issues among people treated for health conditions by primary care physicians. For example, someone with diabetes is twice as likely as the general population to have clinical depression.[10] Common mental disorders seen in primary care are depression, anxiety, substance abuse and somatoform diagnoses.[11]

For people with mild or moderate mental disorders

who are already treated in primary care, integrated treatment may be best furnished through primary care delivery settings. Policies to encourage improved communication and collaboration between primary care and behavioral health providers can reduce barriers to such coordinated care.

Adults and children with serious mental disorders, however, generally receive their specialty mental health care through public systems. To the extent that adults with serious mental illnesses have a "medical home," it is in the public mental health system. While children may have regular pediatric care, they receive continuing and intensive mental health services through various child-serving systems, including mental health, child welfare and schools. Policies to ensure integration of care for individuals with serious mental disorders therefore need to focus on how the public mental health system can address access to quality primary care services for those in its care.

What this report offers

This report focuses primarily on the need for integrated care for people with serious mental disorders, but includes brief discussion of issues arising for individuals with mild to moderate mental disorders. The term "integration" is used to describe situations where physical and behavioral health service delivery is furnished in a unified and holistic manner. The term "coordination" is used to describe situations where there are linkages between separate providers or delivery systems that ensure sharing of information and improved continuity and quality of care.

The first two chapters describe the physical-health issues of adults with serious mental illnesses and children with serious mental and emotional disorders, and summarize barriers to improving integration and coordination of care.

Chapter 3 presents models for integration and coordination of care for people with serious mental disor-

ders, ranging from projects that link care by separately practicing providers to single entities providing fully integrated health care, and discusses how each model addresses the identified barriers.

In Chapter 4 we examine managed care contracting models and how they might encourage integrated care. The final chapter suggests policy approaches that may improve integration of physical and behavioral health care for adults with serious mental illnesses and children with serious mental and emotional disorders who rely on public-sector services.

Methodology

The report is based on information from various sources: a literature review, conversations with experts in the field, site visits to examine four state Medicaid programs, a meeting of experts and a second round of site visits to programs that bring primary health care into public mental health programs.

As a first step, we conducted a comprehensive literature review regarding the physical health care of individuals with serious mental disorders. A round of telephone and in-person conversations then occurred with experts in the mental health field, including providers, managed care executives, administrators in the public mental health system, and adult consumers and families of children with serious mental disorders.

From February to October 2002, the Bazelon Center conducted four case studies on Medicaid initiatives to improve coordination of physical and behavioral health care for adults with serious mental illnesses and children with serious mental or emotional disorders. Our staff, in teams of two, visited four states (Massachusetts, Michigan, Oklahoma and Oregon) for four to five days each. States were selected based on program maturity, emphasis by the state on coordination of care and the managed care arrangement in effect (carve-out or single contract). A broad range of 180 stakeholders was interviewed, using

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a structured topic guide. They included state officials, health-plan staff, physical health care providers, behavioral health providers, advocates and consumers. Managed care contracts and Medicaid regulations were reviewed for requirements, quality improvement projects and performance measures related to integration. We also reviewed all available studies and reports.

We then conducted a further review of the literature on integrated services, focusing on studies of integrated services in managed care arrangements and on co-location of behavioral health specialists in primary care practices.

In the fall of 2002, we convened a meeting of national experts and individuals from the four case-study states. Fourteen individuals participated in the meeting to review and discuss information from the site visits, to discuss the draft of a paper summarizing the barriers to coordination and integration of care and to develop potential policy recommendations. Most participants were from the states studied. In addition, the medical directors of two behavioral health organizations were invited to add their perspectives on integration efforts in Medicaid and private insurance. Individuals from university settings also participated. This group made recommendations concerning effective approaches to improve coordination and integration of care.

With funding from private sources (CIGNA Health-Care), we conducted three more site visits to programs that provide embedded or unified primary care services in a mental health program—an approach recommended by the meeting of experts. Sites were selected based on the size of their program, length of operation and location of the primary care services. Center staff visited each of these sites for two or three days. We conducted further review of embedded programs in two more sites through telephone interviews and review of literature.

The four states visited were: Oklahoma (single Medicaid managed care contracts), Oregon (behavioral health carve-out Medicaid program), Massachusetts

Improving integration of health and mental health care will have an immediate and direct effect on the health and well-being of individuals with serious mental disorders.

(mixed single contract and behavioral health carve-out Medicaid program) and Michigan (partial carve-out Medicaid program). The three sites visited subsequently were: Cherokee Health Systems in Tennessee (a combined community health center and community mental health center); The Center for Integrated Care in Chicago, Illinois (with physical health care clinics operating out of a large psychiatric rehabilitation program for adults with serious mental illnesses) and Comprehensive Care Services in Pittsburgh, Pennsylvania (which established a small physical health clinic in a day-treatment program). The EXCEL Group in Arizona, which offers primary care services through a behavioral health program, was reviewed through telephone contacts. During the site visits to programs, we interviewed the leadership, behavioral health and primary care providers, and consumers of services.

The various programs in the four states and three sites visited afforded a comprehensive sampling of different arrangements for coordination and integration of care.

The potential value of improved integration

Improving integration of health and mental health care will have an immediate and direct effect on the health and well-being of individuals with serious mental disorders. It will also have long-term implications for policy concerning true parity between mental disorders and other health conditions. It supports the goal of the Institute of Medicine (presented in its landmark report, *Crossing the Quality Chasm)*[12] for a safe, effective, person-centered, timely, efficient and equitable health care system.

The potential for integrated care is illustrated in a study of veterans with serious mental illnesses. Using random assignment to an integrated program or to a general medicine clinic, this study found veterans receiving care from the integrated site were significantly more likely to make a primary-care visit (91.5% versus 72.1%)

and less likely to have an emergency visit (11.9% versus 26.2%). They were also more likely to have received 15 of 17 key preventive services, (e.g., blood pressure check and diabetes screening) and to have a single, comprehensive medication list in the chart to assist providers in avoiding adverse drug interactions.[13]

True integration requires all health care providers—primary care practitioners, community health centers, general hospitals and other settings—to furnish mental health care on a routine and regular basis, to the same extent and in the same coordinated manner as any other type of specialty care. However, because health and behavioral health have existed as separate systems for so many decades, it may be necessary to approach the goal of full integration and equal status for mental health in steps. Furthermore, concerns have been expressed among mental health stakeholders that integration could lead to absorption, leaving too little focus on mental health in terms of both time and resources. For all these reasons, we present information in this report on several approaches to integration with the recognition that integration can be challenging and that communities must begin where they are today.

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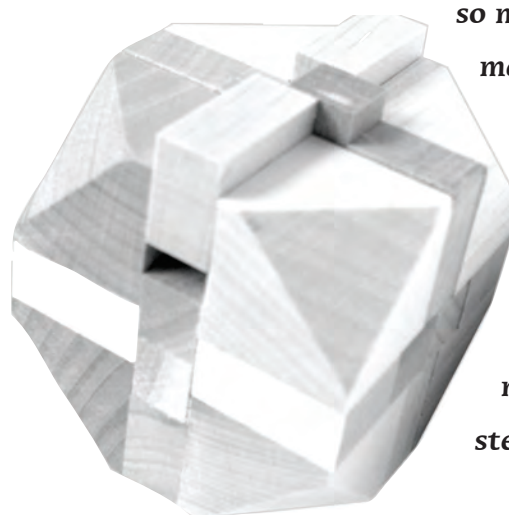
CHAPTER 1

Individuals with Serious Mental Disorders
Have a High Rate of
Serious Physical Illness

Several recent studies have found that people with serious mental illnesses have poor physical health.[14] They are more likely to have serious or multiple medical disorders and the impact of those disorders is usually more debilitating.[15]

Most have physical health problems. Between 40% and 56% of individuals with mental disorders have been found to have a physical health problem.[16] In one study, 42% had at least one chronic physical illness severe enough to limit daily functioning.[17]

A significant percentage have physical health disorders that are severe. A recent study found that 20% of adults with serious mental illnesses who were discharged from a psychiatric hospital had very serious health problems, such as HIV infection, brain trauma, cerebral palsy or heart disease, and 40% had co-occurring substance abuse disorder or substance dependence diagnosis.[18]

This population is also more likely to have multiple disorders. A Massachusetts study of adult Medicaid beneficiaries found that those with a mental illness were twice as likely to have multiple medical disorders than those without a mental illness, 26% compared to 12%. Individuals with both a mental illness and a substance abuse disorder were most likely to have medical problems.[19]

People with schizophrenia have particularly high rates of medical disorders. A study examining the preva-

The consequences of failing to treat medical disorders can be dire. As a result of high rates of disorders, multiple disorders and lack of care, age-related mortality rates are higher among people with serious mental illnesses.

lence of 12 physical health conditions among individuals with schizophrenia found that more than 50% had one or more of them: 75% had diabetes, breathing problems, heart problems and/or bowel problems, and 58% had high blood pressure. High rates were also seen for visual (93%), hearing (78%) and dental (60%) problems.[20]

Several factors greatly increase the risk of serious medical conditions among adults with serious mental illnesses, particularly obesity, smoking, lack of physical exercise and the effects of antipsychotic medications. Individuals with serious mental illnesses should therefore receive regular preventive services as well as monitoring and treatment of ongoing chronic medical conditions. Despite the known risks, the detection of physical health problems among adults with serious mental illnesses is poor. A review of 18 studies found that on average, 35% of individuals with serious mental disorders have at least one undiagnosed medical disorder.[21]

In part, this may be because these individuals often fail to protect or maintain their physical health due to poverty, social withdrawal, apathy stemming from their mental illness or other social factors. It may also result from health care professionals' failure to pay proper attention to the complaints of people with serious mental disorders.

The consequences of failing to treat these medical disorders can be dire. As a result of high rates of disor-

ders, multiple disorders and lack of care, age-related mortality rates are higher among people with serious mental illnesses.

✦ The lifespan for men with schizophrenia is about 10 years shorter than the national average; for women, it is nine years shorter.[22]

✦ Individuals with serious mental illnesses living in the community have death rates 2.4 times that of the general population.[23]

Increased risk of physical disorders is primarily an issue for adults, although lack of research on the physical health of children with serious mental disorders may mask similar issues for this population. Moreover, youth are increasingly receiving psychotropic medications that have been shown to have an adverse effect on the physical health of adults.

Following is a summary of data regarding certain disorders that illustrate the extent of the problem.

Diabetes

Studies have found that people with mental health disorders have high rates of diabetes. This is in part because individuals with schizophrenia have a predisposition to diabetes, as evidenced by abnormalities in glucose regulation documented since the 1920s.[24] Antipsychotics' chemical impact in the brain exacerbates this predisposition.[25]

✦ Individuals with schizophrenia have a lifetime diabetes rate of 14.9% and a current diabetes rate of 10.8%, compared to rates for the general public of 1.2% for the 18-44 age group and 6.3% for the 45-64 age group.[26]

✦ The prevalence rate for diabetes in individuals with major mood disorders is 15%; for schizophrenia, it is 16-25%; for bipolar disorder, 26%; and for schizoaffective disorder, 50%.[27]

In studies comparing newer atypical antipsychotic medications with older medications and with each, certain atypicals have been found to increase the risk of diabetes significantly:

✦ Clozapine, olanzapine and quetiapine put consumers at particular risk of diabetes, as does risperidone, for people under 40.[28]

✦ Clozapine has been found to increase the diabetes rate, weight and other metabolic abnormalities.[29]

This effect is so serious that the U.S. Food and Drug Administration recently requested a label change for all atypical antipsychotic medications to include a warning about diabetes. The FDA urges that individuals on these medications be monitored.

Cardiovascular disease

There is a significant need to monitor lipid levels, glucose and weight among adults with serious mental illnesses since they have high rates both of cardiovascular disease and of risk factors that can lead to serious heart conditions. In addition, their medications may put them at higher risk.

✦ Hypertension rates for people with serious mental illnesses are high, 34.1%.[30]

✦ Rates of heart problems are also high, 15.6%.[31]

A significant risk factor for cardiovascular disease is an elevated level of triglycerides. The newer atypical antipsychotics have been found to raise triglyceride levels, sometimes dramatically.[32]

Weight gain and obesity

Adults with mental illnesses often have significant weight gain and obesity, which in turn are risk factors for diabetes, cardiovascular disease and other physical health problems, such as stroke, arthritis and certain types of cancers:[33]

✦ Rates of obesity for adults who are disabled due to mental illness are significantly higher (23.4%) than for individuals without disabilities (14.9%).[34]

✦ People with schizophrenia have significantly higher body mass index than the general population.[35]

✦ Adults with bipolar disorder are more likely to be overweight (58%) or obese (21%).[36]

Antipsychotics contribute to weight gain. A review of 81 published studies on typical and atypical antipsychotics found that most antipsychotics were associated with weight gain, which increased with length of treatment.[37]

Some medications seem to be more inclined to induce weight gain than others. Among atypicals, clozap-

ine and olanzapine appear to increase weight the most (by 9-10 pounds in one study), but there is large variation among individuals.[38]

Inappropriate diet may also be a cause of weight gain among people with serious mental illnesses, and this is often related to poverty. Another significant cause of weight gain is lack of exercise. People with serious mental illnesses are less physically active; many are sedentary.[39] This may be the result of the sedative effect of their medication, lack of opportunity to exercise or other factors. Individuals on these medications can, however, be helped to lose weight through programs of counseling, exercise and behavioral interventions.[40]

Smoking

Smoking is a major risk factor for a number of health conditions, including heart disease, stroke, lung cancer and chronic lung diseases.[41] Higher smoking rates have been consistently found among adults with mental illnesses. Nicotine's ability to increase dopamine in individuals with schizophrenia and increase andregenic activity in those with depression may explain some of its appeal.[42]

✦ Sixty-one percent of adults with severe mental illnesses have some history of smoking, compared to 46% of individuals without any disabilities.[43]

✦ Studies have found that the rate of individuals with a mental illness who currently smoke is twice that for individuals who do not have a mental illness.[44]

✦ People with mental illnesses make up 44% of the U.S. tobacco market.[45]

✦ Heavy smoking is common among people with mental illnesses, increasing with the number of diagnoses.[46]

Unfortunately, individuals with serious mental illnesses are given little assistance or encouragement to stop smoking. A study of psychiatric patients found that though more than half were current smokers, only 50% had been advised by any doctor to stop smoking.[47]

Other chronic or serious diseases

Other very serious and life-threatening and/or chronic illnesses are prevalent among people with serious mental illnesses.

✦ The breast cancer rate for women with a long-term mental illness is 9.5 times greater than for the general population.[48]

✦ Rates for HIV are also elevated. A non-random sample of individuals with mental illnesses in four states found elevated rates of HIV infection (3.1%, eight times the prevalence in the overall U.S. population).[49]

✦ Individuals with serious mental illnesses also have high rates of hepatitis B and C. Rates for hepatitis B are five times the national prevalence (at 23.4%) and rates for hepatitis C are 11 times the national average (19.6%).[50] The higher hepatitis C rate is likely linked to homelessness and/or incarceration.

In addition, the homeless population, including people with serious mental illnesses, is at risk for tuberculosis.

Children and adolescents

Few studies have examined whether children with serious mental or emotional disorders have a higher prevalence of physical health conditions. Anecdotal information from pediatricians and mental health providers indicates that children with serious mental disorders, unlike adults, commonly have physical health conditions similar to those of children without a mental disorder. However, some children with serious mental disorders may be at higher risk:

✦ Significant numbers of children and adolescents are diagnosed with depression (2% and 5% of youngsters, respectively) and depression frequently co-occurs with common somatic and other problems seen in primary care.[51]

✦ Children and adolescents are increasingly being prescribed the psychiatric medications that correlate with significant physical health problems in adults, such as diabetes and heart conditions.

In addition, children with serious mental disorders often engage in behavior that puts them at risk of other medical conditions. The 2001 Youth Risk Behavioral Surveillance, a national study of adolescents in grades 9-12 conducted by the Centers for Disease Control, identified high rates of behaviors that place children at risk

for health problems, including current smoking (29%), alcohol use (47%), marijuana use (24%), sexual activity (33%) and being overweight (10%).[52]

The complicating factor of dual diagnosis

In addition to the comorbidity between serious mental illnesses and physical health conditions, there is a significant comorbidity between mental illness and substance abuse among both adults and adolescents. Individuals with this dual diagnosis are an important group to target for primary care because they are more likely to have medical problems and to receive fewer preventive health services than those who have psychiatric or substance abuse disorders alone.[53]

✦ Among individuals with serious mental illnesses there is a high lifetime prevalence of substance abuse (29%).[54]

✦ Forty-seven percent of individuals with schizophrenia have had a substance abuse disorder, and 61% of individuals with bipolar disorder also have had a substance abuse disorder.[55]

✦ Adolescents with serious emotional disturbance and severe depression are more likely to be diagnosed with a substance abuse disorder.[56] Between one quarter to one third of these adolescents have dual diagnoses.[57]

Two recent studies show that people with substance abuse disorders often have accompanying medical or psychiatric conditions and higher rates of injuries (fractures, sprains, strains and burns). Individuals with substance abuse disorders were also more likely to require treatment for lower back pain, headache and arthritis and for certain mental disorders (depression and anxiety disorders).[58]

CONCLUSION

The high risk of serious physical health conditions among adults with serious mental illnesses means that health screening, preventive services and regular access to primary care should be a very high priority. While the data available at this time do not suggest that children with serious mental disorders have higher rates of medical conditions than others, all children should receive well-child screening and preventive services. Given that adolescents with serious mental disorders often engage in high-risk behaviors, such as alcohol and drug use, smoking and unprotected sex, there is clearly a need for them to receive regular physical health screening, prevention and treatment.

However, the current separation of health care services from the public mental health system means that many individuals go without necessary care and few receive services in a coordinated or, preferably, integrated way. The next chapter discusses the various barriers that may prevent individuals with serious mental disorders from receiving the holistic care they need.
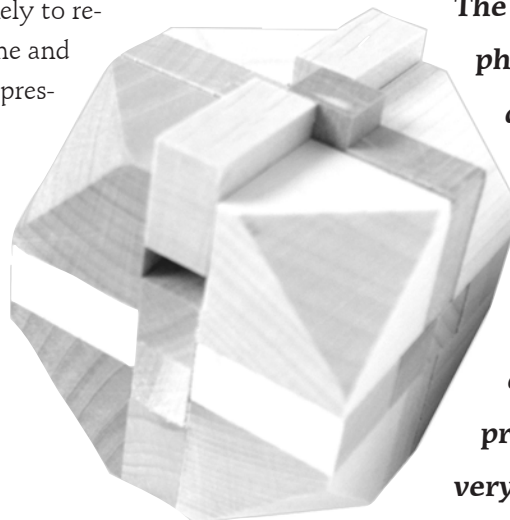
The high risk of serious physical health conditions among adults with serious mental illnesses means that health screening, preventive services and regular access to primary care should be a very high priority.

CHAPTER 2

Barriers to Integration

Barriers to effective integration of physical, mental health and substance abuse care result from how health care is financed; the division between their respective service-delivery systems; the way public behavioral health systems operate; issues relating to practitioners themselves, including their training; and concerns of and problems for consumers. Additional barriers to integrated care for people with serious mental disorders stem from the fact that their lead provider is a specialty provider.

Integration of care confronts many barriers.

For purposes of this report, barriers to effective integration of physical and mental health care are grouped as follows:

✦ patterns of financing—lack of time to collaborate and lack of reimbursement for collaborative work even if time is found;

✦ cultural barriers between primary care and mental health delivery systems and practitioners;

✦ lack of practitioner training in the other areas of health care;

✦ information-sharing issues, including system differences and confidentiality practices;

✦ access problems to either mental health or primary care, which discourage or block referral and collaboration; and

✦ consumer issues and concerns.

Financing patterns are problematic.

Health, mental health and substance abuse services are financed separately in the public sector, and this creates a disincentive for integrated care.[59] With tight budgets, payment for these services does not cover any additional time a provider spends communicating with colleagues and does not encourage identification of issues beyond the primary presenting disorder. Most systems that operate through a managed care approach have continued this separate financing through separate contracts for health and behavioral health care.

Resource pressures on primary care providers have resulted in shorter visits. This makes it less likely that behavioral health issues will be identified and that interactions with behavioral health specialists will occur. Typically, primary care physicians see patients for no more than 13-16 minutes,[60] and these time constraints lead them to focus on procedures rather than talking to patients about potential mental health issues.[61] In such a short interaction, and with the usual primary care interviewing behavior,[62] issues beyond the immediate presenting physical health problem are rarely explored. For children, even when parents demand attention to behavioral issues, pediatricians spend very little time during well-child visits on behavioral or developmental issues.[63] Longer visits (30 minutes or more) increase the likelihood of a consumer's receiving attention to both mental health and physical health issues through preventive medical services.[64]

When behavioral health disorders are identified in primary care, most primary care providers treat the condition themselves. A study found that few sought a psychiatric consult for situational depression, only 25% consulted a psychiatrist for major depression, 45% did so for bipolar illness, and only 30% sought consultation for schizophrenia.[65]

Health, mental health and substance abuse services are financed separately in the public sector, and this creates a disincentive for integrated care.

Many primary care physicians feel they lack sufficient decision support on which patients to refer, which to manage themselves and how to do so.[66] These difficulties are compounded by lack of provider training (see below). Without better behavioral health back-up, the situation is unlikely to change.

Similarly, mental health providers frequently fail to identify physical health complaints. Consumers interviewed for this study reported that they have raised issues related to a physical illness with their mental health provider, only to have their complaints dismissed as psychosomatic or the result of their mental illness. In one study, only 11% of individuals with a severe mental illness received preventive care during a visit to a psychiatrist. In another, 48% of women's health issues were undiagnosed by psychiatrists.[67]

Collaboration takes time and effort. Even when primary care and mental health providers do wish to communicate, neither managed care nor fee-for-service financing systems compensate them for the additional time spent on this collaboration.[68]

Another financing barrier to collaboration arises when mental health professionals and primary care providers are co-located and the individual sees both on the same day. Currently, neither Medicare nor Medicaid will pay for two services (such as a physical and a mental health service) on the same visit. This means a consumer must return to the office for a separate consultation or appointment.

Cultural differences lead to isolation.

Significant barriers to close working relationships between behavioral health and primary care providers stem from basic differences in working style and the isolation of mental health and substance abuse treatment from primary care. Longstanding problems include disrespect, mutual distrust, competition and an overall inability to understand each other.[69]

Most primary care physicians express frustration about their attempts to work with mental health providers or to integrate their care with mental health care.[70] This often occurs because styles of communication are very different.[71]

The long history of separation has left primary care providers and behavioral health providers unfamiliar with the clinical and educational needs of each other's discipline.[72] Generally, psychiatrists see primary care physicians as unskilled in mental health care, while primary care physicians see psychiatrists as inaccessible, non-medical and uncommunicative.[73] Mental health treatment appears to many primary care physicians to be substantially different from the rest of health care. Medical school and residency programs tend to emphasize the technical, biomedical aspects of care, and psychosocial aspects are often viewed as unscientific and irrelevant.[74] Many primary care physicians are skeptical of mental health diagnosis and treatment and question whether it is evidence based.[75] As a result, they overlook signs of mental disorder or fail to refer on the assumption that treatment will not help. Substance abuse treatment is even less technological and seems even further from mainstream medicine to most physicians. In fact, details of substance abuse treatment are of little concern to many primary care physicians, who see the services as social, not medical.

The lack of day-to-day contact between primary care and mental health practitioners is a barrier to good working relationships. In collaborations with specialists, primary care physicians expect to communicate with other physicians. Since they have admitting privileges to the same hospitals, see each other on rounds or in the cafeteria and sometimes even socialize with each other, most physical health specialists and primary care physicians know each other personally. In contrast, psychiatrists often do not provide care in general hospitals and many are isolated from both primary care physicians and other specialists. Primary care physicians may not know, and may rarely even meet, psychiatrists. Because personal knowledge tends to be the most important factor in identifying a

Significant barriers to close working relationships between behavioral health and primary care providers stem from basic differences in working style.

specialist,[76] this creates a barrier to good working relationships and referrals.

Mental health practitioners often do not provide the assistance that is needed. Psychiatrists consider the time they spend with their clients to be sacrosanct and often will not accept calls, while primary care providers are interruptable and can communicate with colleagues at almost any time. This, according to experts participating in this study, is a barrier that primary care providers rarely experience with other specialities and it contributes to their sense that the mental health system is dumping its problems on them.

Primary care providers also may discount, fear or reject individuals with serious mental illnesses because of their presentation, which can appear disorganized, bizarre or agitated.[77] Participants in the meeting of experts pointed out that many primary care providers with little experience working with individuals who have serious mental health and/or substance abuse issues are ill-prepared or unwilling to deal with problems posed by these consumers. They may be concerned about possible suicide risk or the potential of significant noncompliance with treatment. They may also overreact to incidents in their waiting rooms, or assume such incidents will occur even if they never have.

The four state visits revealed a further set of barriers. Primary care providers are accustomed to dealing one-on-one with other physicians and often find it hard to work with an agency and an interdisciplinary team. They may be puzzled and discouraged from collaboration when they cannot reach the psychiatrist but, instead, are expected to discuss the case with another mental health professional or a case manager. When they do reach the psychiatrist, he or she may not have the detailed information the primary care physician is seeking; in fact, the communication may more appropriately involve a case manager or a nurse, who would know more than the psychiatrist about the person's overall health care situation.

Primary care providers are accustomed to dealing one-on-one with other physicians and often find it hard to work with an agency and an interdisciplinary team.

Site-visit interviewees described further difficulties that arise from different modes of practice, such as medical record-keeping. Medical records in primary care are short summaries of diagnoses, treatments and outcomes. Mental health service plans are long and complex with goals, objectives and a variety of services to be re-evaluated over time. Substance abuse plans are likewise focused on the broad array of issues that must be addressed for recovery. Consumers themselves have input into such plans, and their views on treatment are often incorporated. When sent such a treatment plan, primary care providers are often frustrated. They do not have time to read it and cannot easily find basic information they need to know.

The distance between primary care and substance abuse providers is especially wide. Few physicians work in the substance abuse field and particularly in the public substance abuse sector. There are also conflicts between many forms of substance abuse treatment and the treatment of mental or physical illnesses with medications. According to participants at the meeting of experts, a distrust of primary care physicians among some substance abuse providers, who often believe that physicians ignore substance abuse issues, compounds these problems and sets substance abuse even further apart.

Integration of mental health and substance abuse is often problematic as well, according to experts we interviewed, due to a tradition of separate treatment and the rejection of cross referrals between mental health and substance abuse providers. This occurs despite high rates of co-occurring mental health and substance abuse disorders.[78]

Public mental health system providers must increasingly collaborate across various public systems. For children, schools, child welfare agencies and juvenile justice programs provide significant related services that must be coordinated with the child's mental health and/or substance abuse services. For adults, income-maintenance, vocational rehabilitation, employment, housing

and other needs must be addressed. Primary care physicians are generally not prepared to coordinate and collaborate with such agencies in comprehensive systems of care.

Providers need specialized training.

Numerous articles and reports identify the need for mental health training of primary care physicians, although some organizational and attitudinal issues must be addressed before training will achieve its objectives.[79]

Many primary care physicians say they do not have the information on mental illness that they need to effectively refer back and forth with specialty care. As a result, they are less confident about mental health issues than other areas of care. Most primary care physicians do not receive significant training in psychiatry, nor are they given practice guidelines that emphasize the integration of mental health and primary care services.[80] One review found more than a dozen studies examining the poor rate of recognition of mental disorders in primary care settings, showing that in half to two thirds of patients, diagnosable mental disorders go unrecognized.[81] Insufficient knowledge of diagnostic criteria has been cited as one factor related to this low rate of recognition.

Pediatricians have consistently reported that pediatric residencies provide insufficient preparation for treating patients with learning disabilities, attention deficit disorder or mental retardation and psychosocial or behavioral problems.[82] In 1996, fewer than 15% of pediatricians said they were comfortable independently managing adolescent substance abuse, depression, truancy or psychological problems.[83] They receive even less training on alcoholism and drug abuse treatment, beyond basic medical interventions. Few physicians describe their knowledge of adolescent mental health as excellent (although most think it is good) and nine out of ten would like to participate in continuing education courses on this topic.[84]

Repeated failed attempts to secure mental health speciality services for patients in their practice frustrates primary care providers and discourages further collaboration, particularly if the reasons for this failure are not clear.

Primary care providers also lack experience with mental health consumers, particularly in community settings. As a result, many do not recognize signs of mental disorders or substance abuse problems in their patients. Many would like assistance in learning to manage difficult patients with serious mental illnesses.

On the other hand, this situation is not uniform. Some primary care providers have more training in this area than others and in the practice of integrated and holistic care in general. This is particularly true of family physicians and family practice nurses who are trained to bridge both areas.

According to participants in the meeting of experts, psychiatric specialty training also does not provide sufficient training in primary care issues. In addition, mental health providers, including psychiatrists, need training in working with primary care providers. The American Association of Community Psychiatrists recommends training behavioral health providers so they appreciate the different culture in primary care and understand how to collaborate and communicate effectively with primary care providers.[85]

Meeting participants were concerned that neither primary care physicians nor psychiatrists receive significant training in collaborative, integrated practice arrangements. They felt that medical schools do not sufficiently emphasize working in an interagency system or on an interdisciplinary team. Universities training other health care professionals may address these issues to some degree—nurses, in particular, are generally better prepared to work collaboratively with other systems. Overall, however, both physicians and other providers are not acclimated to an integrated service delivery model.

Needed services are often unavailable.

Health care providers are reluctant to refer patients if they believe services are unavailable. Repeated failed

attempts to secure mental health specialty services for patients in their practice frustrates primary care providers and discourages further collaboration, particularly if the reasons for this failure are not clear. A survey of family practitioners found that those who believed that psychiatrists were available for consultation and treatment were more likely to report an increase in mental health visits by their patients.[86]

National data also show that minorities and those with lower incomes have less access to health care and that there is inequality in the quality of care they receive. These disparities are costly, as poorly managed care or missed diagnoses result in expensive and avoidable complications, leading to significant morbidity, disability, lost productivity and high social costs.[87] Lack of access to physical health care, or poor quality of care when it is available, may also discourage mental health from collaborating with primary care providers.

The lack of access to public mental health services is a crisis. According to the President's New Freedom Commission on Mental Health, the public mental health system is "in shambles," with the capacity to provide only a minimal level of care.[88] As a result, certain populations are given priority, and resources do not permit services to be offered to others. Public mental health systems often accept only individuals who have the most serious mental disorders or who are at immediate risk of psychiatric hospitalization. Substance abuse systems likewise limit eligibility for services as they target particular priority populations, such as pregnant women.

According to participants in the meeting of experts, primary care providers often seek a referral for individuals with mild or moderate mental disorders, who form the greater part of their mental health caseload. The narrow focus of public systems becomes a barrier to collaboration when these referred individuals cannot access the mental health system. When primary care providers cannot find the specialty care they are

Lack of access to physical health services also prevents holistic care for people with serious mental illnesses....This lower level of medical service is seen even when individuals have health insurance.

seeking and have little appreciation of the reasons for these limitations, they presume effective collaboration with public mental health is not feasible.

Even for the priority populations, primary care providers may find insufficient capacity. People with serious mental disorders may be unable to get an appointment for months, or until they go into crisis. Individuals with complex needs, such as those who are HIV-positive or have co-occurring substance abuse disorders, are particularly likely to be rejected by public mental health systems even though they are in great need of integrated care.

Lack of access to physical health services also prevents holistic care for people with serious mental illnesses. In a study of people with schizophrenia, fewer than 70% of individuals with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.[89]

Health care utilization rates also vary according to diagnostic category. Among individuals who were homeless, those with schizophrenia had lower rates of medical visits than those with major depression (3.4 vs. 8.1 visits). The difference in access to medical visits between the two disorders is in sharp contrast to a more comparable psychiatric care visit rate (5.3 vs. 6.8 visits).[90]

This lower level of medical service is seen even when individuals have health insurance. A study of 175,000 veterans in California found that individuals with psychiatric disorders were less likely to have medical visits and that those with co-occurring physical health conditions were less likely to have more than one medical visit in a year.[91]

Individuals with mental illnesses also receive fewer preventive health services. The study of veterans cited above found lower rates of pneumococcal and influenza vaccinations and colorectal, breast, cervical and prostate cancer screening among persons with mental illness.[92] Homeless individuals are particularly unlikely to get pre-

ventive services, such as screenings for cholesterol and colon cancer, or to have a full physical examination.[93]

Information-sharing is often impossible.

Differences in information-sharing systems and practices can significantly hamper the provision of integrated care. Software incompatibility and differences in information systems make it difficult to share necessary information from medical records, devise workable reporting forms or even share scheduling information.

Privacy rules and professional practice standards require that consumers sign a separate release before information about their behavioral health treatment can be shared with their primary care providers, and some are reluctant to do so. In the case of substance abuse treatment, in particular, many consumers do not wish to sign an authorization for sharing of this information. Even when consumers are willing to release their information, some behavioral health providers do not ask for this consent, or discuss with consumers whether they would, in fact, appreciate this communication with their primary care provider. Nor do they explain to consumers the advantages of communications among providers.

A study of three Medicaid behavioral health carve-outs found that information-sharing between providers in different systems can be hampered by the differences in confidentiality rules.[94] At sites visited for this study, both primary care and behavioral health systems complained that when they attempt collaboration, the information is sent "into a black hole" and there is no response.

According to participants in the meeting of experts, health plans and purchasers could strengthen information-sharing among providers, but rarely take the necessary steps. They may collect significant amounts of data that could be useful in improving integration of care and invest much time and effort in doing so. Yet these data often are not sufficiently analyzed or used to improve integration of care. For example, if plans and payers were to identify primary care practices with few refer-

Many consumers are worried about the impact of disclosure of a mental illness or a substance abuse problem and the potential for discrimination or social isolation.

rals to specialty mental health care, unexpectedly low identification of mental disorders, or treatment patterns that appear not to meet best-practice standards, this information could be shared with the provider, potentially changing practice patterns. Quality-of-care chart reviews could examine the degree to which the appropriate providers of care are identified and contacted to ensure care coordination.

Consumers have varying concerns.

Consumers participating in the meeting of experts and in meetings during the site visits expressed concerns about several barriers to improved integration of care.

These include some consumers' reluctance to have providers share information about them; the impact of serious mental disorders on access to health and mental health care due to stigma; poverty and a general lack of connectedness; and preferences as to the source of care.

Consumers have differing points of view, based on different experiences or attitudes. Some prefer to be treated in a primary care setting for both physical and behavioral health, while others prefer to keep mental health and substance abuse information from their primary care provider. Some consumers avoid seeking medical care because of prior negative experiences with primary care providers.

Privacy issues are a concern as many consumers are worried about the impact of disclosure of a mental illness or a substance abuse problem and the potential for discrimination or social isolation. Individuals will not accurately and honestly disclose personal information without an assurance that such sensitive information will be handled with some degree of confidentiality.[95] Older adults, who express a great fear of stigma, may be particularly concerned about the sharing of information.[96]

Some consumers worry that their physical health care needs may be dismissed as psychosocial or symptoms of their mental illness if a primary care provider

has detailed information about their mental health treatment. Women are much more likely to have their physical complaints disregarded and their requests for services denied.[97] Consumers are also concerned about how they will be treated in the primary care setting. A study of individuals with co-occurring substance abuse disorders found that the most common reason respondents gave (35%) for failure to receive recommended medical care was a "a fear of being treated rudely or unkindly."[98]

Their concerns are heightened when they do not have access to what has been placed in their mental health records. They may fear that too much information is being shared, particularly with non-health entities, such as schools.

A further barrier to integrated care is that adults with serious mental illnesses seek health care less frequently than others.[99] Social isolation, cognitive impairment or other behavioral factors could play a role,[100] as could cognitive or attentional difficulties that may make their interactions with primary care providers problematic.[101] Fear may also make them avoid medical care. Significant disparities exist in access to and quality of care for individuals in low socioeconomic groups and for minorities,[102] and most adults and many children fall into one or more of these categories.

Adults with serious mental disorders may have difficulty understanding how to get services or how to follow treatment instructions and they report higher levels of perceived barriers to care. In one study, more than half (59%) reported at least one barrier, such as transportation problems, inability to get through on the phone or to get an appointment soon enough, or being unable to see the clinician during regular working hours, while only 19% of the general population reported facing one or more of these barriers.

CONCLUSION

The barriers to integration described above are numerous and varied, ranging from the individual to the systemic. Their overall effect, however, is to leave consumers in the public mental health system to manage their own physical and mental health care and achieve, on their own, whatever integration they can.[103] Inevitably, this leads to poor quality care, as well as unnecessary costs for the health and mental health systems for illnesses that could have been ameliorated with appropriate treatment.

The overall effect of these barriers is to leave consumers in the public mental health system to manage their own physical and mental health care and achieve, on their own, whatever integration they can.
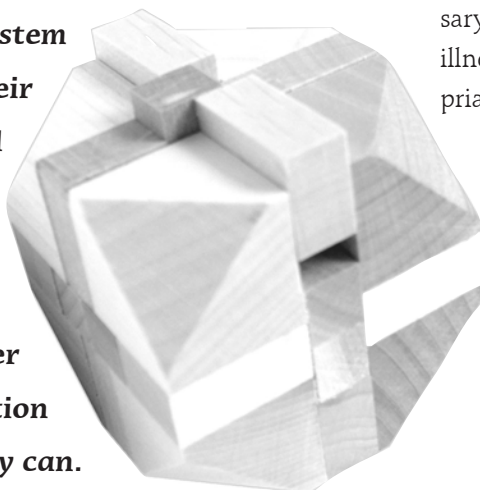
CHAPTER 3

Service-Delivery Models for Integration of Behavioral and Physical Health Care

Although the barriers to effective integrated care for individuals with serious mental disorders are many and some of their causes run deep, an encouraging number of approaches is proving that integration can succeed. This chapter describes four service-delivery approaches and explains now each can address the barriers to integration discussed above. It includes highlights of the strategies and practices that came to light through the seven site visits, the meeting of experts and other research.

Embedding primary care within a program for individuals with serious mental illnesses directly addresses the need for integrated care delivery. It ensures strong working linkages between primary care and mental health providers and is particularly appropriate for adults with serious mental illnesses, whose primary contact with the health system is with their mental health provider.

A more comprehensive yet similar approach is to unify publicly funded primary care and mental health, integrating not only delivery of care but also administration and financing. This model also addresses integration for all populations, including those with less severe disorders.

Co-location of behavioral health specialists within a primary care practice has been encouraged by a number of demonstration initiatives, both privately and publicly funded. This approach, while better suited to serving children and those with mild or moderate disorders, can also assist adults with serious mental illnesses whose conditions are stable and whose care can be effectively managed by a primary care provider. In addition, when individuals with serious mental disorders are seen by public mental health agencies, linkages with primary care

An encouraging number of approaches is proving that integration can succeed.

can be improved if there is a co-located behavioral health specialist who is assigned such a role.

Improved collaboration between independent, office-based primary care and public mental health can also be achieved. This approach is the least disruptive to current systems since it presumes practice as usual. However, it is neither easy nor the most effective approach to achieving integration of care.

The first two models discussed—embedding primary care in a mental health program and unifying mental health and primary care agencies—achieve full integration of physical and behavioral health care delivery for individuals with serious mental disorders. Differences between these two approaches have more to do with financing and administrative issues than with service delivery. However, when a unified program offers a full range of primary care and a full range of mental health treatment, not only treatment for serious mental disorders, these programs represent a higher level of integration than do embedded programs.

1. PRIMARY CARE EMBEDDED IN A PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES

The experts who attended our meeting recommended placing primary care services within programs that serve individuals with serious mental and emotional disorders as a most effective way to address integration for this population. This recommendation is consistent with the literature and with recommendations from the national association representing community mental health provider agencies.[104]

We reviewed four examples of primary care services embedded in mental health programs.

✦ **The Center for Integrated Care**, Chicago, Illinois — a collaboration between Thresholds Psychiatric Rehabilitation Center and the College of Nursing at the University of Chicago — provides primary care in clinics located in Thresholds facilities or designated for Thresholds members at other sites (such as a homeless program). Primary care services are furnished by advance-practice nurses who are College of Nursing faculty family nurse practitioners, their students and psychiatric clinical nurse specialists. A family physician is available for consultation. Approximately 700 of the members (58%) are regular users, averaging 4.3 visits for physical health care a year.

✦ **Comprehensive Care Service**s (CCS), Pittsburgh, Pennsylvania — operated by Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center and staffed by a full-time physician assistant, a full-time nurse and a part-time primary care physician. CCS's mission is to provide high quality, cost-effective care to adults with mental illnesses, to promote staff, consumer and community education, and to conduct clinically oriented research and consumer advocacy. As part of this broad mission, CCS offers primary care and pharmacy services to individuals with serious mental illnesses through its outpatient mental health program. An estimated 850 individuals use the program over a one-year period. Other consumers choose to obtain their primary care through community sources with which CCS coordinates care.

✦ **The EXCEL Group in Arizona** — a nonprofit Medicaid health plan providing services to adults and children with serious mental disorders —has a small primary care clinic staffed by a family-practice physician, nurse practitioner, physician assistant and medical assistants. It provides outpatient services to individuals receiving mental health treatment and also conducts daily rounds at an adult inpatient facility and a child residential treatment center. Approximately 50 patients are seen in a day. The clinic has five private exam rooms and associated business and doctors' offices. It is located in the heart of the behavioral health service area and is a one-stop health service.

✦ **The Massachusetts Behavioral Health Partnership** (a behavioral health carve-out entity) operates three primary care projects embedded in psychiatric day programs in Springfield, Lawrence and Hyannis. One site serves many homeless individuals with co-occurring mental health and substance abuse disorders. The state is studying the value of these three projects before considering whether to expand the concept around the state.

Barrier overcome:
Lack of time, lack of reimbursement

Primary care services located within mental health programs are designed so that primary care providers can spend more time with individuals. Many of these programs are staffed with physician assistants and nurses with relatively flexible schedules that allow them to coordinate care with other providers as needed.

Routine appointments are usually 30-45 minutes and providers spend up to an hour on comprehensive assessments, enabling them to address the complexity of consumers' health needs. The added time is important to improve quality of care for this population whose health conditions are often exacerbated by previous inadequate treatment. Individuals in these programs benefit from a regular source of care, a comprehensive medical record and an ongoing relationship with a provider.

At the Center for Integrated Care in Chicago, nurses providing primary care report they have time to work with consumers and identify issues early, helping to keep people out of the emergency room or hospital, and to follow up with specialists and coordinate care effectively.

Embedded programs have developed enough financial support to make longer appointments routine and allow providers time for interdisciplinary collaboration and consultation. But this has not been easy and none of the programs is operating solely on what it makes through

billing third-party payers such as Medicaid and private insurance.

Comprehensive Care Services in Pittsburgh serves mostly people with public insurance: 40% are on Medicaid and 40% on Medicare, while only 12% have private insurance. Medicaid's rate for primary care services is very low and does not cover the program's costs. Since the clinic is part of a medical center, it can hold down operating expenses through reliance on medical interns and a favorable contract with the medical center's HMO.

The Center for Integrated Care estimates that Medicaid reimbursement covers only 10% of total primary care costs for the adults with serious mental illnesses served by the clinic. The Center funds some services through grants.

Several financial-policy changes were implemented to support the EXCEL Group's primary care clinic. To increase commercial insurance revenue, the clinic is a provider in the clinic's employee health plan, and employees receive their new-employee physicals and prompt, on-site medical care when needed. However, the bulk of the program's funding comes from Medicaid (69%) and state funds (23%).

Another strategy to increase the rate of Medicaid reimbursement is to become a federally qualified health center. Federal law requires enhanced reimbursement for qualified health centers. The Center for Integrated Care is now exploring that option.

Barrier overcome:
Cultural differences between primary care and public mental health

Working on-site at mental health programs enables primary care providers to develop strong working relationships that lead to effective collaboration with their behavioral health colleagues.

At the Center for Integrated Health Care, the primary care and

psychiatric advance-practice nurses continually consult with one another to ensure integrated care. Nurses are particularly well trained in holistic care and able to work very closely with each other and with the psychiatrists and primary care physicians.

These sites have utilized primary care providers who are most interested in working with adults and children with serious mental disorders.

In Massachusetts, the three demonstration sites have been able to connect consumers with physical health specialists who are knowledgeable and compassionate in working with consumers with mental disorders and who are able to build trust in small steps spread over many visits.

Interdisciplinary relationships are strengthened when priority is given to rapid resolution of concerns. Day-to-day discussions between leaders and staff of both the primary care and behavioral health program are helpful.

The Center for Integrated Health Care considers the regular meetings between leaders from the College of Nursing and Thresholds a key to the program's success. There is constant re-evaluation of operations, clinical outcomes and consumer satisfaction, as well as the program's financial situation.

Embedded programs make it easier for consumers to obtain physical and mental health services in an integrated way.

At Comprehensive Care Services, there are no issues with respect to required blood tests for individuals on clozapine because patients get their blood tested at the primary care clinic and then retrieve the medication from the pharmacy. The primary care office calls the patient back if the blood test indicates a problem. The entire mental health/physical health visit lasts only 30 minutes.

Experience with serious mental illnesses improves

> **Individuals in embedded programs benefit from a regular source of care, a comprehensive medical record and an ongoing relationship with a provider.**

primary care providers' ability to identify and distinguish between behavioral health and physical complaints.

The Center for Integrated Health Care has found that regular communication between primary care and Thresholds staff enables the team to separate psychosocial issues from physical health complaints and to furnish better care.

At Comprehensive Care Services, primary care providers find it challenging to sort through an individual's health history since many come into the office with a poor understanding of their current and past health conditions. Collaborating with psychiatrists, the physician assistant has learned to elicit better information from the individual and from other caregivers.

The behavioral health carve-out entity in Massachusetts reports that significant illnesses, previously unrecognized, have been detected, diagnosed and treated as a result of integration.

Primary care and behavioral health practitioners in all the embedded programs report a high level of satisfaction, indicating that practice barriers have been overcome.

Primary care and behavioral health practitioners in all these programs report a high level of satisfaction, indicating that practice barriers have been overcome.

Barrier overcome: Poor information-sharing and lack of confidentiality

Embedded sites frequently focus on the need for an integrated medical record, and many have or are developing electronic record systems to increase efficiency and enable access to data for quality assurance purposes.

At the EXCEL Group, an electronic medical record integrates physical and behavioral health records and progress notes. As a result, primary care providers are aware of mental health problems among their patients. They can identify issues early and prevent emergency room visits and hospitalizations.

Comprehensive Care Services maintains a single electronic medical record for primary care and mental health information.

The combined record allows all providers to be aware of the treatment plan. However, pharmacy information is in a separate database.

These embedded primary care clinics are readily linked to other specialized physical health services, ensuring the delivery of holistic care.

The program run by the behavioral health carve-out entity in Massachusetts reports that consumers are more easily connected with physical health specialists because the primary care providers already have relationships with various specialty providers, whereas the behavioral health programs do not have these relationships.

In addition, contextual information about a member's life puts physical health problems in perspective.

Clinicians in the EXCEL Group report they have found cases where physical ailments were discovered to be a major contributor to behavioral health problems. Also, some clients seen for physical issues needed referrals for behavioral health treatment.

Before seeing a new patient at Comprehensive Care Services, the physician assistant confers with the psychiatrist. In the case of returning patients, the primary care provider reads the electronically recorded notes of the patient's most recent psychiatric visit.

Enabling the flow of information does not lead to inappropriate sharing of information. Consumers' rights regarding information-sharing are recognized and protected.

EXCEL staff strictly follows JCAHO (Joint Center for Accreditation of Healthcare Organizations), federal, state and company privacy policy in dealing with a patient's rights. Each employee also receives intensive training on privacy and ethics.

Consumers and providers in these programs reported during site visits that consent for the sharing of information is not an issue. Consumers more readily agree to the sharing of appropriate information when they know and trust both their mental health and primary care providers, when the need for sharing is clearly explained and when they control what information is shared. If they are initially reluctant, information is not shared but staff discuss with consumers the need for the various releases and the importance of integrated care.

Some programs use the same release form for sharing psychiatric and physical health care. However, when the primary care and mental health services are administered separately, each program is legally required to obtain consumer consent for sharing information. For example, the Center for Integrated Health Care and Thresholds are separate entities and individual releases must be obtained.

Often, integrated programs permit consumers to choose between on-site primary care services and services furnished by a primary care provider in the community. However, program staff see very strong advantages to the on-site services.

At Comprehensive Care Services, consumers who choose to receive care in the community must sign a release to permit sharing of information. However, CSS professionals report that it is more difficult to collaborate with community providers. Information is often not obtained in a timely manner. Some consumers refuse to have information shared, and others do not have a consistent relationship with a single primary care provider.

Barrier overcome:
Lack of access to care

These one-stop operations increase ease of access to physical health care by reducing the need for transportation. The co-location also enhances early identification of physical health conditions and access to appropriate treatment.

Consumers more readily agree to the sharing of appropriate information when they know and trust both their mental health and primary care providers.

At the Center for Integrated Care, breast, prostate cancer and TB screenings are routine. The Center conducts yearly physicals and has found that appropriate physical health screening rates are higher among its regular users (those with three or more visits per year), as follows: female members 18 and older receiving a Pap test in the preceding three years (61%); female members 40 and older receiving a mammogram and/or breast exam (71%); members 50 and older receiving a fecal occult blood test (56%); members 50 and older receiving a digital rectal exam (59%).

Embedded programs also place an emphasis on wellness. Recognizing the high rates of obesity, hypertension and other heart disease, the Center for Integrated Health Care runs a walking program and smoking-cessation programs that include nicotine replacement, frequent follow-up and motivational counseling.

Comprehensive Care Services offers health education and promotion programs on wellness, nutrition, exercise and smoking cessation. These programs are integrated into the psychosocial day rehabilitation program.

In one year, the Center for Integrated Health Care held 40 health-promotion presentations for 705 Thresholds members on issues including breast and prostate cancer screening, nutrition, the risks of sexual diseases, smoking and other aspects of health.

The embedded programs all pay particular attention to the serious physical health needs that are often neglected in people with serious mental illness. Programs have developed initiatives to reduce the higher rates of hypertension, diabetes, tobacco abuse, hyperlipidemia, asthma, HIV, and dental and foot problems. For example, the Center for Integrated Health Care gets students from Scholl's Podiatric School to provide podiatric care, which is particularly important because many of the Center's clients have a history of homelessness and diabetes.

Diabetes is a particular concern in all programs.

At Comprehensive Care Services, a retrospective chart review identified 94 patients with diabetes out of 691 active patients, for a 14% prevalence rate that is twice that of the general population. Most of these individuals had schizophrenia (40%), major depression (20%), schizoaffective disorder (17%) or bipolar disorder (10%).

Individuals with serious mental illnesses and diabetes often have difficulty understanding the need to comply with diet and exercise regimens. Adolescents and young adults with diabetes have a particularly hard time accepting that they have an illness that must be carefully managed every day of their lives. They may eat candy when they are upset or depressed and, as a result, may provoke a diabetic crisis. Many of the integrated programs have focused on diabetes with extremely good results.

The Center for Integrated Health Care found 15% of Threshold members have Type II diabetes. Center nurses spend time with these individuals, building a relationship of trust in order to teach self-care. Improved outcomes have been observed including improved blood glucose, weight, cholesterol and blood pressure levels. Regular users have significantly better health outcomes than occasional users.

Comprehensive Care Services has had considerable success in helping consumers control their diabetes. A review of quality of care for diabetes indicates a high level of control, indicated by the HBA1C level. Sixty-seven percent of patients had decreases in HBA1C at the latest assessment from baseline. This reduction in HBA1C was not related to the type of diagnosis. There was also some indication that younger patients had become more responsive to the need to improve their management of diabetes.

Integration can also lead to unique initiatives to help consumers deal better with a chronic health problem such as diabetes.

The Thresholds Diabetes House is a specialized group-living arrangement for up to 10 individuals who have both a serious

mental illness and diabetes. Individuals choose to live here because of their need for additional assistance. During the day, house members work or attend psychosocial rehabilitation programs. During evenings and weekends they receive support from live-in staff and other residents, and on-site nurses provide intensive ongoing education programs. Members jointly plan weekly menus that promote healthier eating habits.

The importance of integrated mental health and substance abuse treatment for individuals with co-occurring disorders is also recognized in these integrated programs. The Center for Integrated Health Care has a primary care clinic located in a residential program for dually diagnosed individuals. Working together, Thresholds staff and the on-site primary care provider have been able to help residents reduce their use of tobacco, alcohol and other drugs.

At the Thresholds group home for individuals with serious mental health and substance abuse problems, case managers and house staff provide social support to members, many of whom have lived on the streets and have physical health problems. Behavioral health services are provided through integrated treatment. The program has had considerable success with smoking cessation. Many members have worn a nicotine patch for a year or more and others have cut back dramatically on the number of cigarettes they smoke. Members have been motivated to reduce or quit smoking in order to be able to spend their money on other things.

Since these programs are located in mental health settings, access to mental health care is not an issue and there is evidence to suggest that embedded programs may actually increase appropriate use of mental health services.

At the Center for Integrated Health Care, members using the service regularly have decreased emergency room use and increased attendance at psychiatric day programs.

> **Access to mental health care is not an issue and embedded programs may actually increase appropriate use of mental health services.**

Barrier overcome: Inadequate training

Co-location, and the close collaborations that result, can provide continuing education for both primary care and behavioral health providers. Readily available consultation from the other discipline increases quality of care and contributes to on-the-job learning by all concerned.

At Comprehensive Care Services, psychiatrists are able to learn about new physical health medications and the treatment of physical health problems. They have become more comfortable initiating treatment for routine conditions. It is easier for them to stay up-to-date on primary care treatment and manage some patients' entire care.

Organized training sessions are not generally found in these programs because learning occurs naturally in one-on-one case consultations, in broader discussions of integrated care and through informal hallway conversations.

Barrier overcome: Consumers' concerns

These programs often resolve consumer concerns. Transportation problems evaporate because all providers are in the same location. Consumers appreciate the convenience of being able to schedule primary care and behavioral health appointments on the same day. Consumers in embedded programs express satisfaction and believe they have improved their physical health care. This satisfaction is reflected in the number who choose integrated care.

Ninety-five percent of those who receive mental health services from the EXCEL Group choose to have their primary care delivered at the clinic as well. Clinicians report that consumers have an increased sense of self-worth because they have a place that treats their total condition with compassion, professionalism and dignity and does not focus only on their mental health problems.

In all three integrated care projects at the Massachusetts behavioral health carve-out, the number of individuals who have a primary care provider increased, doubling at one site alone.

A third to one half of those using the mental health services offered by Comprehensive Care Services opt to use the in-house primary care services. Approximately 850 people a year receive primary care from the clinic.

Regular users of the services at the Center for Integrated Health Care are highly satisfied with their care, with 95% reporting that the program helped them with their health care needs. In another survey, 91% reported that the primary care staff clearly explained what they needed to do to care for themselves.

Consumers are also more comfortable with all their providers because the providers better understand and appreciate issues related to the other discipline.

Members of Comprehensive Care Services report that the primary care providers have an understanding of mental illnesses and treat them with respect. They also appreciate not having to repeat their history since it is already in the electronic record.

2. UNIFIED PROGRAMS

Many of the advantages of embedded programs are also achieved when behavioral health and primary care are combined, wholly or in large part, at the administrative and financial levels. Quality of care and safety improve.

We studied three sites with unified programs, whose models vary. The largest is a combined community health and mental health center. The others involve collaborations by public agencies.

✦ **Cherokee Health System**s is a nonprofit organization that runs both a community mental health center and a federally qualified community health center in rural East Tennessee. It opened its first integrated primary care and behavioral health clinic in 1984 and now provides integrated services at 21 sites. About 40,000 individuals were seen in 2001, of whom 44% sought primary health care and 56% sought behavioral health care. Cherokee offers a range of primary care and mental health services, including specialized services for individuals with serious mental illnesses, such as day programs and case management. Sub-

stance abuse outpatient services are also available.

✦ **The Washtenaw Community Health Organization** in Michigan is a collaboration between the University of Michigan Health System, a Medicaid managed health care plan, a county and the state. It provides integrated mental health, substance abuse and primary and speciality health care to Medicaid, low-income and indigent consumers. The organization serves a relatively small population with a manageable number of providers.

✦ **The Massachusetts Mental Health Services Program for Youth** is a collaboration of several state agencies (Medicaid, mental health, education, child welfare and juvenile justice) and the Neighborhood Health Plan, a managed care organization affiliated with Harvard Pilgrim Health Care. It has been in operation since 1998 with the goal of providing integrated mental health and physical health care to children and adolescents with severe emotional disturbance at risk of or returning from an out-of-home placement. The program handles 30 cases at a time.

One of the strengths of the unified models is that the financing of behavioral health and health services is also unified.

Barrier overcome:
Lack of provider time and reimbursement

One of the strengths of these models is that the financing of behavioral health and health services is also unified. This permits the agency to adjust the use of providers' time to allow both longer visits and opportunities for collaboration, both on individual cases and on overall procedures that facilitate integrated care.

Cherokee Health Systems is paid by Medicaid on a capitation basis, which provides flexibility in service provision. Fifty-seven percent of users are covered by Medicaid, 17% by commercial plans and 12% by Medicare. Federal and state grants supply an additional 9% of revenue. Adequate capitated payment of primary care and mental health care allows providers to spend more time with individuals with serious disorders.

All participating agencies contribute funds to the Massachu-

setts Mental Health Services Program for Youth and these are pooled and matched by Medicaid. The Neighborhood Health Plan (NHP) is paid on a capitated basis by Medicaid and is then responsible for care planning and provision or purchase of all medical, mental health and social support services for the children with serious mental disorders who are enrolled.

In Michigan, the Washtenaw Community Health Organization provides financial incentives to providers through a risk-sharing approach based on actual service use and financial data. Funds for the project come from community mental health and substance abuse grants and the University of Michigan. A risk pool of $1.5 million is funded through cost savings.[105]

In all three programs, primary care providers are paid through the agency for the time required for collaboration. For example, primary care providers at the Mental Health Services Program for Youth, are reimbursed for in-person attendance at the case-planning team meeting.

There is some indication that unified arrangements are economically efficient. The Mental Health Services Program for Youth reduced per member per month costs in its first year by 18% below the estimated capitation rate, while also improving access to physical health care.

In addition to giving providers more time with each consumer, these programs also make use of case managers to support primary care and mental health providers and ensure coordination for individual consumers. Mental health case managers work with both kinds of providers, conferring with primary care physicians and assisting with issues that arise for their patients.

At the Neighborhood Health Center, care managers lead the planning team and coordinate care with all providers and agencies. Care managers play a critical role in keeping the team accountable to the plan. The care manager is also responsible for engaging in information-sharing with primary care providers who are not affiliated with the plan but who are used by some of the families.

Cherokee Health Systems has behavioral health case management staff who are available to work with adults with serious mental illnesses and children and youth with emotional disturbance. Demand has increased for case managers to assist individuals who have chronic physical problems. Individuals with serious mental illnesses are more likely to forgo needed follow-up for physical health problems and to have difficulty navigating the health care system. Case managers improve the quality of care by sorting out complex histories or accompanying consumers to visits and filling in background information that the consumer is often unable to provide. With the ability to conduct home visits, case managers often provide vital information about the home situation.

Cherokee is a particularly interesting model for underserved areas that lack providers and need an efficient health delivery system. As a federally qualified health center, it can access federal programmatic and financial support targeted to underserved areas and populations, making it a potentially strong model for aiding struggling community mental health and health centers.

Barrier overcome: Cultural differences

Developing and managing an integrated organization requires considerable commitment from its top leaders and mutual understanding at the organization's top levels. To ensure smooth operations and strong collaboration, Cherokee's leadership holds two-hour weekly meetings, and weekly case management meetings include the entire clinical staff. The Mental Health Services Program for Youth gains the support of primary care physicians for its holistic vision of care by listening to provider concerns and responding to their needs.

In a unified system, primary care providers benefit from regular interactions with behavioral health staff that lead to mutual respect and good working relationships. The ongoing relationships that develop reduce opportunities for misunderstanding. By providing care

In a combined system, primary care providers benefit from regular interactions with behavioral health staff that lead to mutual respect and good working relationships.

to the same patients, all providers learn more about the other discipline and effective care practices.

Cherokee Health Systems has a high level of informal collaboration because providers can consult one another freely. In addition, regular treatment team meetings, usually held monthly, focus on difficult-to-treat patients. Occasionally primary care and behavioral health providers see patients together.

Washtenaw Community Health Organization's providers have developed solid personal relationships. There is trust among provider agencies and their staff, backed by support from organization leaders and a conscious and continued effort to create a successful collaboration.

Behavioral health providers do not have to worry about referring a consumer to a provider who has the necessary understanding and patience to work with individuals with serious mental illness. However, programs need to recruit providers who will be comfortable in such a closely integrated environment.

Cherokee Health Systems hires primary care providers who are comfortable with mental health issues and programs that emphasize collaboration, a team approach and consultations with behavioral health.

In a unified model, integration can be an agency-wide effort, involving all clinical and administrative staff as well as the leadership. As a result, individuals with mental illnesses reported that they feel extremely comfortable coming to the clinic.

At Cherokee Health Systems, front-line staff, accounting personnel and all support staff are seen as essential players in an integrated clinic. All are committed to the holistic approach and are comfortable interacting with individuals with serious mental illnesses.

The development of a single treatment plan in unified programs allows the primary care and behavioral

health providers to reinforce the same goals with consumers. Providers no longer unwittingly work at cross purposes and consumers are more likely to visit the primary care provider who is part of their treatment team.

Primary care providers who work on integrated teams find numerous advantages to this approach. They improve quality of care by learning critical information about a consumer's life from behavioral health providers who are able to spend more time with the person. This information often explains why a physical health condition has persisted or a patient has been unable to follow the treatment plan.

Primary care providers at Cherokee Health Systems report that they are frustrated when patients fail to follow treatment plans and make needed lifestyle changes. Behavioral health providers have helped them develop effective strategies to address the needs of consumers who fail to comply with their treatment, such as breaking down a treatment plan into smaller steps that are easier to follow. They gain an understanding of why some patients fail to follow through on beneficial treatment and lifestyle changes.

At the Mental Health Services Program for Youth Neighborhood Health Center, primary care providers participate on the Care Planning Team (CPT) that creates a single service plan for the participant's mental and physical health care. The typical monthly planning meeting involves the youth, family, others invited by the family, the care manager, providers, representatives from the school, case managers and case workers from the agencies involved. The team meeting results in an agreed-upon treatment plan and goals that are shared by all providers and agencies involved in the program, as well as the family.

These interactions are a significant cultural change for many primary care providers. For example, at the Mental Health Services Program for Youth, usually about half of the care-planning team is non-professional.

> **In the unified model, behavioral health care providers learn more about medical issues, treatment and terminology.**

Barrier overcome: Inadequate provider training

In the unified model, behavioral health care providers learn more about medical issues, treatment and terminology. As in embedded programs, most of the learning is the result of informal interactions or experience, rather than through formal didactic programs. However, issues can still arise. For example, the lack of a common vocabulary among providers and agencies at the Mental Health Services Program for Youth continues to cause some difficulties in working together as a team.

On the other hand, training is easier to conduct under the unified model. Programs can develop training on relevant issues and encourage or require staff to attend.

Barrier overcome: Poor information-sharing and lack of confidentiality

Unified programs generally work from an integrated medical record. A single medical record that includes physical health records, behavioral health records and all prescribed pharmaceuticals optimizes information sharing. The increased communication between providers means that consumers do not have to repeat the reason for their visit or recent health history and providers do not have to depend on patient recall to learn about the treatment plan.

Cherokee Health Systems uses an integrated paper medical record available to all treating providers. This includes the primary care record (including lab results and medications), a dental record and the behavioral health record in separate sections of a single folder.

Information-sharing is facilitated in unified programs through computerized data systems.

The Washtenaw County Integrated Health Care Project has created a data warehouse that integrates data on adults and children from seven state and local sources (including Medicaid eligibility files, utilization and cost data, and diagnosis and referral information), allowing the tracking of continuing care

and integration. Washtenaw also has a central information system built on the university's existing electronic record system. It uses a secure web browser and clinicians are able to access an integrated record, including lab results.[106] The effort has been possible through grant support, a commitment to research and the program's relationship with the University of Michigan.

Cherokee Health Systems is developing an electronic medical record. Records are merged into the same database and a data warehouse allows tracking of people with certain characteristics, such as depression or diabetes. The electronic record will eventually include prescription data, lab results and other information.

Neighborhood Health Plan (part of the Mental Health Services Program for Youth collaboration) has a single electronic medical and behavioral health record. However, as a result of heightened concern about the sensitivity of mental health issues of those in their care, the plan restricts access to mental health information for non-mental health providers, based on a need to know.

Individuals with serious mental illnesses are less concerned about sharing information with their primary care provider in a unified program where staff clearly work together.

Washtenaw Community Health Organization includes physical health considerations as part of a unified person-centered mental health treatment planning process. This reportedly facilitates consumers' comfort with sharing of their information.

Even though these models operate through single structures, some represent alliances among different organizations. Information exchange at the highest levels is therefore important.

At the Mental Health Services for Youth Program, commissioners from the five collaborating state agencies, the Secretary of

Health and Human Services and the parent organization are on a state-level steering committee. An Area Level Operations Team has also been formed for the agencies' senior clinical staff.

Barrier overcome:
Lack of access to care

This model creates either a single point of entry or "no wrong door" approach and thus offers increased access to both primary care and behavioral health.

The Washtenaw Community Health Organization has developed a single point of access. Individuals can call Health Services Access and receive screening for service eligibility and enroll in the appropriate public plan.

Referral to a primary care provider is much easier and individuals are able to receive prompt attention. More health conditions are identified and treated and behavioral health screening is improved.

In 2002, Cherokee Health System's Talbot Clinic adopted a tag-team approach to pediatric behavioral health screening. The social worker is introduced as part of the treatment team. In the waiting room, parents are given a Pediatric Symptom Checklist— a standardized list of 36 questions on behavioral health issues. The behavioral health provider scores it and then informs the pediatrician of any child with elevated scores that indicate a need for complete assessment. The pediatrician reviews the checklist results with the parents and then refers a child with elevated scores to the social worker for assessment and treatment. A higher identification rate for mental and emotional disorders among children occurs because systematic screening is conducted during the regular pediatrician visits.

Washtenaw Community Health Organization runs a citywide screening program to identify behavioral and physical health problems. Screeners are cross-trained in physical and behavioral health issues, and back-up specialists are available for dif-

> **The increased communication means that consumers do not have to repeat the reason for their visit or recent health history and providers do not have to depend on patient recall to learn about the treatment plan.**

ficult cases. Washtenaw mental health providers worked with the health plans to develop a screening protocol that includes referrals to primary care providers for acute care or to the mental health program for more intensive services as needed.

These programs include routine preventive health care. For example, at Washtenaw, all community mental health clients receive a yearly health-risk appraisal and physical health issues are included as part of the person-centered mental health treatment plan.

Members with complex needs are more easily followed in these plans.

Cherokee Health Systems has found that individuals with co-occurring substance abuse disorders are being identified and receiving treatment. A diabetes disease management program run by the agency as part of its community health center program enabled adults with serious mental illnesses and diabetes to have access to state-of-the-art care.

Measurable improvements have been seen among participants in the Mental Health Services Program for Youth. Although no control group was used as a comparison, the program reported success since CAFAS (Child and Adolescent Functional Assessment Scale) scores on symptoms and problem behaviors declined by 28% and level of functioning increased by an average of 8% on the Child Global Assessment. Inpatient hospitalization rates fell by 300%.

Barrier overcome:
Consumer concerns

Unified and embedded programs are satisfying to consumers for many of the same reasons. Because they get to know all the providers at the clinic, consumers in the unified programs report they are more likely to visit their primary care physician regularly.

A sample of 85 patients at three integrated care sites at Cherokee Health Systems found especially high ratings regarding access and communication with providers.

> **Unified programs can reduce the stigma of seeking mental health treatment because the clinic is not identified as a "mental health program."**

Unified programs can also reduce the stigma of seeking mental health treatment because the clinic is not identified as a "mental health program."

Consumers in rural Tennessee are concerned about the stigma of seeking care at a mental health program. At Cherokee Health Systems, they do not feel isolated or stigmatized due to their mental illnesses. The local community is aware that people are treated for all types of illnesses at the clinic, and once in the clinic, mental health consumers find that all are treated in the same way.

OVERALL EFFECTIVENESS OF EMBEDDED AND UNIFIED PROGRAMS

Based on anecdotal information, outcomes and consumer satisfaction, embedded and unified programs improve continuity and coordination of care for individuals with serious mental disorders. Consumers respond well to these approaches and benefit from the emphasis on wellness and prevention, easy access to health services and on-going relationships with providers that result in higher quality, less fragmented care. Primary care and psychiatric providers also find they are better able to distinguish between mental health and physical health issues and that information sharing is easier. In addition, these integrated approaches foster innovative projects like the diabetes house at Thresholds and or its group residence for those with co-occurring substance abuse disorders.

We learned from this study that once the program has created a climate for changes to occur, communication barriers simply fall away. Problems of time and space that occur in separated programs just do not exist. Consultation and cross-learning are relatively easy because most staff see each other every day in meetings, in the lunch room or in hallways, and mechanisms for easy communication with other staff are worked out. Interactions across disciplines are more regular and relationships are built that lead to greater understanding of the prob-

lems that previously created cultural barriers between separately practicing providers.

Primary care providers appreciate how mental health can affect physical health treatment and mental health providers gain a greater appreciation of the effect of prompt, effective treatment of physical complaints on mental health status. Primary care providers also learn how to relate more effectively to individuals with serious mental disorders. They grow to understand the importance of other issues in their patients' lives and how mental health relapses mean that compliance with treatment may not be constant. Confidence in these skills builds over time, and staff in all of the programs visited reported learning a great deal from the other discipline.

Formal information-sharing is also facilitated. Embedded and unified programs can develop an integrated record, either paper or electronic, depending on the program's capacity. Consumers are also more likely to feel comfortable about the sharing of information between providers who operate out of the same program and with whom they have a regular relationship. None of these programs reported difficulties in obtaining consumer consent for sharing information.

Embedded or unified programs are considered superior to other collaborative efforts by those who run them. Prior to establishing the in-house clinics, Thresholds found that collaboration with primary care providers in the community did not work well. Too many Thresholds members failed to understand their provider's directions and some did not take their medications for physical disorders.

Consumers in each of the embedded or unified programs visited for this study were uniformly enthusiastic about the approach. In all programs, consumers had a choice, but the majority of them used the co-located services, a sure sign of satisfaction.

The most problematic area is financing, as all of the programs have required funding over and above third-party billings in order to operate. Cherokee has been the most successful in obtaining third party reimbursements to cover its costs. The other two unified programs have

Once a unified or embedded program has created a climate for changes to occur, communication barriers simply fall away.

special funding arrangements: Washtenaw is affiliated with a medical school and the Mental Health Service Program for Youth was begun with a foundation grant and is still supported by state funds. All of the embedded programs have required grant funding or other special cash or in-kind resources to operate their program effectively.

3. CO-LOCATION OF BEHAVIORAL HEALTH SPECIALISTS WITHIN PRIMARY CARE

The co-location of mental health professionals in primary care settings is a third model for moving mental health into the mainstream of general health service delivery. A number of projects have demonstrated its success,[107] especially for individuals with less severe mental disorders.

Studies find that diagnosis and treatment significantly improved in this type of co-location model—not only when the mental health professional provides the diagnosis and treatment directly, but also when the mental health provider has an active role in teaching, supervising and coaching the primary care provider.[108] For individuals with serious mental disorders who may be seen in these settings, it is important for the co-location project to have strong links to the public mental health system.[109]

Generally, these co-location initiatives focus on people who seek and normally receive their mental health care from a primary care provider. These individuals tend to have less severe disorders than people seen in speciality settings. Since depression is prevalent among primary care patients and individuals with depression often come in with a physical health complaint, this model has been studied primarily with regard to depression.[110]

We found co-location of behavioral health care staff at primary care sites in some of the states visited.

In Multnomah County, Oregon, mental health and substance abuse providers are located at several primary care clinics,

depression and anxiety disorders, mostly in six to eight fo-cused, short-term visits. These clinicians rarely treat individu-als with psychotic disorders.

Network Health, a safety-net, provider-sponsored, Medicaid-only managed care organization in Massachusetts, brought behavioral health services in-house and found this increased its ability to work collaboratively on complex cases that involve physical and behavioral health issues. Members are followed by medical, behavioral and social case managers. Integrated team meetings are held weekly to discuss these cases.

Co-location projects also improve treatment for individuals with serious physical illnesses, who often have co-oc-curring depression or other mild to moder-ate mental health disorders.

In Oklahoma Medicaid, many members with an exceptional-needs coordinator have both physical health and behavioral health issues. Long-term chronic physical health conditions can cause behavioral issues, usually around treatment compliance, or the impact of a chron-ic condition can lead to depression. Heartland, one of Oklahoma's health plans, estimates that 50% of members with exceptional needs have behavioral health issues as well. Excep-tional-needs coordinators refer some members for therapy and mental health treatment.

However, co-location is not always successful. In one attempt, placement of a psychologist in a primary care practice was initially successful, with informal dia-logue and training between the providers and easy access to appointments. Unfortunately, time spent discussing cases was not funded, and within six months the psy-chologist had a full schedule of appointments that left no time for informal contact. The psychologist left the practice after less than two years.[111]

> **Co-location projects also improve treatment for individuals with serious physical illnesses, who often have co-occurring depression or other mild to moderate mental health disorders.**

Barrier overcome:
Lack of time, lack of reimbursement

This model can improve the productivity of the primary care provider, compensating for lack of collabo-ration time. As a member of the team, the behavioral health specialist can provide quick response on con-sultations, diagnose patients, and provide short-term interventions and specialty referral. The degree of col-laboration on individual cases depends on the working arrangements established, but the immediate access to the behavioral health specialist encourages quick follow-up and creates opportunities for collabora-tion across disciplines.

Co-location addresses some of the barriers in reimbursement rules because a behavioral health provider who is able to bill for behavioral health triage, consulta-tion and treatment is now at the primary care site. In many situations, the behavioral health specialist is paid by a mental health entity, either through a special grant (public or private) or through the mental health program's budget.

The federal Health Resources and Services Ad-ministration (HRSA) has provided additional grant funds to federally qualified health centers for behavioral health services. The Hackley Community Care Center in Michigan hired a social worker who assesses individuals for men-tal illness, provides brief interventions for those with less seri-ous problems and refers people with serious mental illnesses to community mental health centers.

Barrier overcome:
Cultural differences

As in the embedded and unified models, co-location of behavioral health specialists in primary care can break down barriers related to practitioner issues. Co-located behavioral health specialists have opportunities to inter-act and establish routine working relationships with the primary care providers. The team approach offers the op-portunity for cross-learning between providers.

The Knoxville County Health Department has a psychologist on the same hall as primary care providers. The behavioral health provider is an active part of the team. Adapting to primary care culture, the psychologist allows interruptions for immediate consultations and psychiatric crises. The team has experienced a high level of cross- learning and has seen an increase in the identification of primary care and behavioral health issues.

Co-location allows the linkages between primary care patients and the public mental health system to be made through a behavioral health specialist. Generally, such a specialist can relate better than primary care providers to the public mental health agency's procedures and understands the differences in day-to-day operation, including how, when and with whom to collaborate in the mental health program.

Lifeways, a community mental health program in Michigan, has located a psychiatrist at a local health center one day per week. She provides psychiatric consultations and medication evaluations. The psychiatrist is paid by Lifeways. The health center has also made case managers responsible for linking primary care clients who have behavioral health issues with other needed services.

Barrier overcome: Lack of training

The presence of a speciality mental health provider on the team supports the primary care provider in identifying mental disorders and taking on an expanded role in managing mental health problems. The specialist can give the primary care provider—particularly one who may be reluctant to initiate screening and treatment—information and the confidence to begin screening and managing patients for uncomplicated mental health and substance abuse conditions.

Many of the practitioner-training initiatives described under other models can be used in this model and therefore are not repeated here.

With a behavioral health provider on site, access to behavioral health crisis evaluation and short-term therapy improves at the primary care clinic.

Barrier overcome: Poor information-sharing and lack of confidentiality

Improvement in the sharing of medical, behavioral and pharmacy information is immediate. On-site behavioral health providers, responsible for triage and short-term treatment, can share information with primary care providers. As in embedded or combined programs, consumers are more willing to sign consent for such sharing when providers are seen to be working as a team.

However, in some cases, the behavioral health provider continues to be employed by a behavioral health organization. In this case he or she will likely use separate medical records and patient consent forms.

In Multnomah County, Oregon, mental health providers in primary care clinics are employed by a separate division of the state, and an additional consent form is required before information can be shared with primary care providers. This has proved burdensome.

Sharing of information about consumers with serious mental illnesses will depend on the degree to which the primary care site (including the co-located behavioral health specialist) provides services directly to this population. If the behavioral health specialist provides long-term care, information can be more easily shared.

Barrier overcome: Lack of access to care

With a behavioral health provider on site, access to behavioral health crisis evaluation and short-term therapy improves at the primary care clinic. The presence of a behavioral health provider alleviates primary care providers' concerns that mental health referrals are not seen promptly.

In Multnomah County, Oregon, a depression collaborative has placed behavioral health specialists in the East County Health Clinic, a community health center serving a predominantly Latino population. The project uses a standardized instrument

for identifying and measuring the severity of depression and implements the planned-care model approach to treating chronic illnesses. Identification of major depression increased more than 200% overall from the pre-collaboration rate. All clients with major depression have a structured assessment and more than half are seen for follow up within six weeks.

In South Carolina, a community mental health center has placed two masters level clinicians at two primary care clinics in Charleston's inner city. The mental health professionals work with a pediatrician, and a psychiatrist goes to the clinic about once a month. The primary care providers can refer children and families easily and be assured of a quick response. The mental health clinicians have their own office and each serves about 25 children and families at any one time. Most of the children have Attention Deficit Hyperactivity Disorder, often with other co-occurring disorders.

Barrier overcome:
Consumer issues

Consumers find primary care settings to be less stigmatizing and they appreciate having all of their health care needs addressed at one site. In the case of children, the family relationship with the pediatrician may help in facilitating discussion of behavioral health issues.

Overall effectiveness

A number of demonstration projects have shown this model to be effective for the treatment of mild and moderate mental disorders.[112] Since the costs of all health care are managed in one setting, primary care providers' practices may benefit from any cost-offsets resulting from the furnishing of prompt and effective mental health care.

As a general rule, the co-location sites currently meet the needs of children and adults with mild and moderate mental illnesses more than the needs of adults with serious mental illnesses. However, such arrangements may avert burnout among primary care providers serving individuals with serious mental disorders. Further, to the extent that primary care providers now serve many individuals with serious mental illnesses whose conditions are stable, this model can provide mental health backup and quick intervention and referral if there is a relapse.

4. IMPROVING COLLABORATION BETWEEN SEPARATE PROVIDERS

When behavioral health and primary care providers practice separately and have separate administrative structures, information systems and financing streams, furnishing integrated care is extremely difficult. This model requires numerous adjustments and special activities to overcome the isolation of physical and behavioral health providers and to address the barriers. On the other hand, this model causes the least disruption to traditional practice. In many places, it may be the only approach possible in the short term.

Initiatives to improve collaboration among separate providers are most often developed to address primary care providers' most pressing concerns regarding mental health—e.g., improving the detection and treatment of depression and increasing access to mental health consultation, crisis evaluation and referrals. Less common are policies to encourage coordination and collaboration in meeting the needs of individuals with serious mental disorders.

The four statewide Medicaid systems studied (Massachusetts, Michigan, Oregon and Oklahoma) all address coordination of primary care and behavioral health for people with serious mental disorders in some fashion. Strategies employed in these states include special targeted programs, financial incentives for collaboration, managed care contract requirements, provider education and training initiatives.

Barrier overcome:
Lack of time, lack of reimbursement

Lack of reimbursement for the time needed to engage in effective collaboration remains an issue in all four of the statewide systems reviewed. Although each provides a higher capitation rate for individuals eligible for Medicaid as a result of severe disability (that is, receipt of federal SSI benefits), few systems increase the capitation rates for individuals with the most serious mental illnesses whose care might require significant collaboration time. In contrast, some of these systems provide higher capitation rates for certain physical health diagnoses. Only Or-

egon provides an enhanced capitation for any group of individuals who need behavioral health care, and this is limited to substance abusers on methadone. As a result, capitation rates do not always correlate with workload.

In place of financial compensation, some initiatives in these states may reduce primary care providers' workload by ensuring behavioral health backup when they treat individuals with significant mental health disorders. For example, primary care providers reported that adults with mental illnesses often fail to show up for appointments, but the provider is unable to bill for this lost time.

The Massachusetts Behavioral Partnership, a carve-out plan, offers targeted outreach to difficult-to-engage consumers with medical and behavioral health issues. Primary care providers can request targeted outreach for members who fail to follow up for treatment or appointment referrals. The service helps offices with heavy workloads that can't afford the extra time to track hard-to-reach patients. These outreach workers were seen as successful in reaching individuals lost to follow-up.

To reduce the no-show rate, several programs, including Lifeways in Michigan, have case managers provide transportation and/or accompany members to appointments.

Oklahoma and Massachusetts require that health plans have staff available to assist providers in reaching members who are disconnected with the health system or who may fail to show up for referrals.

Behavioral health care staff also can respond when the primary care provider needs assistance with a particular situation.

Beacon Health Strategies, a behavioral health plan in Massachusetts, developed a mobile assessment team that is available to screen individuals in a psychiatric emergency. The team will arrive within an hour at primary care provider offices. About

When behavioral health and primary care providers practice separately and have separate administrative structures, information systems and financing streams, furnishing integrated care is extremely difficult.

125 people a year are evaluated. Provider response has been positive and nearly all individuals seen were diverted from hospital care.

States can provide financial incentives to encourage behavioral health plan efforts to support primary care providers.

Massachusetts has quality-improvement projects linked to bonus payments. The effort focused on the 7,500 individuals with serious mental illnesses who were dual beneficiaries of Medicaid and the Department of Mental Health services. These consumers were seen as most in need of assistance in negotiating the health care system. The state used large financial incentives to ensure that the behavioral health carve-out entity improved communication and collaboration with primary care. These efforts included assistance to pediatricians for mental health screenings, expanded case management and increased coordination of physical health care for psychiatric inpatients.

The most common strategy for overcoming barriers to coordination of care between separately located providers is to assign this responsibility to case managers. The managed care contracts in all four states require health plans to offer case management or care coordination for complex and high-cost cases. Consumers for whom case management services are appropriate are typically identified though their use of hospital or other high-cost services. In addition to the case mangers who provide in-person clinical care and support at the offices of behavioral health providers, there are often plan-level case managers. Some states require more than one level of case management.

The Oklahoma Medicaid contract requires health plans to provide exceptional-needs coordinators (ENCs), who are registered nurses, to manage the care of members qualifying for Medicaid due to disability. In addition, behavioral health specialists coor-

dinate medical and behavioral health care for individuals with serious mental disorders. An estimated 30-50% of members who have an ENC also have behavioral health issues. In one plan, the ENCs and mental health case managers work in the same office, conduct home visits together and coordinate closely on individuals' needs. In another plan, they meet via conference call once a week.

Massachusetts requires that the behavioral health organization and managed health care organizations provide three levels of case management: 1) intensive case management (ongoing support to individuals with serious illnesses who have repeated hospitalizations), 2) care coordination (periodic, short-term support to improve the appropriate use of health care and prevent use of higher levels of service) and 3) targeted outreach (brief, one-time outreach to difficult-to-engage consumers with health issues).

Case managers also perform periodic reassessments and contact consumers on a regular basis to make sure they continue to make progress. In Oregon, Josephine Behavioral Health funds case managers to accompany consumers to medical appointments and to make home visits that can provide additional information about the individual's living situation and social environment.

Case manager qualifications vary, but utilization of nurses or physician assistants is particularly effective for case managers who are responsible for both physical and behavioral health care coordination.

Barrier overcome: Cultural differences

While the embedded and unified programs can draw on day-to-day proximity to bridge cultural divides, it is more difficult to overcome barriers between individual providers using only policies to improve coordination.

In Massachusetts, a behavioral health provider and the Neighborhood Health Plan, a managed health care organization, report finding coordination between physical health and mental health an enormous challenge due to the fragmentation of the

While the embedded and unified programs can draw on day-to-day proximity to bridge cultural divides, it is more difficult to overcome barriers between individual providers.

health care system and the priority that individual providers place on autonomy.

Sometimes, however, special initiatives have produced collaborations that break down these barriers.

Josephine Behavioral Health (JBH) received a $100,000 state grant to develop an 18-month project to improve the quality of care for depression through activities promoting coordinated care. JBH is in a rural county with a history of collaboration between primary care and mental health providers, due in part to the lack of psychiatrists (fewer than five in a county of 70,000). A steering committee brought together public and private agencies, including the Department of Human Services, Pathways to Care Network (a voluntary group representing providers) and the enhanced-needs care coordinator from the Medicaid health plan. Participation on the steering committee increased understanding between agencies and improved their coordination of services. The project's success required a commitment from the top leadership of both public and private primary care and mental health agencies and considerable investment by direct-service staff.

Michigan mental health programs have attempted to address some primary care physicians' preference for referring patients to individual psychiatrists rather than an agency or other mental health professionals.

North Central community mental health agency reorganized psychiatric schedules into half-hour appointments to increase capacity. The agency also organized quarterly meetings with each primary care physician's office to discuss opportunities to improve relationships and ensure appropriate referrals.

Several of the sites reported that some primary care providers are much better able than others to work with individuals with serious mental illnesses. The depression management project of Josephine Behavioral Health came

to this conclusion. In Michigan, mental health providers cite Medicaid's low payment rate, high no-show percentage, some consumers' poor hygiene, and provider discomfort with mental illnesses as reasons why some primary care providers do not work with individuals with serious mental illnesses. This was confirmed by families and consumers in interviews. Family members complained they were unable to find primary care providers who work well with their child and can treat their child's complex physical and mental health problems. Adult consumers reported that some primary care providers attribute all their problems to psychiatric origins.

Recognizing these frustrations, programs often choose to refer consumers to primary care providers who are most interested in working with individuals with serious mental disorders. Other programs try to engage a broader group of primary care providers.

Josephine Behavioral Health organized educational sessions for primary care providers to meet and socialize with psychiatrists they did not previously know. As a result, the primary care providers gained a better understanding of the limited resources that force the mental health agency to prioritize its service recipients.

Some additional activities can enable primary care providers to become more comfortable treating mental health conditions and in understanding when to refer to speciality care. Primary care providers appreciate psychiatric and pharmacy consultation services that help them serve individuals with mental disorders.

The Oregon Health and Science University runs a 1-800 consulting service for all licensed providers. Psychiatrists who have expressed an interest in working with primary care providers handle psychiatric consultation calls, usually for non-emergency situations.

West Michigan Community Mental Health System makes staff available to primary care providers for in-office and phone

consultation and to serve as a resource for information, training and presentations to health professionals.

In Massachusetts, Beacon Behavioral Health System established a consultation line for primary care providers, including pediatricians, to speak to psychiatrists. It also maintains and updates a list of behavioral health providers on its website.

Barrier addressed: Poor information-sharing and lack of confidentiality

When providers are in different physical locations, information-sharing is slow and cumbersome. While information is typically faxed between provider offices, plan officials in Oregon report that practice differences create problems. The behavioral health record—the substance abuse treatment plan, in particular—is often too long for many primary care providers to read in the time they have available. Some mental health programs in Massachusetts, pressed for time, reportedly copy the entire mental health record, a practice that frustrates busy primary care providers.

To better meet primary care providers' needs, several mental health programs have adopted referral and information-sharing practices that are customary between primary care physicians and other specialists. For example, forms for sharing information include only the basic information that is needed. The entire treatment record is not forwarded.

Another common complaint from both behavioral health and primary care providers is that often they do not receive feedback after making a referral.

Ceres in Portland developed a strategy for improving communication between primary care and mental health providers, who would normally have little interaction. Its contracts require mental health providers to send letters to inform primary care providers when individuals contact or use mental health services. However, this initiative did not result in the primary care providers' reciprocating.

> **Several mental health programs have adopted referral and information-sharing practices that are customary between primary care physicians and other specialists.**

Macomb-Oakland Regional Center in Michigan has improved information-sharing by having psychiatric nurses who accompany individuals to primary care appointments obtain copies of the reports for the psychiatrists and clinical staff at the mental health program. In some areas Assertive Community Treatment (ACT) teams also do this.

In Michigan, concerns are addressed in face-to-face meetings between community mental health program staff and primary care providers.

The leadership staff of Lifeways meets annually with the 80 largest primary care organizations/ providers to discuss concerns. Common concerns are mental health providers' failure to acknowledge referrrals and consumers' reluctance to sign releases of their mental health information to primary care providers. Lifeways adopted a policy that mental health providers must contact all referring primary care providers and must allow patients to decide what information will be shared with the primary care providers.

Some health plans use their quality assurance mechanisms to assess coordination, but results indicate that the necessary information-sharing often still does not occur.

Providence Behavioral Health Connection in Oregon uses annual chart reviews to check for signed releases and any record of communication and follow-up treatment between mental health, substance abuse and primary care providers. A 2001 chart review found that at least eight of every ten records included a primary care provider's name and phone number and documented coordination with the primary care provider (such as a list of physical diagnoses and medications or treatment plan sent to the primary care provider). However, the plan reportedly found more communication from the mental health provider to the primary care provider than in the other direction.

In Massachusetts, the Medicaid agency and the mental health authority collaborate in targeting improved coordination and

The most critical area for information-sharing relates to pharmacy. The accuracy of pharmacy information can be improved if providers develop a system to regularly update each other on new prescriptions.

collaboration between systems. Medicaid includes requirements in its managed health care contracts for annual improvement goals and special projects aimed at increasing the level of communication and collaboration. The state has several years of experience with such requirements and has seen improvements in several areas as a result.

The most critical area for information-sharing relates to pharmacy. The accuracy of pharmacy information can be improved if providers develop a system to regularly update each other on new prescriptions. Otherwise, accurate information depends on patients' self-report.

In Michigan, Macomb-Oakland Regional Center uses a pharmacy benefit manager (PBM) to assist in coordinating psychiatric and other medications. The PBM identifies inappropriate prescribing, potential drug interactions and notifies its providers of these issues as well as unfilled prescriptions.

The Medicaid agency and behavioral health carve-out entity in Massachusetts have developed a comprehensive database that contains behavioral health, physical health and pharmaceutical information. The database is easily manipulated to identify members with high service-use rates. Medicaid also requires its managed care entities to identify and track members with complex needs and frequent use.

Problems in coordination also result from failure to share information at times of transition, such as following psychiatric hospitalization.

Providence Behavioral Health Connection in Oregon tracked notification of providers when an individual is discharged from a psychiatric hospital and found that in only 55% of cases were primary care providers notified within three days.

In Massachusetts, it was found that institutionalized youth often lose follow-up on physical health treatment and medication.

Confidentiality issues can be a barrier to information-sharing, either because of tighter rules for sharing of mental health and substance abuse information or because consumers have concerns and are unwilling to have their information shared.

In Oregon, some primary care providers' efforts to work with mental health and substance abuse providers are frustrated when, because of the state's heightened protection of mental health information, they are not informed about the status of a referral. State law increases these difficulties by limiting consent to six months.

However, in most states, confidentiality laws are not the barrier, provided the consumer signs a consent. Mental health provider practices can be a more significant impediment. To overcome this, states and health plans may encourage mental health providers to routinely ask all consumers to sign a release so information can be shared with their primary care provider.

Office systems can also be set up so that patients sign medical and behavioral health information releases at the same time. An effective approach is a dual release form for patients to sign at the initial primary care visit. This allows primary care providers to learn if a referred patient initiated behavioral health care.

When seeking consent, systems need to be sensitive to consumers' concerns about who will have access to information related to their psychiatric condition. Consumers interviewed during the site visits expressed concern about the practice in Massachusetts of sharing an entire psychiatric record with primary care providers; some are concerned about even sharing their diagnosis. Consent for oral communication between providers makes some consumers uneasy. Forms that easily allow consumers to indicate what mental health information can be shared (and therefore to prevent the sharing of other information) are an advantage.

When seeking consent, systems need to be sensitive to consumers' concerns about who will have access to information related to their psychiatric condition.

The Multnomah County Health Department has developed a standard one-page release of mental health information. The release easily allows consumers to indicate specific information that they are willing to share, such as problems, medications and lab tests.

Barrier overcome: Lack of training

Experience in several states indicates that one of the biggest challenges in improving coordination of care is educating busy primary care providers about mental health disorders, the services available for referral and evidence-based practice. It is important not to waste time and effort on general education initiatives that may have extremely limited success. Instead, plans and mental health programs have been more successful when the information they furnish is relevant to concerns that are a high priority for the primary care providers. Health plans and behavioral health organizations in all four states had conducted educational campaigns aimed at primary care providers. Written materials often focused on how to identify and treat specific mental health disorders and included a list of available mental health services.

In 2001, the Massachusetts Medicaid agency, the Department of Mental Health and the Massachusetts Behavioral Health Partnership developed a two-page guide for primary care providers on providing care to members with serious mental illnesses. The guide was developed in collaboration with a consumer advisory council and primary care providers experienced in working with with people with serious mental illnesses. It includes information from a consumer focus group. Appointment-scheduling, communication during the office visit and the importance of allowing extra time to build rapport are discussed. A companion cover letter reminds providers that they can use a billing code that reflects the visit's complexity, thereby increasing reimbursement.

JBH in Oregon is training primary care providers on how mental health services are accessed and how to appropriately treat

mild to moderate depression. They have provided training to 10 primary care providers on how to treat depression, using a curriculum developed by the MacArthur Foundation. The trainings include information about how to refer individuals with more serious illnesses to mental health organizations. Many primary care providers, including two who initially seemed uninterested, have learned about the treatment of depression and changed the way they treat it.

The Massachusetts Behavioral Partnership, the behavioral health carve-out entity, also offers continuing education programs for health providers. Sessions focused on dealing with challenging patients had larger primary care attendance than sessions described as focusing on mental illnesses, even though similar material was covered.

Trainings are generally geared to address common primary care provider interests, particularly identifying behavioral health issues, providing evidence-based treatment of depression and dealing with difficult patients.

In Michigan, community mental health programs typically begin by meeting face-to-face with primary care providers with whom they have the most frequent interactions and asking how they might be helpful. The programs have found that most primary care physicians want information in targeted, concise and practical formats.

Our visits found various other approaches to provider training:

In 2002, the Oregon Medicaid agency organized "Making It Work: Primary Care and Mental Health Care," a statewide conference on physical health and mental health coordination. More than 200 primary care providers and psychiatrists attended the two-day conference and received extensive materials. The conference raised the profile of this issue and allowed individuals from across the state to learn from each other's experience.

One of the biggest challenges in improving coordination of care is educating busy primary care providers about mental health disorders, the services available for referral and evidence-based practice.

CommunityCare, an HMO in Oklahoma, has developed a videotape for primary care providers describing the latest depression treatment. Initially, CommunityCare planned to conduct live presentations, but found that providers were too busy to attend. The video format allows providers to view it at their convenience.

Barrier overcome: Lack of access to care

Stakeholders in all the states noted that the shortage of behavioral health providers had an overriding adverse affect on coordination, referral and consultation with primary care. The behavioral health providers had limited time to spend on issues outside of direct clinical care and agencies could often not even schedule initial appointments with newly referred individuals. This discouraged referral by primary care providers. However, sometimes this barrier is more perceived than real.

In Michigan, Summit Point, a community mental health services provider serving the Battle Creek area, reorganized to work more effectively with primary care providers in managed care. Summit Point created a position responsible for outreach and educational programs for primary care providers. To learn about the referral process and the available mental health services, this staff person usually communicates with office managers at individual provider or group practices. In addition, a yearly meeting is held with 25 to 30 of the 200 primary care providers in the area, targeting those who have the greatest contact and share the most patients with Summit Point.

In Oregon, Josephine County officials found that primary care providers often did not know what services were available and how to access them. In response, some community mental health centers that collaborate with primary care have opened up their schedules to respond to provider concerns about inaccessibility.

Access to behavioral health care is often hampered by lack of identification of mental disorders in primary

care. Three of the states (Massachusetts, Michigan and Oklahoma) have prioritized screening by primary care providers to improve identification and each has seen improvements from these efforts.

However, providers may believe that they are already identifying those with serious mental or emotional disorders. During our site visit in Massachusetts, state officials described a project several years ago, which found that despite promotion of a standardized mental health screening instrument (the Pediatric Symptom Checklist, PSC) by the Neighborhood Health Plan and its behavioral health subcontractor, only a small percentage of children were screened. From the 2,000 PSCs completed, only 20-25 children were identified as in need of further mental health diagnosis and treatment (compared to an estimated 11% of American children who have a diagnosable mental or addictive disorder associated with a significant impairment[113]). Convincing pediatricians and other health center providers of the importance of a thorough mental health screen was clearly the key to widespread implementation. Other barriers to a systematic adoption of the screen included limited provider time and resistance to a standardized instrument.

Early identification of an individual's mental health needs can reduce the burden on primary care providers to conduct such evaluations. In Oklahoma, plans have an incentive to identify members with serious mental illnesses because these members have a higher capitation rate. Members in the Special Programs for the Aged, Blind and Disabled eligibility category are eligible for enhanced services, as are members who qualify for Medicaid due to low family income if they meet certain criteria. Nonetheless, despite an increase in identification rates in 2002, the state Medicaid agency has the impression that primary care providers are still underidentifying mental health issues in children and adults.

In Massachusetts, Neighborhood Health Plan's member services conducts a comprehensive health risk assessment of 33%

Three of the states have prioritized screening by primary care providers to improve identification and each has seen improvements from these efforts.

to 50% of its new members. New members are asked whether they have ever had any mental health treatment. Members who answer affirmatively are asked whether they would like help now and if someone can call them back. If a member has more immediate mental health issues, NHP member services can effectuate a transfer to the behavioral health care provider, provide a 1-800 number for the member to call or have the behavioral health care provider call the member.

PrimeAdvantage, a health plan in Oklahoma, conducts home visits for its members who qualify for case management. During the visit, an enhanced needs coordinator, who focuses on physical health issues, and a mental health case manager meet with the member at the same time. This approach increases the identification of co-occurring mental and physical health conditions.

Another strategy is prepayment of mental health visits, which allows access to emergency consultation and treatment for an individual with mental health problems.

To reduce emergency room use and care delays, Beacon Health Strategies pays in advance for a limited number of behavioral health provider visits for services that are particularly difficult to access, such as child psychiatry and evaluations. Providers are paid for the hours whether or not a patient shows up. Beacon currently purchases 30 hours per month, and these hours are available to Medicaid and other insurers. The strategy has been successful; most of the pre-paid slots are used.

Barrier overcome: Consumer issues

Consumers in systems where behavioral and physical health care are furnished by separate providers report finding very little collaboration. Many individuals interviewed for this report complained that even to ensure that their medications are safe, they must take their pill bottles to each provider to ensure that all providers are aware of all medications. They view themselves as providing their own case management.

Overall effectiveness

Although these approaches to improving collaboration among separate providers have some success in improving relationships and bridging the cultural divide, it was apparent from this study that many problems remain and results are at best mixed. Despite some provisions relating to capitation and reimbursement issues, this approach does not fully address the dual problems of lack of time and inadequate funding for meaningful collaboration.

Also, with a heavy emphasis on the primary care providers' need to treat depression and other acute disorders, few of these initiatives focused on improving the identification of physical health issues in individuals with serious mental disorders in behavioral health settings or developed training on medical care for behavioral health providers.

Nonetheless, some of the activities described above may be necessary for consumers who remain with separate providers or whose conditions are stable and appropriately managed through primary care.

Although collaboration between separate providers has shown some success in improving relationships and bridging the cultural divide, it was apparent that many problems remain and that results are at best mixed.
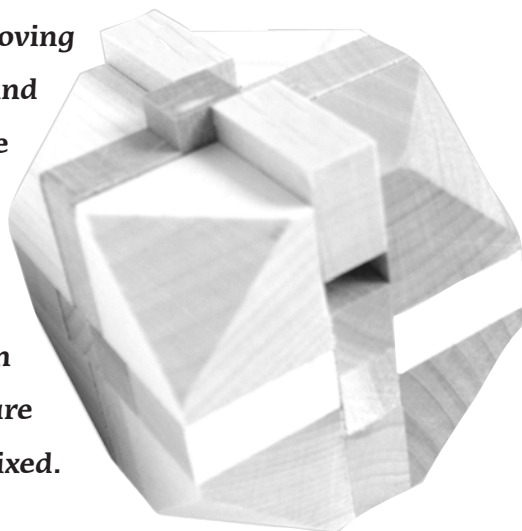
CHAPTER 4

Models of Contracting to Encourage Integrated Care

If integrated care is to become system-wide and part of the routine provision of health care to adults and children with serious mental disorders, the models of service delivery described in Chapter 3 must be incorporated into state financing systems. Public-sector mental health services are now heavily reliant on Medicaid funding, especially for community care, and Medicaid is now the major source of funding for community services.

Physical health care funded by Medicaid is predominantly provided in a managed care environment. Because of the unique challenges of accomplishing integration of physical and mental health care in the context of managed care, this chapter discusses issues related to Medicaid managed care contracting.

Creating integrated contracts does not automatically lead to integrated care for individuals.

ORGANIZATION OF MEDICAID MANAGED CARE ARRANGEMENTS

More than half (56%) of all Medicaid enrollees are in some form of managed care.[114] Often a single managed care entity is responsible both for medical and surgical (health) care and for a limited behavioral health benefit—e.g., 20 outpatient visits and up to 30 inpatient days. This limited benefit may work for individuals with transient or mild to moderate mental disorders. Some states utilize primary care case management systems, but normally the intensive mental health services provided through the public mental health sector are not incorporated into these models.

Instead, most Medicaid programs fund managed behavioral health care services for people with serious mental illnesses through fee-for-service arrangements or through separate (carve-out) contracts for managed behavioral health care. Carve-out managed care contracts are sometimes with private vendors and sometimes with networks of private, nonprofit community agencies, such as community mental health centers. In only a few states is a single entity charged with managing all medically necessary health and behavioral health services for adults and children with serious mental disorders.

About one third of states now use carve-out behavioral health managed care plans.[115] Carve-outs generally have separate budgets, provider networks and incentive arrangements. They are required to cover a broader array of mental health services than the HMOs or other managed health care organizations operating in the same geographic area. Financial risk and monetary incentives may also vary from those imposed on HMOs.

Most Medicaid managed health care plans (such as HMOs) have a limited behavioral health benefit. This is often subcontracted to a specialized vendor, creating a carve-out at that level. In these situations, the state has no direct role in planning or oversight of behavioral health care, behavioral health stakeholders have no input, and the relatively few data-reporting requirements do not support a full evaluation of services. Moreover, the health plan controls the budget for behavioral health services.

Managed care and integrated services

Integration of health and behavioral health service delivery is a different issue from integration of the financing arrangements through managed care contracts. Creating integrated contracts does not automatically lead to integrated care for individuals. Overall, however, managed care arrangements do have the potential to improve coordination between physical and behavioral health care at the delivery level. One national study found that Medicaid managed care improved coordination between physical health and mental health in almost two thirds of the state reforms studied, had no effect in almost one third and worsened coordination in 9%.[116]

The structure of the managed care contract—carve-out or single plan—is often cited as affecting the level of collaboration among network providers. Some states have initiated single-entity Medicaid managed care contracts in the expectation that this integrated financing will lead to integrated services.[117] However, state Medicaid agencies face strong pressures to maintain separate contracting arrangements. For example, the funding streams for Medicaid matching funds are already separate (with mental health authorities usually contributing the match for behavioral health care). There is also strong stakeholder pressure to maintain this separateness. Stakeholders have expressed concerns that an integrated contract will divert funds previously allocated to behavioral health services into medical/surgical care. As a result, single (integrated) contracts are not widespread at this time.

Advantages cited for single, integrated contracts include:

✦ a financial incentive to identify behavioral health issues early and treat them promptly in order to avoid costs on the physical health care side;[118]

✦ improved continuity and coordination of care between health and behavioral health care providers;

✦ reduction of stigma because a single managed care entity enhances acceptance of mental health and substance abuse services;

Integrated contracts do not appear to ease communication between primary care, mental health and substance abuse providers.

✦ potential for integrating pharmacy information; and

✦ ease of administration for the Medicaid agency, with only one contract to manage.

The advantages cited for carve-out behavioral health plans include:

✦ purchase of the special expertise of managed behavioral health care entities in authorizing an appropriate array and level of behavioral health services;

✦ attention to the specialized needs of people with the most serious mental disorders, such as for psychiatric rehabilitation services, with which health plans have little experience from their private-sector contracts;

✦ use of behavioral health care funds to purchase behavioral health care services, rather than diverting them to other health services[119] (case studies in 10 states found that single-contract integrated health plans allocate a small percentage (3-6%) of the health dollar to behavioral health compared with carve-outs, which typically allocated three to four times as much);[120] and

✦ avoidance of adverse selection (in a single contract a health plan may attempt to avoid high costs by encouraging those with serious mental disorders not to enroll or to drop out).

EVALUATION OF INTEGRATED CONTRACTS

It is important to know whether the policy decision to integrate financing by setting up single contracts for all health and all behavioral health care can overcome the barriers to integrated service delivery outlined in Chapter 2. Few studies have examined whether integration of financing leads to coordinated service delivery at the patient level,[121] and none that have examined advantages and disadvantages of carving out or integrating mental health services for people with serious mental disorders have found consistent advantages in either model.

Integrated contracts do not appear to ease communication between primary care, mental health and substance abuse providers. Focus groups of adults with

serious mental illnesses in systems with varying contract arrangements all reported difficulty in obtaining coordinated physical health care and mental health care, which led to miscommunication, adverse drug interactions and gaps in care.[122]

A study of five states found that the model selected is less important than whether the model is flexible or how well it matches the particular state environment. That study found that integrating mental health and substance abuse treatment into managed health care contracts solved some pre-existing structural and care delivery problems, created some new ones and left others unchanged.[123] Another study of providers in four state Medicaid programs with different mental health contracting arrangements found little coordination of care between mental health and physical health care providers.[124]

A national study of public managed care reforms for children and adolescents found improved coordination through the use of managed care, but at nearly the same rate in single, integrated contract systems (57%) and in carve-outs (61%).[125] Stakeholders universally complained that primary care providers were not familiar with or trained in behavioral health disorders of children and adolescents.[126] Identification of disorders and referrals by primary care practitioners were considered inadequate, regardless of the design of the managed care contracting system. In coordinating with other public agencies, carve-outs performed better than integrated designs.

When a plan holding a single, integrated contract then subcontracts for the behavioral health services, the result is unlikely to be any better with respect to service integration than when the state creates a carve-out. Florida's Medicaid Prepaid Mental Health Plan in Tampa operates a behavioral carve-out and HMOs. An ongoing evaluation has found little evidence that services are better coordinated in the HMO arrangement,[127] presumably because the carve-out and the HMOs contracted with the same behavioral health providers.

Our study also found that integrated contracts in

A study of five states found that the model selected is less important than whether the model is flexible or how well it matches the particular state environment.

the states studied did not necessarily lead to integrated service delivery.

In Oregon, the state contracts for physical health and chemical dependency services in one contract with fully capitated health plans. Two of these plans also have contracts for mental health services and both have subcontracted the mental health and chemical dependency services to a managed behavioral health care plan.

In Oklahoma, the largest Medicaid health plan with a single, integrated contract subcontracts for behavioral health services, although it has hired a pharmacy benefit manager to be responsible for all medications. Electronic medical records cannot be shared, however, due to differences in medical record systems, and the plan has had to engage in primary care provider education on how to access available mental health services.

Despite the expectation that single contracts will encourage early identification of behavioral health issues, in the integrated financing arrangements studied for this report, mental health issues appear to be under-identified in both children and adults. This is true even when, as in Oklahoma, plans have an incentive to identify members with serious mental illnesses because of higher capitation rates. Identifying members with substance abuse problems is even more difficult.

States that have both carve-outs and single, integrated health plan contracts encounter disagreements over which plan is responsible for psychotropic medications, specific services or special-needs populations (individuals with neurological impairments, autism or Tourette's syndrome).[128] Among the states reviewed for this report, problems were found with these split arrangements where health plans and carve-outs exist side-by-side, because they often fail to collaborate effectively.

In Michigan, individuals with mild to moderate symptoms or functional impairment, or whose serious mental illness is in

remission and thus requires only routine medication management, are the responsibility of the health plans. Those with serious mental disorders, as indicated by diagnosis, severity and impaired functioning, are the responsibility of the behavioral health managed care system. However, according to mental health provider agencies visited during this study, this approach has not worked well. Health plans are concerned that some individuals are transferred back to them before they are stable, and mental health plans report that mental health issues are not always well addressed by the health plans. There are sometimes disputes about which entity is responsible for a consumer's care.

Clearly, integrating contracts and effectively integrating service delivery are not one and the same.

Oregon contracted for integrated physical health and substance abuse starting in 1994, but found the goal of integration elusive. Integrated health plans shifted from direct relationships with substance abuse providers to contracts with behavioral health carve-out entities. Referral for substance abuse treatment by the health plans' physicians was infrequent and integrated care did not appear to be a high priority for those plans.[129]

The key issue is not the contracts' structure. Instead it is most likely the commitment of the purchaser and the health plan to integration and the approach used for reorganizing service delivery.

Contract requirements must address coordination.

Since improved coordination seems to be associated more with targeted efforts than with the design of managed care contracts, it may be important to have specific language regarding collaboration and integration in the contracts with health care and behavioral health care entities.

The National Committee for Quality Assurance (NCQA) requires the managed care organizations that it accredits to address continuity and coordination of care. The NCQA standards are general and emphasize exchange of information among providers, including coordination between medical and behavioral health providers, and the collection and analysis of data relevant to continuity of care and coordination. The NCQA standards represent only a minimum floor, but Medicaid programs can use them as a starting point for contract requirements on integration.

States have encouraged plans to improve coordination or integration of care by including in the managed care contract legal requirements that relate to:

✦ coordinating and collaborating with other providers by sharing relevant information and communicating as appropriate;

✦ assignment of case managers;

✦ maintenance of appropriate information systems;

✦ coordination of pharmacy data; and

✦ setting performance and outcome measures.

However, to date, most states have not included detailed requirements in their Medicaid managed care contracts. A review of 52 of these contracts found only three specifically referencing the link between primary care and behavioral health.[130] Thirty-eight states included broad, general provisions requiring coordination between primary care providers and mental health and substance abuse providers. While case management was often required, only five state contracts made care coordination the subject of performance measurement. No contracts stipulated the information-system capabilities expected in the area of care coordination and only three mentioned the information that contractors are expected to maintain. The contracts also do not reference confidentiality issues when information is exchanged.[131]

States can also adjust risk and payments, creating incentives and penalties to ensure coordination or integrated care. Enough resources to handle the cases of individuals with complex physical and/or behavioral health issues are also necessary.[132]

To effectively encourage integration through its contract language, a state must monitor contracts actively and provide significant oversight. However, few states

> **Clearly, integrating contracts and effectively integrating service delivery are not one and the same.**

have included performance or outcome measures related to integration in their managed care contracts,[133] and the contract-management skills needed are seldom present in Medicaid agencies. When states include performance and/or outcome measures, they do not always receive the required data from the plans and, even when data are submitted, state Medicaid agencies rarely have the capacity to assess the information. States do not generally penalize their managed care plans for failures to implement these details of a contract. Penalties result, if at all, only from excessive abuses or failure to meet a contract's basic goals.

EXPERIENCE IN STATES AND SITES STUDIED

Several of the programs described in Chapter 3 exist in a managed care environment, since all of the four states studied employ some form of Medicaid managed care. In addition, of the sites offering embedded or unified programs, two—Cherokee Health Systems and EXCEL—operate with Medicaid managed care capitation payments.

Cherokee, as a single provider agency for health and behavioral health services to a defined geographic area, has been able to negotiate a capitation rate from TennCare, the state Medicaid managed care program, that covers the costs of its integrated services.

EXCEL receives a capitated payment from the behavioral health carve-out entity in Arizona, financing its primary care services through a combination of funds from capitation, the employee health plan and other public sources.

CONCLUSION

It would be a mistake for policymakers to assume that a single contract for all care will lead to integrated service delivery. When the prime contractor with a single contract then carves out behavioral health care, this may, in fact, be worse for consumers with serious mental disorders. In these situations, the purchaser cannot set the level of funding for behavioral health care, cannot engage in behavioral health planning and has no direct oversight. Too often the prime contractor lacks expertise in behavioral health care issues, fails to engage in behavioral health planning, does not provide for input by stakeholders and conducts little evaluation.

Contract structure generally has little direct effect on integration of physical and behavioral health care. Furthermore, while contract provisions stipulating care integration may be part of the solution, it is not a simple matter. Most states have only broad and general provisions regarding integrated care in their contracts. Without specific details on how it is to be achieved and without incentives, penalties or even active monitoring of these provisions, states are unlikely to overcome the barriers to provision of integrated care. To make a real difference, effective oversight of contracts is needed, along with very specific requirements for contracting policy.

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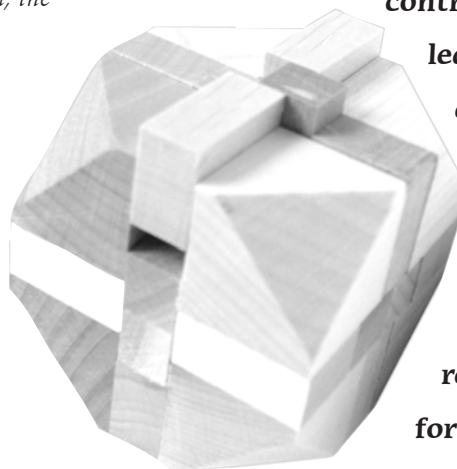
CHAPTER 5

Policy to Ensure Integration of Physical and Mental Health Services for Individuals with Serious Mental Disorders

It is well understood that individuals with serious mental disorders need access to timely and effective physical health care. This report documents the barriers that have left their need largely unmet and describes several models of service integration that offer them holistic care.

Policy initiatives are now needed to translate the information learned from these models into more systematized, effective integration of physical and behavioral health care for individuals whose care is the responsibility of the public mental health system. While this may appear a daunting task, emerging trends in health and behavioral health suggest that now may be a propitious time to press for such changes:

✦ Increased recognition of the consumer as a purchaser of health care is leading to consideration of consumer preferences, and consumers generally prefer to be treated as a whole person.

✦ The expanding role of medications to treat both physical and mental illnesses creates a recognized urgency for information-sharing and collaboration.

✦ Disease-management approaches for chronic illnesses are alerting primary care providers to the array of psychosocial issues that affect treatment success.

✦ Greater recognition of the prevalence of mental illness, its impact on health and the effectiveness of treatments is encouraging primary care providers to consider behavioral health issues more often.

✦ Improved outcome and performance measurements in health care systems encourage a view of the total impact of all health care.

✦ Information-system technology now makes integration possible.

The President's New Freedom Commission on Mental Health has stressed the importance of a recovery-oriented public mental health system with services based on a single, comprehensive plan focusing on all of a consumer's service needs.[134] In a recovery-oriented system, physical health care issues must be as central to a consumer's service plan as housing, job training or education. This means that ensuring access to primary care services should be a routine part of what mental health delivery systems do and of what policymakers consider central to the public mental health authority's mission.

This section lays out a range of policy options that can be adopted to nurture integrated care, with a focus on the needs of adults with serious mental illnesses and children with serious mental or emotional disorders.

In a recovery-oriented system, physical health care issues must be as central to a consumer's service plan as housing, job training or education.

PRINCIPLES TO FOLLOW

Significant changes in policy usually occur incrementally. It is not practical now to pursue policies that fully integrate behavioral health care into health for everyone, as if there were no stigma attached to behavioral health, no distinct public mental health system and no barriers to reimbursement, such as arbitrary limits on length of treatment in private insurance plans.

Full integration must await changes in public attitudes toward mental health, parity in insurance coverage and new capability in health systems to administer the intensive community services adults and children with serious mental disorders now receive from the public mental health system. It will also require equitable funding, management and monitoring of behavioral health services.

However, setting full integration of behavioral and physical health care as a goal enables policymakers to take important interim steps in that direction. Initial steps must recognize certain realities: the separateness of the services system for people with serious mental disorders and primary care providers' growing understanding of mild and moderate mental disorders. This means that integration policies implemented today will be most successful if they address integration of care differently for different population groups. Initiatives are more likely to succeed if they focus on integration within each population's current "health care home." For example, individuals with mild to moderate mental disorders will likely do best if behavioral health services are integrated within their primary care delivery site, while the reverse is probably true for those with serious mental disorders.

Integration policies also must take into account consumer concerns, at root the product of stigma, by allowing different approaches to integration within each target population group. It is important to recognize that some consumers prefer not to share all information about their health with all of their providers and do not wish providers to collaborate in their care.

Three approaches to integrated service delivery emerge from our research.

1. For adults with serious mental illnesses in particular, and also for many children with serious mental or emotional disorders, by far the most effective approach for immediate change is for public mental health systems to take responsibility for integrating primary health care into their programs. This approach can be implemented in different ways. Integrated programs

Initiatives are more likely to succeed if they focus on creating integration within each population's current "health care home."

can be created by bringing separate organizations together (Massachusetts Neighborhood Health Center and Washtenaw Community Health Organization); mental health programs can bring primary care into their sites (Thresholds and Comprehensive Care Services); or mental health and physical health care can be operated through a single administrative entity (Cherokee Health Systems).

2. An approach that is most similar to usual practice is to encourage coordination and collaboration between separate providers (as we found in each of the four state Medicaid programs studied). For policymakers, this approach means that each of the several barriers to integration must be addressed, often separately, and a complex array of policies is often needed to make a difference.

3. Co-location of behavioral health specialists in a primary care setting shows evidence of success from several demonstrations and research projects, but studies of this concept have focused on individuals with mild to moderate mental disorders. However, this approach might also be valuable for individuals with serious mental disorders whose condition is currently stable and being managed by a primary care provider.

For each of these models, policy issues involving service delivery, financing, monitoring and quality assurance must be addressed. Integration policy must focus first on ensuring that clinical integration actually occurs and then design the structures and the financing mechanisms to support them. Integrating financing streams and/or integrating health plans does not automatically lead to clinical integration (see Chapter 4). On the other hand, clinical integration cannot be achieved without addressing financial and structural issues. Policymakers must consider changes in how services are financed, how delivery systems are organized and how providers behave. In addition, policymakers may wish to initiate activities to help compensate for lack of training across disciplines.

Policy issues for each model are discussed separately in this chapter, along with service delivery and financing

questions. Monitoring, quality assurance, privacy protection, consumer education and training apply regardless of the model chosen, and are discussed later. Finally, we examine broad policy issues (such as privacy law) and present policies that might be adopted by federal agencies.

State and local policymakers may wish to consider pulling together working groups to consider not only these options (and the various program activities summarized in Chapter 3), but also new approaches that seem particularly well suited to their own geographic area and health delivery systems. Advocates may wish to encourage greater attention by state mental health authorities and other policymakers to the need for integration of physical and behavioral health care in order to improve the health and safety of those who use the public mental health system.

POLICY MODELS FOR INTEGRATION IN EMBEDDED AND UNIFIED PROGRAMS

Given the high probability of significant health problems among adults with serious mental illnesses, combined with their low utilization rates of physical health care services, efforts to make health care more accessible to adult consumers in the public mental health system should be a high priority. Bringing primary care in-house—embedding it within a program responsible for community care for adults with serious mental illnesses or unifying programs of behavioral health and physical health care—expands access, improves quality of care and makes holistic care the norm.

Embedded and unified programs studied for this report have overcome most of the barriers to integrated care highlighted in Chapter 2. One of the most striking findings is that, in both embedded and unified programs, many of the barriers to integration simply disappear, particularly those that stem from lack of provider training or cultural differences. Better integration and more informed, coordinated approaches to care emerge without a great deal of effort on the program's part.

Another immediate gain is improved access. One of the motivations for this approach is awareness that con-

sumers with multiple problems have "too many front doors" into services. Because systems are too complex, consumers often do not receive all the services they need, relying instead on emergency rooms and crisis-oriented health services that could otherwise be averted. Consumers in the embedded and unified programs visited for this study participate enthusiastically in preventive health services, receive regular monitoring and treatment for diabetes and other serious disorders and have access to routine and speciality health care. If they miss appointments, their case managers can respond and resolve any issues.

By creating these programs, policymakers will ensure that a number of the barriers to integration are overcome. Embedded and unified programs:

- ✦ ensure that individuals in the program have a consistent and regular source of primary care prevention and treatment;
- ✦ ensure readily available mental health back-up for primary care;
- ✦ overcome various practice differences and difficulties;
- ✦ facilitate information sharing;
- ✦ allow the development of a single unified plan of care;
- ✦ improve the skills of all providers; and
- ✦ please consumers.

There are other indications of success. The embedded and unified sites visited for this study show evidence of more effective and cost-effective care.

- ✦ Data show significantly improved physical health care for consumers, especially improved glucose levels among those with diabetes, and reports of effective treatment for hypertension, heart conditions and other serious physical ailments.
- ✦ The programs reduced the use of emergency rooms for physical complaints.
- ✦ Cost-savings were achieved. The Mental Health Service Program for Youth had an 18% reduction in costs per member per month.
- ✦ Some programs have intriguing data that show improved mental health outcomes as well, such as reduced hospitalizations.

✦ There is an opportunity for health promotion and attention to wellness. All programs furnish regular physical health checkups. The value of anti-smoking initiatives and walking and nutrition programs is recognized and may become a priority, with significant payoff for consumers.

✦ Programs have universally reorganized (and obtained the resources) to give primary care providers more time for each patient seen, improving the quality of care dramatically.

✦ These programs are more likely to appreciate the need to furnish integrated treatment for substance abuse as well.

Creating embedded programs

Mental health policy should require community mental health agencies to incorporate primary care delivery in each consumer's recovery-oriented service plan and to deliver this care through services embedded in their agency. The mental health team, including the psychiatrist and the case manager, must take responsibility for ensuring that consumers access primary care services on a regular basis and that critical aspects of treatment, especially medications, are coordinated.

Primary care services that should be mandated include:

✦ health assessments (upon admission and regularly thereafter);

✦ health-promotion activities, such as smoking cessation, walking and nutrition education programs;

✦ consumer education on physical health issues;

✦ ongoing monitoring and care for chronic conditions such as diabetes, hypertension, HIV and other disorders; and

✦ treatment, or referral as appropriate, for acute and chronic physical disorders.

Since this is a new approach for many public mental health agencies, building in flexibility is important so programs can adapt it to local circumstances. Policies adopted to initiate embedded programs, discussed below,

There are significant advantages to incorporating primary care within a rehabilitation program...where case managers and other staff already focus on consumers' life issues.

should leave agencies a certain amount of leeway on issues such as qualifications of the providers used to deliver primary care (although incentives would be advisable to work with family practice physicians, physician assistants or advance practice nurses, who are already more oriented to holistic care), staffing ratios, clinic location and other factors.

Within the array of programs and agencies that constitute a state or local mental health system, policymakers will need to decide which community mental health provider agencies should be responsible for sponsoring an embedded primary care clinic. All of the embedded programs reviewed for this study furnish services in facilities that are most frequently utilized by individuals with serious mental illnesses. Transportation problems are resolved if the health clinic is located in the same building as a program to which the consumer will be traveling anyway.

There are significant advantages to incorporating primary care within a rehabilitation program. Such programs have an emphasis on recovery and case managers and other staff already focus on consumers' life issues. In many communities, rehabilitation programs are operated by comprehensive community mental health agencies, in which case the decision is easy. In other communities (Chicago, for example), the rehabilitation program may operate separately. If they are large enough and deemed capable of sponsoring a clinic, rehabilitation programs might be the first choice for placement.

For consumers not using day programs, primary care services should be available in an outpatient mental health clinic program. Primary care services should also be required as an integral part of assertive community treatment and intensive case management teams.

Financing embedded programs

Resource issues are key to the success of any policy to provide integrated care. A principle economic barrier

to integrated care has been separation of the funding for mental health from the funding for general medical services.[135] The embedded approach can provide integrated financing to mental health agencies, simplifying resource-flow issues.

Medicaid's historically low reimbursement rates pose an obstacle to quality health care for individuals with serious mental disorders. Grants and financial incentives may be needed in order to effect change. Initially, embedded programs will require funds to cover start-up costs (primary care clinical and office equipment and hiring of staff). Once the program is established, reimbursement will be needed for services furnished, including the higher costs associated with spending more time per visit with individuals with serious mental disorders and time for cross-discipline communication.

Start-up costs for embedded programs have been an issue in several sites, and were the biggest obstacle for EXCEL. Options for start-up funding include:

✦ using grants to cover start up costs—from the mental health agency, out of general fund dollars or from private sources, such as foundations;

✦ inviting primary care providers to establish a practice in a mental health program—in Chicago, the university's school of nursing established the primary care program; and

✦ negotiating with a local community health center for the establishment of a satellite primary care clinic on the site of the mental health program.

For ongoing reimbursement of the costs of primary care services, policymakers or program directors can consider:

✦ having embedded primary care providers credentialed by the local Medicaid managed health care organizations (possibly with support and/or pressure from the state Medicaid agency);

✦ providing to Medicaid managed health care plans a higher capitation payment for individuals with serious mental disorders, such as those on SSI, and

Once the program is established, reimbursement will be needed for... the higher costs associated with spending more time per visit with individuals with serious mental disorders and time for cross-discipline communication.

further adjusting this rate so as to pay more for services to individuals with complex comorbidities, such as chronic physical health problems coupled with serious mental illnesses. Such individuals might be identified through diagnostic coding or through their high utilization of both behavioral and physical health care services. Increased costs associated with this risk adjustment may well be offset by reduced use of hospital and other high-end or crisis services due to improved health.

✦ allowing, in fee-for-service plans (Medicare, Medicaid or private insurance), billing at a higher rate for services to individuals with significant mental and physical health comorbidities;

✦ authorizing the use of state or local mental health funds for primary care services for those who are uninsured. Alternatively, the state or local health agency may be amenable to collaboration on funding or, if the primary care services are sponsored by a collaborating community health center, that center should be able to support some of these costs;

✦ covering the additional costs of primary care services in an embedded program by allowing state or local health authorities to pool resources with mental health and substance abuse authorities or, for children, to pool resources with mental health, substance abuse, child welfare and juvenile justice authorities.

For Medicaid-covered individuals, who will normally be in a managed health care plan, a key issue to address is the health plan's credentialing requirements, so that the primary care providers working in mental health programs—physicians, nurse practitioners, physician assistants—are considered part of its network. The most direct method would be for the Medicaid agency to require the health plan to credential the primary care providers in the clinic (provided they meet the managed care entity's standards). This may have to be encouraged through specific contract terms. Also,

it typically takes time for staff to become credentialed; start-up costs will need to accommodate this by paying for covered services in the interim. Otherwise, it will be difficult for programs to underwrite these professionals' salaries while awaiting approval.

An alternative approach would be for the Medicaid program to allow individuals with serious mental disorders to opt out of their managed health care organization for primary care services (but not for speciality care), bringing their capitation payment to a mental health agency primary care program. This arrangement would be similar to, but the reverse of, policies that require managed health care plans to provide basic mental health outpatient and inpatient services. In states where mental health services for individuals with serious mental illnesses are still in fee-for-service, the capitation payment would be directed to the mental health agency or to its primary care clinic, whichever is appropriate. In states with carve-out behavioral health plans (BHOs) this would require mandates for the BHO, since it would then be responsible for the primary care services and would receive the primary care capitation payment. Two of the embedded programs studied are in managed care states, demonstrating that this is feasible.

The contracts with managed behavioral health care plans that will receive payment for primary care services should require mental health provider agencies to furnish on-site primary care for their consumers with serious mental disorders, including space for the clinic and appropriate staffing. Additional requirements will need to be included in the contract, specifically:

✦ requirements related to delivery of care— for example, all consumers should receive an initial physical health screen and annual physicals;

✦ requirements that embedded primary care staff provides routine treatment for physical health conditions as well as referral and coordination with other health specialists; and

What may be more effective than overly detailed contract requirements is ongoing work between the purchaser and the contractor's senior management to resolve promptly any issues that arise and refine practices system-wide.

✦ specifications regarding the role of case managers. In some states studied, there are two separate case management systems—one for consumers with serious physical conditions and one for those with serious mental disorders. For embedded programs, a single case manager who is given responsibility for ensuring continuity of care for all health conditions is more efficient.

However, purchasers should leave many of the details to the health plan. Issues such as staffing patterns and staffing levels should not be dictated. Embedded programs will work out issues of information-sharing, confidentiality and working relationships as a result of the close proximity of providers and the responsibility for overseeing holistic care. What may be more effective than overly detailed contract requirements is ongoing work between the purchaser and the contractor's senior management on their approach to integration, to resolve promptly any issues that arise and refine practices system-wide through knowledge gained.

Monitoring and performance measurement will be very important in a managed care arrangement to ensure that the managed care plans take this requirement seriously and to assess the cost-effectiveness of providing integrated care in this manner. Monitoring issues are discussed later because they apply regardless of the model of integrated or collaborative care.

Creating unified programs

Combining a community mental health center and a community health center into a single entity should be given very serious consideration. All of the advantages of embedded programs apply in a combined program, which also has the advantage of integrated program management and a single point of access, no matter whether the individual presents with a physical or a mental health problem. In underserved communities, particularly rural areas, the extreme shortage of all

providers and a heightened sense of stigma make such a merger a very attractive option, with considerable efficiency of administration, physical plant and other costs.

However, establishing such a program will require either creation of an entirely new program or collaboration among the leadership of previously separate entities. Accordingly, logistical issues are potentially more difficult to resolve when establishing unified programs. States may wish to begin by experimenting with this option through development of one or more demonstration projects that can test how this might be accomplished in the particular state.

Financing unified programs

Financing for a unified program should be far more straightforward in both fee-for-service and managed care systems than financing an embedded program. The unified agency will need to meet the same requirements and standards as a community mental health program and a community health center or community clinic. Once this is accomplished, resources should flow from both the health and the behavioral health systems through Medicaid, private insurance and federal, state and local grants.

Policymakers need to ensure appropriate reimbursement rates. In managed care arrangements, in particular, capitation rates need to reflect the severity of disorders in this population, acknowledging the need for longer office visits and collaborative, cross-disciplinary discussions. In Tennessee, Cherokee Health Systems was able to negotiate a single capitated rate for all its behavioral health and physical health services from the statewide managed care program, TennCare.

There could be other issues in unified programs. In managed care, combining physical and behavioral health benefits under the auspices of a health plan has frequently led to significantly reduced resources for behavioral health.[136] From a service-delivery perspective, individuals with serious mental disorders require unique, intensive and costly services not needed by individuals with mild or moderate disorders.

States may wish to begin by experimenting through development of one or more demonstration projects.

Primary care providers are generally unfamiliar with these services, which include psychiatric rehabilitation, behavioral aides for children, assertive community treatment, supported employment, supported housing, among others. A community health center or other health care organization has little or no experience with this population or these services. Cherokee was organized and continues to be led by mental health professionals. Policymakers should exercise caution if they choose to initiate combined programs by authorizing a community health center or other health organization to include full service behavioral mental health care.

In some states studied, the unified program is not a single entity, but a collaboration across a number of agencies. States can set up these arrangements by pooling funds from the various appropriate public agencies, as has been done by the Massachusetts Program for Youth and Michigan's Washtenaw Community Health Organization. Agencies that may be interested in pooling funds would include mental health, substance abuse, health, Medicaid, maternal and child health, child welfare and juvenile justice. In time, such arrangements may evolve into a more unified health care system meeting both physical and behavioral health care needs.

POLICY MODELS FOR CO-LOCATION OF BEHAVIORAL HEALTH IN PRIMARY CARE SITES

Co-locating a behavioral health provider in a public agency providing physical health care, such as a community health center, provides a mechanism both for ongoing monitoring of people with serious mental disorders who are stable and for treatment of mental disorders that the public mental health system cannot address. This approach is a supplement to other policies designed to improve integration of care for individuals who are actively engaged with the public mental health system.

It has been suggested that any co-location practice

arrangement should provide four options for managing patient care:[137]

✦ quick consultations for a specific question;

✦ one-time consultation to support a primary care provider who is treating an individual;

✦ shared care providing intermittent mental health support and joint management of the individual; and

✦ transfer of care to the mental health professional for specialty care.

Start-up costs for adding behavioral health services to a primary care program may need special funding. Primary care settings need to hire psychologists, social workers or other behavioral health providers, allot space and provide administrative support. Such costs are likely to be minimal, however, given that behavioral health care does not require significant technology.

States or localities might provide additional funding through special grants or by policies to ensure that the health clinic or office can bill for related behavioral health services.

Another approach would be for the community mental health agency to employ a behavioral health specialist but place that individual in a community health center or private primary care practice. In this case, the mental health system would provide reimbursement for behavioral health services through the community mental health agency that has hired the provider.

States and localities can encourage community health centers and other health clinics to co-locate behavioral health providers by educating them about the need and providing information on how this can be done. As these initiatives move forward, more collaboration between community health centers and community mental health centers is expected.

Health care entities, such as HMOs, can also encourage the co-location of mental health providers within primary care group practices in their networks by increasing reimbursement levels to permit additional time

Policymakers must ensure that public-sector funders make it clear to separately operating providers and health plans that integrated care is a priority and an expectation.

for consultation. Medicaid contracts can also provide incentives to health plans that successfully negotiate these arrangements with their providers.

In the long term, such arrangements should prove cost-effective for both health plan and purchaser as clinical outcomes improve, primary care providers reduce wasted time, and cost offsets are realized.[138]

POLICY MODELS FOR COORDINATION/ INTEGRATION WITH SEPARATE DELIVERY SYSTEMS

Coordination of separately located primary care and mental health programs will likely be necessary for some consumers. Some will choose this option, while others will have a stable mental health condition that can be managed through primary care. Still others may have mild or moderate mental disorders that the public mental health system does not normally accommodate. Embedded and unified primary care clinics may also not have the capacity to serve all consumers in a particular program, especially at first. Consequently, improving collaboration so as to integrate care across separate delivery systems continues to be a priority.

Policymakers must ensure that public-sector funders (such as Medicaid agencies or mental health authorities) make it clear to separately operating providers and health plans that integrated care is a priority and an expectation. As purchasers or payers, these agencies have the ability to encourage integration between separate providers by paying for necessary infrastructure and time for integrated care, and by rewarding and/or penalizing health plans or providers for failure to achieve integration.

However, isolated service delivery requires more complex policies than embedded or unified programs in order to improve collaboration or, if possible, to integrate physical and behavioral health care. For this reason, specific policy strategies adopted in the sites studied for this

report are listed below, organized around the major barriers to effective integrated care.

To overcome lack of time and lack of reimbursement

All of the sites with separate delivery systems that we visited addressed providers' lack of time to collaborate and the lack of reimbursement for the time they spend doing this. All found case managers to be valuable in linking mental health and primary care providers.

Both mental health and primary care systems can utilize case managers for the coordination of care. Health care case management, often termed exceptional-needs coordination, is furnished to individuals with significant and/or complex and costly physical health care needs (usually indicated by hospitalization). Behavioral health case management is furnished by most public mental health systems to coordinate mental health and support services. Exceptional-needs coordinators and behavioral health case managers do not replace each other.

Case managers have flexibility in time and location of service and can assist adults with serious mental illnesses or families of children with serious mental or emotional disorders in negotiating the complex health care system. Individuals who fail to access primary care services may be assisted by case managers or other staff who conduct outreach to them at home, on the street or elsewhere.

A second valuable strategy is for mental health systems to ensure that primary care providers have sufficient behavioral health support. To make this approach manageable, systems can identify primary care providers with large caseloads of individuals with serious mental disorders and ensure that these providers have significant behavioral health support.

✦ Psychiatric phone consult lines (funded by the public mental health system or furnished through teaching hospitals or universities) can be set up to provide immediate response to primary care providers.

✦ Mobile mental health teams can respond to requests from a primary care provider for on-site interventions in cases where direct intervention is required. One of the principal barriers to identification of

mental health problems—and one of the main reasons for inadequate attention to the physical health problems of an individual with a serious mental illness—is simply the lack of time for conversations that elicit the necessary information. It is critical to restructure primary care providers' time so they can be effective in their care for this population. Policies that can be considered include:

✦ creation of half-hour slots, as opposed to 10-15 minutes, for primary care providers seeing individuals with serious mental illnesses;

✦ encouragement of psychiatrists to take calls for "curbside" (two-minute) consultations with primary care providers, even during sessions with other patients. More detailed follow-up consultations can occur at a more convenient time;[139]

✦ designation of a special visit or billing code that can be used when providers see individuals with serious and complex health and behavioral health needs, thus allowing reimbursement for the additional time both to work with the individual and for consultation; and

✦ adoption of effective and easy-to-use screening tools for adults and children in primary care settings. Some children's screens, now computerized, can be completed by family members while waiting for an appointment and then quickly scored to guide the pediatrician without using a significant amount of his or her time.

To overcome cultural barriers

When providers are separately located, it is very difficult to overcome the longstanding cultural divide between disciplines. Several attempts at improving integration of care and collaboration between providers have floundered as a result.

Some strategies used in states and localities with separately located providers have proved somewhat effective:

✦ ensuring that primary care physicians who are clearly willing to work with individuals with serious mental disorders have support and backup from mental health agencies;

✦ providing continuing education and written materi-

als to help primary care providers acquire the skills to work with challenging individuals with serious mental disorders. Continuing education credits can encourage participation, as can offering the training at convenient locations and convenient times (e.g., over lunch);

✦ arranging these educational sessions or collaborative work sessions so that they include time for social contact, enabling providers to get to know each other and begin building a working relationship; and

✦ having mental health agencies reach out on a regular basis (for example, annually) to meet with local primary care providers who serve significant numbers of their clients to discuss problems of collaboration, identify the barriers and problems that primary care providers see in working with the agency, and to work out solutions and new approaches.

To improve information-sharing

When providers operate from separate locations, information-sharing is slower and more cumbersome. The following strategies that can be helpful.

✦ To share appropriate information, mental health authorities can develop forms for mental health provider agencies' use to give primary care providers the information they need, and no more, in a manner that is quickly and easily understood. Information should not be too detailed but must, at a minimum, include diagnosis, medications prescribed and prognosis.

✦ To improve primary care visits, mental health case managers or psychiatric nurses can accompany individuals to their primary care provider to facilitate information-sharing. With consumer consent, relevant written information can be taken back to the mental health program.

✦ To provide feedback, mental health agencies can be required as part of their contracts to respond within

Privacy laws should permit consumers to control when (and how much of) their information can be shared for the purpose of improving integration of treatment.

a reasonable time following a referral with, at a minimum, confirmation that the individual has been seen, an indication of whether the individual will be treated and a list of medications prescribed.

Because of the importance of avoiding adverse drug reactions, states may wish to consider ways to better integrate pharmacy information. Pharmacists should be available to monitor prescriptions and identify potential adverse interactions. Giving individual clinicians access to a pharmacy benefit manager's prescription data would be extremely valuable, especially since these data are available in real time and indicate not only the prescriptions written but also which ones were filled. This may require that contracts with pharmacy benefit managers authorize such sharing of data and will also, of course, require the consumer's consent.

Policymakers may also need to review their mental health and substance abuse privacy laws to ensure that they comply with the federal privacy rules and protect behavioral health information appropriately. These laws should also permit consumers to control when (and how much of) their information can be shared for the purpose of improving integration of treatment. Consumers' wishes should be honored regarding the sharing of information between treating health providers and pharmacists who are well trained in the necessity of confidentiality.

Issues of confidentiality can also be addressed by providers and state agencies:

✦ Behavioral health agencies can ensure that every consumer has the opportunity to provide consent for sharing of key information with his or her primary care provider, and mental health staff can ensure that all consumers fully understand the importance of sharing this information.

✦ Uniform forms can be developed by the state to assist community agencies in obtaining consents and to enable consumers to limit their consent and choose what information they do not want shared.

To overcome lack of access

Greater ease of access to public behavioral health services would facilitate referral and integration of care. However, even in today's limited environment, mental health access can at least be made more comprehensible to primary care providers.

✦ Primary care providers should have information on accessing mental health services. A list of mental health practitioners who are accepting new patients is helpful (on the web, if updated routinely).

✦ Primary care providers need to know who can be referred to a public agency (i.e., the priority population) and to whom and how to make that referral, so that consumers receive timely assessment and services. They also need to know where to refer other individuals whom they deem to need specialty behavioral health care.

✦ States and other payers can pre-pay mental health providers to conduct mental health assessments on individuals referred by primary care, ensuring appropriate referral for the consumer and reimbursement for the provider, even if the person fails to show.

✦ Follow-up upon hospital discharge can be improved. Psychiatric facilities should screen for physical health issues at admission and notify primary care providers when an individual is released to facilitate follow-up on physical health issues.

To increase access to primary care services by people served by the behavioral health system, behavioral health agencies can be required to ensure that a primary care assessment is conducted for all new consumers.

Health plans can also be required to screen new members regarding their prior use of behavioral health services and provide to those who have used these services a list of behavioral health providers in their network or information on how to contact a provider in a carve-out plan. This would facilitate earlier intervention, potentially creating savings in the long term.

To overcome training deficits

Overcoming physician training deficits is not easy in separately operating systems. Feedback and treatment advice regarding depression treatment by primary care physicians was found to have little effect on consumer outcome or on process measures consistent with high-quality care.[140] Projects studied for this report also found many of their approaches ineffective, especially when pursued in isolation. In particular, literature alone made little difference, according to several sites studied.

Generally, programs found it more effective to target training to physicians who showed a particular interest in working with people with mental or behavioral disorders and, in recognition of the physicians' busy schedules, to make the training targeted, concise, convenient and practical.

Policies to expand educational opportunities for primary care providers might include:

✦ encouraging mental health programs to develop working relationships with primary care providers who serve their clients and offering them educational sessions that address issues such as identification of behavioral health disorders, evidence-based treatment for depression, anxiety and other mild and moderate disorders, and how to access behavioral health resources in their community;

✦ making changes in behavioral health programs' working styles to accommodate the concerns expressed by primary care providers, such as by offering quick "curbside" consultations;

✦ creating incentives, such as continuing education credit and lunch, to attract more physicians to training sessions; and

✦ within a managed care context, requiring health plans to encourage their providers to engage in appropriate training sessions, such as by mandating training in behavioral and physical health care coordination through their provider credentialing requirements.

Other training issues arise in all models and policies, and activities that states may wish to pursue are discussed more fully below.

To address consumer issues

A number of mental health consumer issues surface when providers operate separately and some of the policies proposed above can assist consumers. One of

the most effective will be a strong case management program, where case managers have responsibility for ensuring access to physical health care. To be effective, the case managers must be accessible so individuals can have an easy way to reach a care coordinator at all times. In addition:

✦ To access services more easily, consumers could be provided transportation passes and/or case managers or peer program staff with the responsibility of accompanying consumers on visits to primary care offices. While the presence of a case manager at a physical health care visit does not achieve the level of integration of other models described in this report, it does represent a significant step beyond simple administrative coordination of separate providers.

✦ Mental health agencies should be required to focus on helping consumers understand the importance of having a regular source of primary care services and the necessity of sharing at least some information between behavioral health and physical health providers.

✦ Primary care providers should be encouraged to write notes for inclusion in the individual's behavioral health care record.

To finance integration in separate delivery systems

Financing integrated care when providers operate separately requires more complex rules. To encourage change among separately operating providers, research suggests that financial incentives are more likely than penalties to be influential with both providers and health plans.[141] Factors that have been found to influence the effectiveness of incentives are:

✦ the size of the incentive;

✦ peer knowledge of provider performance;

✦ perceived and accurate data;

✦ providers' recognition of the need for change; and

✦ the simplicity and directness of the incentive program.[142]

Since most public-sector consumers will be in managed care arrangements for their physical health care, the first area that should be addressed is the Medicaid managed care contract. Important aspects of integrated care need to be among the legal requirements of managed health care contracts. Similarly, integration requirements should be part of any Medicaid carve-out managed behavioral health plan.

States and/or localities should engage consumer and advocacy groups in designing managed care contract requirements for collaborative or integrated care, in order to ensure that the provisions adequately address consumer issues and are seen as advantageous by consumers in the plans. Purchasers must then be sure to consider the impact, if any, of each of these provisions on costs for the plan and adjust its payment rate accordingly.

Managed health care contracts should:

✦ clearly identify the target population for integrated care;

✦ mandate case management services (exceptional-needs coordinators) to link consumers to all providers;

✦ lay out expectations with respect to collaboration with behavioral health providers, with an emphasis on developing compatible information systems;

✦ require development of systems for timely and effective information exchange between providers;

✦ define expected confidentiality practices that encourage consumers to grant permission for sharing of the minimum necessary information to ensure safe, effective care; and

✦ require the health plan to maintain a comprehensive database that includes all prescribed medications (including those prescribed by behavioral health providers) and that can be accessed by all providers who need to know.

Contracts for behavioral health carve-out plans should:

✦ clearly identify the target population for integrated care;

✦ mandate that physical health care issues be addressed in the consumer's plan of care and that appropriate linkages with primary care providers must be established;

✦ include physical health care coordination in the

responsibilities of behavioral health case managers, including accompanying consumers to their primary care visits if the consumer so desires;

✦ specify provision by the behavioral health plan of psychiatric consultation and backup for primary care providers who treat consumers in their plan;

✦ designate staff to visit difficult-to-reach members at home or other usual location;

✦ require facilitation of information-sharing with primary care providers through development of a form that provides the essential information to the primary care provider while allowing consumers to limit what information is shared; and

✦ provide for access to emergency mental health and primary care services to ensure appropriate referral.

In fee-for-service behavioral health systems, many of these same requirements can be built into the responsibilities of public mental health agencies that receive either Medicaid or state or local grant-in-aid. Specific requirements regarding collaboration and integration of primary care services must then be accompanied by the resources that will enable these agencies to fulfill these obligations.

OVERARCHING POLICIES THAT CAN FACILITATE INTEGRATED CARE

State policies on monitoring, quality assurance, evaluation

State policymakers will expect concrete results from these initiatives and outcomes should be tracked. As a first step, policymakers should ensure that all health and behavioral health managed care plans adhere to the standards on integration and collaboration in the National Committee for Quality Assurance accreditation standards and that providers adhere to the standards required by JCAHO or similar accrediting bodies.

Effective monitoring depends on good data. Resources to ensure the collection of such data must be provided and sufficient time allowed to analyze the results. In order to evaluate the effectiveness of integration efforts, the following information should be collected:

✦ data on a manageable number of measures of im-

proved physical health. These measures should reflect the high-risk issues for consumers with serious mental disorders—e.g., blood sugar levels for diabetics, blood pressure readings, numbers of individuals receiving routine cancer screenings in accordance with appropriate guidelines, number of consumers who quit or reduce cigarette smoking;

✦ data on use of emergency rooms for physical health care issues (pre- and post-integration) for a group of consumers;

✦ data on total admissions to psychiatric facilities and average lengths of stay (pre- and post-integration) for a group of consumers.

✦ in managed care settings, data from health plans and from behavioral health carve-outs on the number of individuals for whom integrated care is furnished, with a particular emphasis on individuals with diabetes, hypertension and other chronic conditions;

✦ in fee-for-service systems, data from providers on the number of adults with serious mental illnesses and children with serious emotional or mental disorders in their practice who received coordinated primary care and mental health services; and

✦ consumer satisfaction surveys regarding integration and engagement in health and behavioral health care (pre- and post-integration).

In addition to mining data, states may wish to contract for an evaluation by an independent entity of the cost-benefits of the new initiative for integrated care. This evaluation should be conducted after three years of operation and should examine data over five years in order to capture long-term savings.

Purchasers can also consider the use of financial incentives to encourage quality care. Bonuses and increased fee schedules are important components of value-based purchasing.[143] Purchasers can provide funds to health and behavioral health plans for quality-improvement projects, as has been done in Oregon and Massachusetts (see site-visit summaries in Chapter 3), or link integration success with bonuses. In addition, plans will often change the way they operate in response to non-financial incentives, such as technical assistance, special awards and recognition of exceptional performance.

The National Health Care Purchasing Institute recommends that incentive programs should:[144]

✦ target clear and valid measures of performance;

✦ create incentives that are significant enough to motivate plans to improve;

✦ remain a priority for purchaser and plans;

✦ focus on areas within the plan's control;

✦ provide timely feedback and rewards or penalties tied to performance; and

✦ reinforce joint responsibility for the incentive program's success.

Other quality assurance that would apply in either managed care or fee-for-service systems might include:

✦ surveys of consumers to solicit their views on integrated services, problems that they have encountered and suggestions for improvement;

✦ surveys of providers to solicit their views on integrated services, problems that they have encountered and suggestions for improvement;

✦ chart review for signed releases to share information;

✦ review of mental health charts to see indications of communication between the mental health provider and the primary care provider (Oregon, Michigan and Massachusetts all conducted such reviews). All mental health records should have the primary care provider's name and number and should document communication, at a minimum, on medications prescribed;

✦ identification of individuals who have prescriptions for both behavioral health and physical health medications and monitoring of prescribing practices and linkages between the various prescribers;

✦ identification of individuals who are high utilizers of behavioral health and medical care in order to ensure that primary care providers serving significant numbers of high utilizers are provided the backup and support they may need on integrated care practices;

✦ monitoring of outpatient follow-up by primary care after discharge from a psychiatric facility;

✦ sending providers profiles that show how they compare to their peers in issues related to the care of consumers with dual physical and mental health

service use, including prescribing practices, preventive screening rates, rates of emergency room usage, diabetes management and rates of specific preventive health services such as cancer screening.

State policies to promote training

State policymakers may wish to run programs that improve practitioners' understanding regarding the other discipline. Activities that have proven effective among the sites visited for this study include:

✦ conferences for those working in integrated settings and for others who need training in order to improve collaboration;

✦ continuing education credit for training programs on aspects of integration. Topics would best be selected by polling the providers for whom the training is planned, but training might address clinical issues for primary care providers, cross-discipline clinical issues, organizational issues for program administrators and confidentiality issues for professional and para-professionals;

✦ training and consultation to guide primary care providers on how to relate to individuals with serious mental illnesses in the primary care context, to ensure that all health issues are identified and can be effectively treated;

✦ requirement or funding of yearly meetings of local primary care and mental health provider agencies; and

✦ social activities for primary care and mental health providers.

State policies to develop software

There is a critical need for improved software in community mental health agencies, particularly for the development of software that is capable of handling integrated physical and behavioral health care records. Software development has been costly and time-consuming for the programs studied for this report.

States should consider either developing model software packages for agencies to use or offering grants to enable provider agencies that intend to engage in significant integration of care to develop their own software.

State policies to protect privacy

States should ensure that all providers engaged in integrated care are aware of and are following the privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). Among other requirements, federal rules under HIPAA require that mental health provider notes not be shared without a specific and separate consent from the consumer, that individuals have access to their own medical record if they wish (knowledge of what is in the record and to be shared can alleviate consumer concerns regarding the sharing of information) and that there be documentation when a record is shared.

In addition to HIPAA requirements, states should consider additional privacy protections.

✦ Consumers should be asked to consent specifically to sharing of mental health and substance abuse information with a primary care provider.

✦ Primary care providers should be made aware of special issues regarding confidentiality of behavioral health information, especially about sharing information with family members, since the primary care provider cannot know the extent to which the family has been informed of mental health treatment and may inadvertently break confidentiality.

✦ To protect electronic record-sharing, fax and email systems must be secure and not accessible to office staff. Electronic records should have mechanisms to block access by unauthorized individuals and encryption should be required before data is sent to other locations electronically.

✦ Mental health agencies should be specifically authorized to acknowledge when an individual has followed-up on a primary care referral.

✦ Primary care providers should not send records received from behavioral health providers to third parties (even treating providers) without specific consent.

✦ Discussions of confidentiality concerns with consumers should be documented.

State policies on consumer issues

Consumers would benefit from communication training to fully appreciate the connections between their mental and physical health and to enable them to be more assertive with their providers. Such training can be effectively provided through peer-to-peer initiatives.

Consumers could also be helped to engage in self-management of both their physical and behavioral health disorders and be given greater access to information on these problems. State mental health authorities or local mental health provider agencies could develop consumer education literature, host websites and run programs to deal with common health problems facing individuals with serious mental disorders. Included should be information on wellness, particularly weight control, exercise and nutrition, the impact of smoking on health, and information about common physical illnesses (e.g., diabetes and heart disease) and self-management skills. Mental health programs serving meals should emphasize healthy eating and be supportive of consumers who are trying to lose weight.

Consumers could also be helped to engage in self-management of both their physical and behavioral health disorders and be given greater access to information on these problems.

State agency communications

Integration of care can be impeded by state-level barriers. Communication and collaboration are essential between a state's Medicaid agency, its mental health authority, its substance abuse agency and its health department. In addition, consumers, families and other stakeholders should be engaged in discussions around how to improve integration of care.

The top decisionmakers in public mental health agencies and Medicaid health plans should consider holding a series of discussions on this topic and how they can improve communication and collaboration between their agencies, as well as how to encourage appropriate practices in the delivery system.

Federal government policies

The federal government can also play a role in improving policies to enhance integration of care for adults and children with serious mental disorders.

Given the importance of Medicaid funding for services to this population, federal Medicaid policy needs to be supportive of integrated care delivery. Currently, federal Medicaid policy from the Centers for Medicare and Medicaid Services (CMS) does not allow payment for more than one visit to a provider's office on the same day, precluding reimbursement for a physical health and behavioral health treatment visit on the same day. This is a very significant problem for embedded and unified programs and is counterproductive to good care.

Other federal agencies should also invest resources and provide technical expertise on integration. Examples:

✦ One or more national agencies—the Institute of Medicine, the Agency for Healthcare Research and Quality, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA)—could develop quality of care and performance measures for integration.

✦ SAMHSA could fund demonstration projects of embedded primary care within community mental health agencies.

✦ SAMHSA and HRSA could develop demonstrations of unified community health and community mental health centers.

✦ HRSA should continue and expand its initiative to provide funds to community health centers for an increased role in providing co-located behavioral health services. These initiatives should focus on individuals with mild or moderate mental disorders and those with stable serious mental disorders that can be managed in primary care.

✦ HRSA, SAMHSA and the CMS could jointly fund demonstration projects to improve collaboration between separately operating physical health and mental health providers, evaluate them and replicate successful projects.

✦ SAMHSA and HRSA could jointly fund provider training programs on collaboration and on developing expertise for behavioral health and primary care providers.

The federal government could also play an important role in providing resources to improve infrastructure of provider organizations and systems. Federal grants should be available for physical and behavioral health care providers and states to update their data systems and create integrated electronic systems capable of handling physical health and behavioral health information.

Existing federal training programs could also encourage integration of services:

✦ The Public Health Service could provide loan forgiveness for providers who work in integrated arrangements in community health centers or community mental health centers.

✦ CMS could devote a percentage of Graduate Medical Education funds for unmet public health need related to integration of behavioral health and physical heath.

✦ A nursing reinvestment program might support the concept of Graduate Medical Education payments for nurses who work in integrated programs.
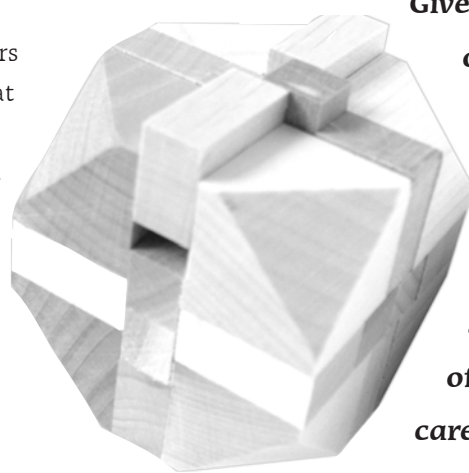
Given the importance of Medicaid funding for services to this population, federal Medicaid policy needs to be supportive of integrated care delivery.

CONCLUSION

Integration of physical and behavioral health care for individuals with serious mental disorders is a priority concern of the Bazelon Center. Until now, discussions of integration have tended to focus on the need for behavioral health support within primary care practices, principally to address mild or moderate mental disorders such as depression. Very little has been written about how to integrate care for people with serious mental disorders.

Any recovery-oriented system must develop a consumer-driven vision of integrated care. Therefore, regardless of the specific approach considered, it is extremely important to engage consumers, families and other advocates in the development of these new policies.

The site visits conducted for this report are encouraging. They indicate that embedding primary care within, or unifying it with, a mental health program is by far the best approach for individuals using public mental health services. As this report shows, once primary care and behavioral health providers are working in close proximity, thorny problems of communication and cultural differences disappear and extensive policy micro-management is unnecessary.

Given Medicaid's historically low payment rate, special grants or additional financial incentives may be needed to initiate change. However, in the long term the integrated approach is likely to result in far more efficient use of both physical health and behavioral health resources.

Creating integration requires multiple changes in all elements of the health care system — academic training centers, provider offices, health plans, public purchasers, all relevant state agencies and consumers. Both state and local governments as well as the federal government have several key areas of policy change to pursue. Medicaid agencies and mental health, substance abuse and health departments need to be engaged in the effort.

It is time for policymakers to decide how people with serious mental disorders fit into a unified health care system that offers parity between health and mental health care. Integration of primary care and mental health services holds the promise of creating a true wellness- and recovery-focused system for adults and children with serious mental disorders and of moving behavioral health care delivery closer to mainstream health care. The case studies conducted for this report and the experiences of those who attended the meeting of experts confirm that where there is a will, there are many ways to approach this problem—and with significant possibility of success.

Models exist. What is needed now is the political will to get it together and action to make the necessary changes.

Integration of primary care and mental health services holds the promise of creating a true wellness- and recovery-focused system for adults and children with serious mental disorders and of moving behavioral health care delivery closer to mainstream health care.
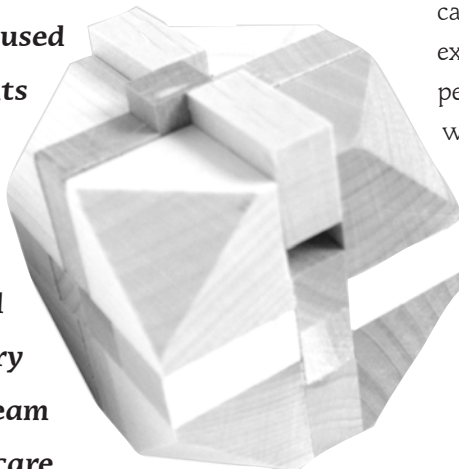
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Models exist. What is needed now is the political will to get it together and the action to make the necessary changes.